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COMMUNITY ORIENTED POLICING SERVICES
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Combat Deployment and the Returning Police Officer

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The Internet references cited in this publication were valid as of the date of this publication. Given that URLs and web sites are in constant flux, neither the author nor the COPS Office can vouch for their current validity.



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Dear Colleagues:

In recent years, police officers from all over the country have been called up to serve in the Military Reserve and National Guard because their units were activated in the defense of our nation. Some officers have found themselves engaging in direct combat and experiencing the effects associated with combat. For others, the impact of deployment can, on its own, result in significant hardships. Lifestyle changes, family disruptions, increased anxiety, stress, and other outcomes can present challenges for officers returning to the workplace. Accordingly, many police agencies are faced with the tasks of preparing for the officers' return and helping them transition back into the agency and into their role as a police officer in the community.

This report, *Combat Deployment and the Returning Police Officer*, reviews the issues concerning the reintegration of police officers who have been deployed in combat zones. Included are discussions of the psychological effects of combat deployment and methods used by police agencies to support a successful transition back to work. The report reviews strategies being used by four police departments to assist returning officers and their families, and offers recommendations for further study.

The Office of Community Oriented Policing Services is proud to fund this project that addresses a topic of great import to law enforcement. We are grateful to all of those in the field who have dedicated themselves to supporting officers returning from deployment, and the Institute for Law and Justice for researching this important issue and compiling this report. And, most important, we are grateful to the men and women of law enforcement who answered the call to serve their nation during war with the same commitment that they apply as police officers in the service of our communities.

Sincerely,

Carl R. Peed, Director
The COPS Office



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1. More than 101,000 Guard and Reserve personnel were reported as mobilized in May 2006 compared to approximately 98,500 in October 2006. The total includes Guard and Reserve personnel from all branches of military service; about 80 percent are Army National Guard and Army Reserves. Updates are published regularly in U.S. Department of Defense press releases published at www.defenselink.mil/releases.
2. Paul Reickhoff, founder and executive director, Iraq and Afghanistan Veterans of America, “Penguin Podcast 10: Paul Reickhoff on the Iraq War,” <http://us.penguingroup.com/static/html/podcast/archive.html>.
3. Although the focus of this report is on combat stress, PTSD can also result from such life-threatening events as natural disasters, terrorist acts, serious accidents, and rape and other violent personal assaults.

Introduction

About 100,000 members of National Guard and Reserve units were on active duty in any given month in 2006¹, some serving in Iraq or Afghanistan for the second or third time. A portion of these men and women are police officers, with a recent report indicating that public safety professionals comprise 10 percent of National Guard and Reservists deployed to Iraq (Ritchie and Curran, 2006). In addition, future police recruits will include some of the military service members who are active in combat now. Some who conduct psychological screenings have identified this as a serious issue (Best, 2006).

What does this mean for police departments? As one Iraq war veteran explains, “Not everyone [returning from war] is damaged, but everyone is changed.”² In sponsoring this report, the Office of Community Oriented Policing Services (the COPS Office) wanted to better understand how police officers’ lives are changed by their combat experiences, and to explore police departments’ efforts to help their members make successful transitions back to work.

Overall, people who experience or witness combat show an incredible capacity to move on with their lives after their return home. The danger lies in acting as if this will happen automatically. Almost 35 percent of U. S. military personnel who serve in Iraq seek help for mental health concerns through military programs (Hoge et al., 2006). Some are diagnosed with Post Traumatic Stress Disorder (PTSD)—essentially, a disorder of physical and emotional arousal brought on by the experience of traumatic events.³

Combat zone deployment does not always mean engaging in direct combat or witnessing others being killed or injured, experiences that greatly increase the risk for developing PTSD. Exposure to traumatic events is possible regardless of the military unit’s assignment in Iraq or Afghanistan; and depression, substance abuse, anxiety, and sleep disorders are also problems for some who have served there.

In addition to service members who request or are referred to military resources for assistance with PTSD or other mental health concerns, unknown numbers of others have problems but do not seek help, or turn



to private service providers not affiliated with the military health care system.⁴ Some will not need or will not ask for professional help until years after their return, with recent research showing the likelihood of delays in the development of symptoms (Grieger et al., 2006). Although much remains to be learned about the effects of combat zone deployment on police officers specifically, clearly some officers and their families will need professional services to deal successfully with the changes in their lives, and all will need some form of support, including support from the workplace.

4. For example, see “Stressed-Out Soldiers: Men at One Base Say the Army Is Ignoring PTSD Cases,” CBS Evening News, July 12, 2006. www.cbsnews.com/stories/2006/07/12/eveningnews/main1798343.shtml.



Project Background

5. See, for example, “PTSD Combat: Winning the War Within,” a blog edited by Ilona Meagher at www.ptsdcombat.blogspot.com. Also see the “PTSD Timeline,” a database of reported OEF/OIF combat

posttraumatic stress-related incidents, developed by Meagher and other members of ePluribus Media™ at <http://timelines.epluribusmedia.net>.

6. One news article that discusses police specifically is P. McGreevy, “After Duty in Iraq, They’re Back on the Beat,” *Los Angeles Times*, December 31, 2006, B1, available for purchase from the *Los Angeles Times* archives, <http://pqasb.pqarchiver.com/latimes/advancedsearch.html>.

7. The study did not specifically address law enforcement officers’ combat zone service in capacities other than as National Guard and Reserve members—for example, police officers who take extended leaves of absence or resign to train policing counterparts in combat environments, or federal law enforcement personnel who conduct criminal investigations within combat zones. Future research projects should consider exploring these groups’ needs and the resources available to assist them.

The Institute for Law and Justice (ILJ) conducted an exploratory study for the COPS Office to address two questions: (1) What are police agencies doing to help their officers make successful transitions from combat zones to their work, families, and communities? (2) What more should be done to assist in this effort?

The study was launched during a period of heightened public awareness of PTSD and other mental health concerns among military personnel and veterans. New research reports were published regularly on combat stress and PTSD among those who have served in Iraq and Afghanistan. Major media outlets drew attention to these reports and to unmet needs for mental health care. In addition, veterans’ organizations, alternative media, and blogs dedicated to PTSD and combat⁵ kept these issues before the public. Much less attention, however, had been paid to the effects of combat stress on police officers or police organizations.⁶

The ILJ project involved reviewing literature from multiple disciplines; identifying resources that address PTSD related to combat and natural disasters; and conducting interviews with 30 police managers (primarily at large agencies) and other service providers. The police representatives interviewed were a mix of human resources directors and managers, behavioral services personnel, and sworn police managers. They were asked about the number of police personnel who had been called to active duty; effects of combat zone deployment on returning police officers and the department; new personnel policies or programs developed specifically to address returning officers’ needs; and ideas for what else the department or other agencies might do in this area.⁷ In addition, eight reviewers (psychologists and policing practitioners) provided written comments on drafts of this



report⁸ and contributed information and recommendations that were invaluable for improving the final product. These and other individual perspectives obtained during the study were extremely helpful, although much more extensive research is needed before conclusions can be drawn about the effects of combat zone deployment specifically on police officers and police agencies.

Similarly, because of the study's limited scope, the extent to which police departments nationwide are providing specialized services for returning officers is still unknown. The study, however, did identify a number of programs and policies that police agencies have implemented to address the needs of police officers who have served in combat zones. These represent a core set of practices for other departments to consider in improving services for their own officers and their family members (see "Law Enforcement Agency Responses").

Finally, this study's focus was on PTSD and other combat-related mental health concerns; it did not explore in depth the effects of physical injuries on returning police officers or police recruits. Traumatic brain injury, for example, has been described as a "signature wound"⁹ of the conflicts in Iraq and Afghanistan. Recent research by the Department of Defense (DOD) and the Department of Veterans Affairs (VA) has been exploring the potential long-term consequences of concussions caused by blasts from bombs and other explosive devices.¹⁰ This topic deserves greater attention in future research on police officers and applicants who have served in combat zones.

8. Drafts of this report were reviewed by four experts in police psychology and four reviewers retained by the COPS Office to provide additional perspectives.

9. See Veterans for America, *Trends in Treatment of America's Wounded Warriors: Psychological Traumas and Traumatic Brain Injuries: The Signature Wounds of Operation Iraqi Freedom and Operation Enduring Freedom*, November 6, 2007, www.veteransforamerica.org/2007/11/trends-in-treatment-of-americas-wounded-warriors. Also see Thompson, Mark, "Dying Under the Army's Care," *Time*, February 14, 2008, www.time.com/time/printout/0,8816,1713485,00.html.

10. For example, see C. Hoge et al., "Mild Traumatic Brain Injury in Soldiers Returning from Iraq," *New England Journal of Medicine*, January 31, 2008.



11. Babwin, D. "Vets Get Help for Post-Traumatic Stress Syndrome," Associated Press, April 10, 2006.

12. See "National Center for PTSD Fact Sheet: What Is Posttraumatic Stress Disorder (PTSD)?" www.ncptsd.va.gov/ncmain/ncdocs/factsheets/fs_what_is_ptsd.html.

13. The *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, categorizes mental disorders and guides U. S. mental health professionals in making diagnoses. See www.psych.org/MainMenu/Research/DSMIV.aspx.

14. Bentley, Steve, "A Short History of PTSD: From Thermopylae to Hue Soldiers Have Always Had a Disturbing Reaction to War," 1991. Reprinted in *The VVA Veteran*, Vietnam Veterans of America, March 2005, p. 1. www.archive.vva.org/TheVeteran/2005_03/feature_HistoryPTSD.htm. Bentley served two tours of duty in Vietnam and later worked as a Vet Center counselor.

15. Also see "The Soldier's Heart," Public Broadcasting Service, March 2005. This documentary and a transcript are available for viewing at www.pbs.org/wgbh/pages/frontline/shows/heart.

Psychological Effects of Combat and Natural Disasters

*Back home, a veteran "drives as close to the middle of the road as he can. Over on the side, in a plastic bag or stuffed in the carcass of a dead dog, that's where he knows the enemy intent on killing him hides bombs. . . . [He] left Iraq more than 16 months ago. . . ."*¹¹

Within the first few days after exposure to a life-threatening event, it is common for people to experience nightmares, flashbacks, insomnia, feelings of detachment or emotional numbness, and a range of other reactions—both physical and emotional—that may interfere with their ability to function as before. This initial set of reactions is not the same as PTSD, which is a medically recognized anxiety disorder that may be diagnosed about a month or later after the trauma.¹²

PTSD and Other Consequences of Service in Combat Zones

It was not until 1980, several years after the Vietnam War, that PTSD was first included in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM).¹³ But as Vietnam veteran Steve Bentley explains, "PTSD is a new name for an old story—war has always had a severe psychological impact on people in immediate and lasting ways."¹⁴ Bentley's article on the history of PTSD drives this point home, beginning with an Egyptian warrior who described how he felt when facing battle 3,000 years ago: "Shuddering seizes you, the hair on your head stands on end, your soul lies in your hand."

People have given the psychological effects of war many labels, including "soldier's heart" in the American Civil War; "shell shock" in World War I, which some attributed to concussions resulting from exploding shells; and "battle fatigue" in World War II.¹⁵ Currently, making



a formal diagnosis of PTSD involves assessing three clusters of symptoms and behaviors:

- **Intrusion**, in the form of intrusive thoughts, nightmares, or flashbacks, “when sudden, vivid memories, accompanied by painful emotions, take over the person’s attention.”¹⁶ The person may feel like he or she is actually reliving the traumatic experience.
- **Avoidance** of close emotional relationships with family, friends, and colleagues and of activities and situations that remind the person of the traumatic event. Also included in this category is the inability to feel or express emotions at all; depression; and feelings of guilt over having survived while others did not.
- **Hyperarousal**, which includes being easily startled and constantly feeling that danger is near. Other reactions in this category include anger and irritability, loss of concentration, and disturbed sleep.

Flashbacks and startle reactions can be prompted by the sound of gunshots or a truck backfiring, or by any of the sights, sounds, smells, and tastes that an individual closely associates with a particular traumatic event. As in the example above, returned Iraq veterans often mention the sight of objects lying by the roadside. The smell of wet drywall became unbearable for one first responder who pulled bodies from the Pentagon following the September 11 terrorist attacks.¹⁷

Although PTSD may develop soon after a traumatic experience, it may not occur, or may not be reported, until months or years later (Grieger et al., 2006; Price, 2006; Hoge, 2006). Effective treatments are available, but left untreated, PTSD may take on a chronic course, waxing and waning throughout the person’s lifetime. Findings from the National Vietnam Veterans Readjustment Study indicated that nearly one-half million Vietnam veterans—15 percent of the men and 8 percent of the women who served—suffered from PTSD 15 or more years later (Price, 2006).

Research related to PTSD has been extensive during the past 25 years; for example, Tolin and Foa (2006) identified 2,477 articles on PTSD (i.e., books, book chapters, and journal articles) published in English between 1980 and 2005. Recent research, much of which has been conducted with police officers, includes

16. American Psychiatric Association, *Let’s Talk*

Facts About Post Traumatic Stress Disorder. 2005. www.healthyinds.org.

17. Jenkins, C. L. “For Lifesavers, Stress of Rescue Still Hits Home,” *The Washington Post*, Alexandria Arlington Extra, September 5, 2002, 9–10.



18. Prospective studies look for outcomes that occur during the study period (e.g., development of a disease).

In contrast, retrospective studies look backward to examine outcomes that were already known when the study began.

19. The term “survivor’s guilt” is sometimes used to describe feelings of guilt or shame associated with having survived a tragedy while others did not. It is not a psychiatric disorder, nor is it among the diagnostic criteria for PTSD.

studies of biological markers and symptoms associated with PTSD, as well as prospective studies¹⁸ of public safety professionals, which allow for an improved understanding of risk and resilience factors of PTSD development (Neylan et al., 2005; Otte et al., 2005; Pole et al., 2005).

In addition, diagnostic criteria for PTSD have changed since 1980. Originally, for example, PTSD was defined as a “normal response to an abnormal event,” but this was deleted from the *DSM-IV* (currently in use) because studies showed that most people experience at least one traumatic event during their lifetimes and a majority do not develop PTSD as a result (Kessler, 2000). The *DSM-IV* also introduced two additional diagnostic criteria: the related event must involve actual or threatened death or injury, and the person’s response must involve either “intense fear, helplessness, or horror” (APA, 1994; Tolin and Foa, 2006).

Other potentially long-term mental health consequences of exposure to traumatic events include major depression; substance abuse; and more generalized anxiety or overwhelming worry, panic attacks, and phobias (Hoge, et al., 2004; Najavits, 2002, Armstrong et al., 2006). While grief and “survivor’s guilt”¹⁹ are not clinical disorders, these feelings, if they persist, can portend a serious depression and may indicate a need for professional help (Sherman, 2006; Gray et al., 2004). Family disruption and financial problems are also stress factors that may place an individual at risk for developing psychiatric postrauma disorders (Hobfall et al., 1991; Bray et al., 2006).

A further complication of wartime trauma involves soldiers being both victims of trauma and agents trained to inflict trauma on others (Elhai, North, and Frueh, 2005). The latter is critical for those returning to police work because a need to control others’ behavior goes beyond their wartime experience and, in effect, is a feature of their jobs. This has implications for police departments in monitoring complaints and use-of-force rates among returning reservists.



Prevalence of PTSD

In 2004, the *New England Journal of Medicine* published a groundbreaking study that examined the mental health of soldiers and Marines involved in combat operations in Iraq and Afghanistan. This was “the first time there had been such an early assessment of the prevalence of psychiatric disorders, reported while the fighting continues” (Friedman, 2004). The researchers administered an anonymous survey to members of four combat infantry units either before their deployment or 3 to 4 months after their return. Outcomes included major depression, generalized anxiety, and PTSD. As Friedman (2004) observes, the study results “force us to acknowledge the psychiatric cost of sending young men and women to war.” Further, “perceptions of stigma²⁰ among those most in need” was identified as an important barrier to receiving mental health services” (Hoge et al., 2004).

A follow-up study published in the *Journal of the American Medical Association* examined help-seeking among soldiers and Marines (Hoge et al., 2006). Again, the results raised concern:

- The prevalence of reporting a mental health problem was 19.1 percent among service members returning from Iraq and 11.3 percent among those returning from Afghanistan.
- 35 percent of Iraq veterans accessed mental health services in the year after returning home; 12 percent were diagnosed with a mental health problem.
- Fewer than 10 percent of service members who received mental health services were referred through the DOD screening program (discussed later).

A report published in early 2005 by the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II), which is chartered by the U. S. Army Surgeon General, concluded that mental health and well-being showed improvements compared to an earlier assessment but that “[a]cute or posttraumatic stress symptoms remain the top MH [mental health] concern, affecting at least 10 percent of OIF-II Soldiers” (MHAT-II, 2005, 3).²¹

20. Stigma in this context refers to fears that disclosing a mental illness will result in negative consequences—for example, harm to one’s career or perceptions by supervisors, unit members, or others of being different or weak.

21. Another study of the health and mental health of military service members is the DOD-sponsored “Survey of Health Related Behaviors Among Active Duty Military Personnel.” Conducted nine times since 1980, the December 2006 survey report (based on 2005 data) provides detailed findings on substance abuse, stress, PTSD, help-seeking behaviors, and other concerns but did not report findings specific to service members in Iraq and Afghanistan (the sample involved more than 16,000 service members randomly selected from throughout the world).



22. Later, Harvard Medical School researchers found similar results after polling 1,043 adults between January 19 and March 31, 2006.

The researchers concluded that 31 percent suffered some type of mental illness (compared to 16 percent in a 2003 general population survey); and that 11 percent suffered a serious mental illness such as PTSD or depression. See Kessler, R. C., et al., “Mental Illness and Suicidality After Hurricane Katrina,” *Bulletin of the World Health Organization*, 2006. www.who.int/bulletin/volumes/84/10/06-033019.pdf.

pdf.

23. This assessment used the Center for Epidemiologic Studies Depression Scale and the VA checklist to identify symptoms of PTSD.

24. 888 of the police officers responded to questions about depression.

25. 494 of the firefighters responded to the questions about depression.

26. Knickmeyer, Ellen and Dlovan Brwari. “Deadly Deception at an Iraqi Market: ‘Attacker Posing as Vendor Kills 19 in City Called Model by Bush.’” *Washington Post Foreign Service*, May 10, 2006, A17.

Clearly, there are pronounced differences between serving in a combat zone and surviving other traumatic events, and it is difficult to compare results from studies of PTSD prevalence among survivors of different wars and survivors of other events involving mass casualties. Researchers have used diverse survey instruments and methods, and they have conducted the surveys within a variety of time frames (e.g., weeks or months after the event compared to years later). Nevertheless, the reported prevalence of PTSD symptoms and depression associated with Hurricane Katrina—among first responders as well as other survivors—appears to be similar to that reported among Iraq veterans. Hurricane Katrina hit the U. S. Gulf Coast in August 2005, and in mid-October 2005 the Centers for Disease Control and Prevention (CDC) conducted a survey of randomly selected adults returning to Orleans Parish and Jefferson Parish, Louisiana. The CDC determined that of the 166 respondents, 33 percent had a probable need for mental health assistance and 50 percent had a “possible” need for such assistance (Weisler, Barbee, and Townsend, 2006).²²

Seven to 13 weeks after Katrina, the CDC conducted another assessment, this time of New Orleans Police Department and Fire Department personnel.²³ Of the 912 police officers who completed the questionnaire, 19 percent reported PTSD symptoms and 26 percent reported major depressive symptoms.²⁴ Of the 525 firefighters who completed the same questionnaire, 22 percent reported PTSD symptoms and 27 percent reported major depressive symptoms (Weisler, Barbee, and Townsend, 2006).²⁵

Nature and Duration of Exposure

“BAGHDAD, May 9 – Attracting a crowd by hawking flour at half-price from a pickup truck, a suicide attacker in the northern city of Tall Afar on Tuesday detonated bombs hidden beneath the flour sacks, killing at least 19 people, many of them women shopping with children, police said.”²⁶

The nature of a person’s exposure to war is one of the critical determinants of combat stress and PTSD (Schlenger et al., 1999). Exposure to casualties and the types of casualties to which a person is exposed—particularly dead and wounded civilians and soldiers—



have been linked to higher distress scores for symptoms of posttraumatic stress. The prevalence of PTSD symptoms among veterans of the 1991 Persian Gulf war, for example, (Kang et al., 2003; Southwick 1995; Alder et al., 1996) appears to be relatively low compared to findings about Iraq and Afghanistan veterans, Hurricane Katrina responders, or survivors of the genocide in Rwanda in 1994 (24.8 percent, according to a recent study [Pham et al., 2004]). Clearly, exposure to the death and injury of children is difficult under any circumstances and a potential risk factor for PTSD.

Historically, personnel deployed to Iraq have exhibited significantly higher rates of PTSD than those deployed to Afghanistan, a difference that has been linked to trauma exposure and strongly associated with intense and prolonged combat (Hoge, 2004; GAO, 2006). In addition, deployment length and multiple deployments place military personnel at significantly higher risks for developing mental health problems (MHAT-V, 2008). Many service personnel in Iraq and Afghanistan have little respite from daily exposure to death and life-threatening events, and many serve several tours of duty or must stay longer than expected.

For first responders to catastrophes like Hurricane Katrina and the September 11 attacks, the intensity and duration of exposure to trauma are factors, as well. Casualties may include family members, friends, and coworkers. Responders may work long hours for weeks or months afterward, at the same time dealing with the disaster's personal impact on their own life circumstances.

Both the military and law enforcement stand to gain from future research on reducing the risk of PTSD and other long-lasting psychological problems associated with traumatic experiences, keeping in mind both the differences and similarities between exposure to trauma in combat zones and in other environments with multiple casualties. For example, what lessons can be applied from research on resilience and on specific protective factors, such as training, personality type, age, gender, prior traumatic experiences, and other possible factors, singularly and in combination?



Important messages for police agencies based on what we do know are that (1) we cannot predict with certainty who will develop PTSD or other potentially long-term mental health problems, and (2) assumptions that those things happen only to weaklings have no basis in fact. We do have some knowledge of protective factors, but it is not safe to assume that police officers in National Guard or Reserve units will be spared by virtue of their age or maturity alone (MHAT-II, 2005). Not every memory of a crisis is painful, and not every painful memory is debilitating, but PTSD can affect anyone experiencing traumatic events.



27. For an overview of the Army's Combat and Operational Stress program, see "Army Behavioral Health: Combat and Operational Stress General Information," www.behavioralhealth.army.mil/provider/general.html#cosr. For more specific information about front-line interventions, see "Army Behavioral Health: Traumatic Event Management," www.behavioralhealth.army.mil/provider/traumatic.html.

Intervention and Treatment

Efforts to reduce the risk of PTSD related to combat and disasters are grouped into three categories: (1) primary prevention—the selection, preparation, and training of people who are likely to be exposed to traumatizing events; (2) secondary prevention—a number of techniques that are offered immediately or shortly after such events; and (3) tertiary interventions, which include various treatments for PTSD (Deahl et al., 2000).

Military Interventions, Screening Processes, and Treatment Resources

The DOD's combat stress control program includes components for training service members on early signs and symptoms of combat stress. DOD teams of mental health professionals also travel to units to reinforce this information and help identify persons at risk. According to the Army's MHAT-II in January 2005, two-thirds of soldiers in Iraq "reported receiving training in handling the stresses of deployment and/or combat," although only 41 percent said this training was adequate (MHAT-II, 2005, 4).

To provide immediate interventions after trauma, the military has increased the number of behavioral health professionals deployed to the front lines, although shortages of these personnel, difficulty reaching soldiers, and burnout among behavioral health personnel are significant obstacles (MHAT-V, 2008). The philosophy of Proximity, Immediacy, and Expectancy (PIE) has long driven the provision of front-line interventions in the military. Essentially this involves treating distressed soldiers close to the battlefield (proximity), as soon as possible (immediacy), and with the expectation that they will return to duty (expectancy).²⁷

Postdeployment, the DOD uses a "postdeployment health assessment questionnaire," followed by an interview, to identify both physical and mental health problems. In practice, however, the required postdeployment interview process varies from base to base and may be done in a group setting led by a chaplain or senior officer, rather than a one-on-one interview.



The DOD postdeployment questionnaire includes this screening question for PTSD:

Have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you

- have had any nightmares about it or thought about it when you did not want to?
- tried hard not to think about it or went out of your way to avoid situations that remind you of it?
- were constantly on guard, watchful, or easily startled?
- felt numb or detached from others, activities, or your surroundings?²⁸

Other postdeployment identification efforts are needed for several reasons. First, problems may not emerge until much later (Grieger et al., 2006), indicating a role for employers in identifying signs of PTSD and other mental health issues. Second, the DOD postdeployment questionnaire is a brief self-report. Service members may believe that checking “yes” to PTSD symptoms (or any other item related to mental health) will have negative consequences, or they may be unwilling to risk retention at the base while others leave to reunite with loved ones.²⁹ Third, responses on the screening questionnaire indicating PTSD symptoms may not result in referrals for additional assessments; or service members may not follow up on referrals. Among service members back from Iraq who reported either three or four PTSD symptoms on the screening questionnaire, only 23 percent of soldiers and 15 percent of Marines received referrals for further mental health evaluations (GAO, 2006). Further, 50 percent of those referred were not found to have sought treatment within the first year of their referral (Hoge et al., 2006).

The DOD has recognized these issues and has begun to address them. Current policy is to conduct a second post-deployment screening for health and mental health concerns after 90 days but no later than 180 days (Guard and Reserve members may still be eligible for military health and mental health benefits for up to 180 days post deployment). All service members who complete the first post-deployment screening form—not just those who identified concerns at that time—are asked to participate in the second screening.³⁰ Even with this additional screening process, however, employers cannot be certain

28. Question # 12, DOD Post-Deployment Health Assessment (Form DD 2796).
29. Also see the section in this report on “barriers to treatment.”
30. DD Form 2900 is completed for the second screening. For a description of this new Post-Deployment Health Reassessment (PDHRA) Program, see www.pdhealth.mil/dcs/pdhra.asp.



31. See the GAO report noted under “Resources and References” for a summary of DOD and VA mental health evaluation and treatment resources.

32. See “Choosing a therapist,” in the National Center for PTSD Fact Sheet, Finding a Therapist, available at www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_finding_a_therapist.html#choosing.

33. For a brief explanation, see “Exposure Therapy Helps PTSD Victims Overcome Trauma’s Debilitating Effects,” American Psychological Association, www.psychologymatters.org/keane.html.

34. Latin for “in life.”

that all issues will have been identified and addressed through military channels because, again, individuals may be reluctant to report a problem, or problems may not emerge until a later date.

All branches of the U.S. military, as well as the VA and its National Center for PTSD, have been developing additional resources to treat PTSD and other mental health concerns. Through the military health care system, service members can receive mental health evaluations and treatment for PTSD while on active duty and for specific periods after discharge or release from active duty. The VA also provides mental health benefits to veterans through more than 200 Vet Centers, and through its hospitals and clinics. At the Vet Centers, multidisciplinary staff teams include many professionals who are also combat veterans. In addition to counseling and referrals for mental health services, Vet Center services include help with applications for benefits and with troubleshooting related to eligibility issues, paperwork delays, and other concerns.³¹

Treatment Approaches

Effective treatment for PTSD is available, but approaches and programs are not all alike. It may take some time for an individual to find the right fit. The National Center for PTSD offers a short list of questions that those seeking mental health care should ask of a potential therapist (e.g., treatment approaches, provider qualifications and experience, fees).³²

The type of intervention proven most effective for treating PTSD is cognitive behavioral, exposure-based therapy (Foa et al., 2004). “Prolonged imaginal exposure” carefully exposes the individual to “prolonged and repeated imagined images of the trauma until the images no longer cause severe anxiety,”³³ while “in vivo”³⁴ interventions expose the individual to situations or objects they avoid or fear because of their association with the trauma (for example, highway underpasses, which some Iraq veterans may avoid because they remind them of times when they were under sniper attack). The exposure treatments are combined with other cognitive behavioral approaches that focus on learning



to change patterns of thinking about the traumatic event and the person's relationship to it. These approaches may be combined with others, such as eye movement desensitization and reprocessing; teaching coping skills such as relaxation techniques, anger management, and sleep hygiene; traumatic grief treatment; and prescribing medications, such as antidepressants (Ruzek, 2001).

Researchers continue to explore other approaches to PTSD treatment, as well as new means to deliver treatment services. The field of telemedicine, for example, may hold promise as a service delivery option, although more needs to be learned about the effectiveness of "telemental health services" for assessing and treating PTSD. As the National Center for PTSD explains, the term refers to "behavioral health services that are provided using communication technology;" and include clinical assessments, individual therapy, group therapy (e.g., via videoconferencing), and other interventions that may benefit those who are isolated from in-person services (Morland et al., 2003).³⁵ Another example is research on the role of adrenaline in PTSD, which may offer hope for new medications that permit more timely interventions.³⁶

Police administrators and managers, while not expected to become mental health treatment or research experts, need some familiarity with research results on effective interventions and treatment. "Psychological debriefings" or "stress debriefings," for example, although used by some military and civilian mental health workers, have not been proven effective in reducing the risk of PTSD, depression, or anxiety and, for some individuals, may be harmful.³⁷ Another example is peer support programs, including law enforcement programs and "vets helping vets" programs developed by veterans' organizations. These programs may be a resource for some police officers returning from combat zones; however, they are not a form of treatment and should follow strict guidelines.³⁸ None of these findings suggest that persons distressed by traumatic events should be left alone; rather, they suggest that police administrators need to consult with mental health experts to stay current about effective interventions and treatment methods. A resource for police is the International Association of Chiefs of Police (IACP) Psychological Services Section, which has offered presentations at recent IACP annual conferences on police officers' return from combat zones (Ritchie and Curran, 2006; Best, 2006).

35. Also see "Virtual Training's No Game," a public radio program aired November 23, 2006, that discusses adapting video gaming software, including "America's Army," as part of critical incident management training, including stress management (http://marketplace.publicradio.org/shows/display/web/2006/11/23/virtual_trainings_no_game).

36. See CBS News, "A Pill to Forget? Can a Medication Suppress Traumatic Memories?" November 26, 2006, www.cbsnews.com.

37. The value of various forms of stress debriefings is still debated; however, the VA's National Center for PTSD has concluded that psychological debriefing is "inappropriate for acutely bereaved individuals" and cautions: "... the best studies suggest that for **individuals with more severe exposure to trauma, and for those who are experiencing more severe reactions such as PTSD, [stress] debriefing is ineffective and possibly harmful.**" [emphasis in original]. See National Center for PTSD Fact Sheet: "Types of debriefing following disasters," www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_type_debriefings_disaster.html.

38. See the IACP Psychological Services Section's 2006 "Peer Support Guidelines," www.theiacp.org/div_sec_com/sections/PeerSupportGuidelines.pdf.



39. For example, see the National Public Radio report by Daniel Zwerdling, “Soldiers Say Army Ignores, Punishes Mental Anguish,” www.npr.org/templates/story/story.php?storyId=6576505.

40. Called *Combat Stress Reactions: Normal Responses to Abnormal Conditions*, it is has segments geared to Marines and Navy service members, their families, and command staff.

Military and Police Cultures

Nancy Sherman, author of *Stoic Warriors* (2005), refers to “a culture of suck it up” (Sherman, 2006) when discussing military organizations’ historical reluctance to admit that their members may need help coping with the ravages of war. Police agencies and officers, steeped in paramilitary traditions, also have a vested interest in being perceived as always in control—able to withstand trauma by sheer will and get on with the job. Beyond providing for a short break from extremely stressful duties—what the military calls “three hots and a cot”—organizational resources for maintaining mental health and dealing with stress have been slow to evolve in both the military and in policing.

Barriers to PTSD recognition and treatment for military service members and veterans are often reported in the news and, in some cases, are being investigated. They include instances of supervisors ridiculing officers with PTSD or refusing to release them from drills for appointments; and allegations that some officers with PTSD, including those who served with distinction in combat zones, are purposely being discharged on less than honorable grounds—for example, for a pattern of misconduct.³⁹ In addition, there are concerns that officers with extreme combat stress or PTSD are being kept on duty in combat zones because of a shortage of personnel.

At the same time, the military and the VA have acknowledged and made efforts to address the stigma that many service members associate with seeking help for mental health concerns. One example is a video CD developed by the Navy⁴⁰ that directly addresses some of the most difficult barriers: fears that difficulties in coping are, or will be viewed as, weakness and will be ridiculed; or that prospects for a promotion, a security clearance, or an entire career will be sacrificed because of asking for help. Materials and outreach efforts by other branches of the military also seek to convey the message that combat stress is normal and that effective treatments for PTSD are available if needed. Some of the materials are geared to the particular needs of reservists in Iraq, some target their civilian employers, and other outreach efforts target military families.

A reluctance to seek help for mental health concerns has also been prevalent among police (Delprino, 2002). Over the years, however, many police agencies have



come to recognize a need for mental health resources, as evidenced by the psychological or behavioral services units in some departments; and by the growth of city, county, and police department employee assistance programs and police peer support teams in the 1990s (Finn, 2000).

Employee assistance and behavioral services programs also have been a cornerstone of police organizations' efforts to assist their officers when they return from combat zones. The next section of this report illustrates a range of department responses to assist returning police officers and their families. In addition, some law enforcement agencies have developed related training. A partnership in Wisconsin of the Dane County Sheriff's Department, Madison Police Department, and the state's Department of Veterans Affairs resulted in a new, required 1-hour training session for all enforcement officials. Its purpose is to heighten police officers' awareness of veterans' experiences in combat zones, whether the veterans are police officers, their family members, or citizens who come to police attention.⁴¹ In Holyoke, Massachusetts, veterans' advocates, mental health experts, and prosecutors held a training program for police, dispatchers, and other emergency workers, in part to help police identify troubled veterans in the community and refer them to appropriate services.⁴²

41. Jones, M. "Police Learn to Help Vets with Cultural Shift: Home Front Presents New Battle," April 15, 2007, *Milwaukee Journal Sentinel/JS Online*. www.jsonline.com/story/index.aspx?id=591503.

42. Reitz, Stephanie, "1st Responders Trained to Spot 'Troubled Vets,'" Associated Press, February 4, 2008. www.armytimes.com/news/2008/02/ap_troubledvets_080202.



43. Discussion at “PTSD: The Newest Community Issue, A Roundtable Discussion for Service Providers,” Washington, D.C., March 23, 2005.

Law Enforcement Agency Responses

One limitation of this report is that it leaves many important questions unanswered about the nature and extent of specific problems that returning police officers are experiencing. The study was too small to survey police officers who have returned from combat zones, and most of the agency representatives who were interviewed on the telephone provided only general observations. For example, one said that some officers had difficulty transitioning from the “go-go-go mindset” of active duty to the slower pace of in-service training or routine police duties. Another said “signs of stress” had been reported regarding a few officers. Several emphasized the importance of outreach to deployed police officers’ families, while others suggested that equal or greater attention be paid to potential problems among combat veterans who apply for police work. Similarly, psychologists who reviewed a draft of this report expressed concerns about the adequacy of current psychological screening instruments for identifying unresolved, combat-related mental health issues among police recruits. Finally, several interview participants emphasized the importance of recognizing the benefits that military veterans can bring to policing, such as leadership skills, teamwork experiences, and weapons training.

The study did find a wide range of police department responses to officers returning from combat zones. In some departments, officers simply go back to work. As one police officer and SWAT team member explained, his return from combat to law enforcement was essentially a matter of “here’s your gun back,” no questions asked.⁴³ Other departments required some type of reorientation, training, and/or a conversation about the availability of personal and family assistance. They required, for example, firearms retraining and recertification, and a meeting with a supervisor (but not with a professional mental health or family services counselor). At various departments, the supervisor brought the officer up to date on policies and procedures that had changed and/or reminded the officer that personal and family resources were available if needed, such as through the department’s (or a city/county) employee assistance program, psychological or behavioral services unit, or a peer assistance team.



In other departments, the screening and intervention process for mental health or family concerns is more deliberate and formal: officers returning from combat zones are required to meet with a mental health professional before resuming their duties. The police departments in Dallas, Louisville, Houston, Los Angeles, Kansas City (Missouri), New York City, and Chicago are among those with this requirement.

The New York City Police Department, which has approximately 40,000 members, reports that between September 11, 2001, and November 2005, approximately 800 officers were called up for Guard or Reserve duties. The department did not report developing any new policies related to these officers; however, they must meet the same requirements as officers who leave and return for other reasons. This includes a debriefing with a staff psychologist and a 2-week training course for firearms requalification.

Several departments also mentioned making concerted efforts to stay in touch with officers while they are on military duty. The Chicago Police Department, for example, reports that “the union helps a lot with keeping in contact” with police officers overseas, and the department includes their families as honored guests in special events such as holiday celebrations.

One police department member interviewed for this study said his own agency might do more simply by consulting with members who had been deployed (about 10 to 12 a year), asking them more specifically about their needs and concerns, and then determining whether there were commonalities that the department could address. Another much larger department with a retraining and assessment process in place suggested that “any department could always do more” but may have to work within budget constraints and draw on existing department services.

The Los Angeles Police and Sheriff’s Departments, the Kansas City Police Department, and the Richland County (South Carolina) Sheriff’s Department are among agencies that have implemented comprehensive, proactive approaches to address officers’ transitions from combat zones.



44. In October 2005, about 60 police officers were on leave for active duty, with 6 to 12 leaving or returning every pay period.

45. "The Department of Defense Honors the Los Angeles Police Department for Its Support of Employees Serving in National Guard and Reserves," Los Angeles Police Department. www.lapdonline.org/inside_the_lapd/content_basic_view/6578.

Los Angeles Police Department Military Liaison Program

The Los Angeles Police Department (LAPD) reported having about 500 officers who are reservists, about 200 of whom were called to active duty soon after September 11, 2001. The department's military liaison officer position was created during that period,⁴⁴ in part to handle the many inquiries from, and concerns of, deployed officers' families.

Assistance to families is still a significant part of the military liaison officer's job, but it has evolved to include assisting officers before, during, and after their deployment with any of their needs, including issues related to pay, promotions, and transfers. The chief of police and the organizational culture generally were described as very supportive of officers on military deployments, and commanders are encouraged to stay in contact with officers' families during that time. While officers are out, the LAPD provides pay differential and annual pay step advances, continues benefits, and provides accumulated annual vacation and tenure for the duration of their military service. Officers are still eligible for promotional consideration and can take promotional exams while on military leave.

As of February 2005, each officer returning from military duty is required to complete a confidential interview with Behavioral Sciences Services personnel, who provide resource materials and extend offers of individual or family assistance. Also within the past 2 years, the department developed a new reintegration program for officers separated from the department for more than 1 year for various reasons, including military service. Returning officers are assigned to the police academy for a month of retraining; receive both physical and mental health assessments; and undergo background checks.

In 2005, the LAPD was one of 15 employers nationwide to receive a Freedom Award from Employer Support of the Guard and Reserves (ESGR) (www.esgr.mil). ESGR is a DOD organization created in 1972 to promote cooperation between Reserve members and their civilian employers. One of the LAPD officers who helped nominate the department was a Marine Corps Reserve sergeant who had been injured in Iraq by an IED. He described the department and the military liaison officer as having given him "the utmost support."⁴⁵



Los Angeles Sheriff's Department Military Activation Committee

In September 2004, the Los Angeles Sheriff's Department (LASD) was also a winner of the ESGR Freedom Award for its military repatriation program. At the time of the award, 151 of the department's 365 military reservists had been called to active duty.

The Military Activation Committee (MAC) was created after the September 11, 2001 terrorist attacks to address the needs of employees who were military reservists called to active duty. A key goal of the MAC is to ensure that department members return to a welcoming environment.⁴⁶ Each key unit in the department has a military liaison officer.

While department members are on leave, the LASD continues benefits, makes up the difference between military and department pay, provides support to families, and keeps in touch with personnel deployed overseas. Returning department members are partnered with a mentor for 3 days, primarily to receive updates on policies, procedures, and job skills. They also meet with their unit commander and military liaison officer. In addition, the program includes a confidential, informational briefing by a psychologist, who offers counseling assistance to the returning officer and his or her family, with periodic follow-up.

A recent news article provides one example of LASD support. A new LASD deputy's Marine Reserve unit was called to Iraq after he had spent only a few days on the job. While overseas, he suffered a brain aneurism and was transported to Walter Reed Hospital in Bethesda, Maryland. The LASD raised enough money to allow several family members to visit him, and the sheriff called the officer personally to assure him he would have a job waiting for him when he returned.⁴⁷ Another example is a yard sale held in 2005 at the sheriff's training academy and at a retail parking lot. The sale raised nearly \$5,000, a portion of which was used to purchase equipment requested by the MAC—special holsters designed for drawing a sidearm while seated in a military vehicle and wearing body armor.⁴⁸

46. Tempest, R. "The Hidden Cost of Iraq War," *Los Angeles Times*, May 23, 2004.

47. "Local Hero." *Los Angeles Garment & Citizen*, February 23, 2006. <http://garmentandcitizen.com/category/archives/archived-local-hero-stories/2006-02-23-2.php>.

48. County of Los Angeles Sheriff's Department, "Year in Review 2005." www.lasd.org/sites/yir2005web/22text.htm.



Kansas City (Missouri) Police Department

In the past few years, about 35 to 50 Kansas City police officers have been called to Guard or Reserve duty in combat zones. A representative of the department's employee assistance program (EAP) explained that each officer participates in an interview with a critical incident psychologist upon returning to the department.

New within the past few years is a military support group made up of officers who have served in combat. In addition, other services—chaplains, peer counseling, psychological services, EAP—are available to employees and their families.

Police officers' families continue to receive insurance benefits while officers are deployed; upon their return, vacation time that officers may have missed is reinstated, and they have an opportunity to request time off. The EAP representative notes that the department is very supportive of the officers, and that if it could do more, she would like to see it make up lost pay.

Richland County (South Carolina) Sheriff's Department

The president of Post Trauma Resources, a firm that contracts with the Richland County Sheriff's Department (RCSD), reports that approximately 5 to 10 officers a year are called to active duty from the RCSD. The sheriff recognizes that their experiences could have some effect on their ability to do their jobs and wants to make sure that officers are ready to return to work.

Beginning in 2005, an RCSD policy made it mandatory for returning officers to meet with a Post Trauma Resources psychologist before returning to work. The psychologist does not do a full assessment but has a conversation with the returning officer to determine whether further assessments are needed and makes referrals to other services, if needed. Post Trauma Resources cautions against relying on military resources to meet the mental health needs of returning police officers. One reason is that members of the Guard or Reserves' eligibility to access these resources may run out before PTSD symptoms occur.



Conclusions and Recommendations

Brief Review of Findings and Issues

We do not know how many police officers have unresolved mental health concerns when they return to work from combat zones. We do not fully understand the ways in which police officers may be different from others who serve in combat zones—the extent to which their personal characteristics, training, experience, support systems, or age, for example, may serve as protective factors.

We do know, however, that police who have unresolved mental health concerns—whether or not those concerns are associated with their combat-related experiences—are at risk of harming themselves or others because of the nature of their jobs. Police officers' occupational tools include vehicles often driven at high speeds, and weapons. Police are governed by use-of-force policies that differ greatly from military Standing Rules for Use of Force and Rules of Engagement in the combat environment. Further, it is far more likely that police officers will be exposed to, or involved in, work-related trauma than will veterans who return to or enter many other occupations.

This study identified a wide range of police department responses to officers returning to work from combat zones. The proactive and comprehensive services that were found represent practices that other departments can consider.

The study also identified several issues that were not fully explored but may have important implications for police departments. One is the concern among some in law enforcement about recruits who have served in Iraq or Afghanistan. Many police departments are in a hiring crisis (Woska, 2006), unable to attract qualified applicants for unfilled positions. Is there more that departments can do to assist Iraq and Afghanistan veterans who apply for police work, for example, those who are well qualified but have minor, unresolved issues related to combat stress?

In addition, this report has not discussed the potential impact on police organizations of returning vets and potential hires who have physical limitations because of injuries sustained in Iraq or Afghanistan. If physical



injuries prevent a returning vet from performing previous job functions, what accommodations can be made? Can the department offer assignments that are equivalent to the predeployment work and level of responsibility, benefits, and promotional opportunities?

Before developing programs to assist returning police officers or veterans applying for police work, police departments should obtain legal advice from experts in employment law. Programs should be consistent with federal laws providing important protections for veterans, including the Uniformed Services Employment and Reemployment Rights Act (USERRA)⁴⁹ and Title I of the Americans with Disabilities Act (ADA).⁵⁰ USERRA prohibits employers (regardless of number of employees) from discriminating against applicants or employees based on military status or obligations, and it also provides reemployment rights for persons who leave civilian jobs for military service. The ADA prohibits employers with 15 or more employees from discriminating against individuals on the basis of disability. Both USERRA and the ADA require employers to make reasonable accommodations for individuals with disabilities, “however, USERRA requires employers to go further than the ADA by making reasonable efforts to assist a veteran who is returning to employment in becoming qualified for a job.”⁵¹ Although legal definitions of disability vary, veterans who were wounded or became ill while on active duty may meet both the definition of “disabled veteran” and the ADA’s definition of “individual with a disability.”⁵²

Finally, police departments may need to examine their procedures for handling certain misdemeanors involving veterans in the community and expand their referral sources to include specialized services for veterans.

Recommendations for Police Departments

Police departments should do more to create a “welcome-home” environment and serve police officer reservists who return to work from assignments in Iraq or Afghanistan, whether or not the department is large enough to have its own EAP or military liaison position. Many people are reluctant to ask for mental health

49. 38 U.S.C. §4301-4334. The USERRA statute is available from www.justice.gov/crt/military/statute.htm. USERRA is enforced by the U. S. Department of Labor, Veterans Employment and Training Service (VETS). See www.dol.gov/vets/programs/userra/main.htm. Also see VETS’ “USERRA Advisor,” www.dol.gov/elaws/userra.htm. Another resource for USERRA information is Employer Support of the Guard and Reserve (ESGR), a U. S. Department of Defense program, which provides assistance to employers and an extensive list of frequently asked questions at www.esgr.org/userrafaq.asp.

50. 42 U.S.C. §12111-12117. See www.eeoc.gov/policy/ada.html. The ADA is enforced by the U. S. Equal Employment Opportunity Commission. Section 501 of the Rehabilitation Act applies the ADA’s nondiscrimination and reasonable accommodation standards to federal agencies and the U. S. Postal Service.

51. U. S. Equal Employment Opportunity Commission, “Veterans with Service-Connected Disabilities and the Americans with Disabilities Act (ADA): A Guide for Employers,” 1, www.eeoc.gov/facts/veterans-disabilities-employers.html.

52. U. S. Equal Employment Opportunity Commission, 2.



services, and considerable time may pass before PTSD or other mental health concerns begin to interfere with work and daily life. Every department should consider the following questions:

- Is the department's organizational culture supportive of officers' transitions back to work after being in a combat zone or experiencing any type of traumatic event?
- Are supervisors and managers advocates of employee assistance programs and similar resources? Do they recognize that these resources can provide them with tools to be better managers?
- Have department supervisors and other members received sufficient education and training about traumatic stress?
- Is someone from the department or a department-affiliated volunteer organization staying in touch with department members and their families, while they are on military duty?
- Is a specific supervisor or officer, trained in issues related to combat stress, assigned to welcome returning officers, update them on training and procedures, and remind them of available sources of confidential assistance?
- Do supervisors and department members know what to watch for in others who have lived through traumatic events (e.g., heavy drinking, taking unnecessary risks, incivility in dealing with community members, warning signs associated with suicide risk)?

Individual police departments, at a minimum, can make sure that returning officers have information about confidential sources of help for themselves and their family members. We recommend that departments go well beyond the minimum.

- Police departments should have an experienced mental health professional conduct a confidential meeting with each officer returning from military duty. The purpose is to assess the individual's well-being and need for assistance, if any, including family support. This is not the same as a fitness for duty examination. Departments should obtain legal advice to ensure that the assessment does not violate USERRA or the ADA's employment provisions.



Family members should also be included in this process or should have a similar meeting with an experienced counselor, social worker, psychologist, or psychiatrist. Periodic follow-up should be done with veterans for the first 2 years after deployment.

- Depending on the size of the agency and number of returning officers affected, departments should consider implementing a special reintegration program for officers separated from the department for military tours of duty.

In addition to the initial and follow-up confidential meetings noted above, program components to consider include a review of police use-of-force policies, firearms and other recertifications, a means to make up missed in-service training, and physical health assessments. Again, departments should consult with their legal advisors in developing such a program to ensure that it does not violate USERRA or other employment laws. In addition, human resources experts, psychological services experts, and employee representatives (e.g., unions) should be consulted.

- Departments should develop partnerships with other state, county, and local agencies to share resources for the reintegration program, such as veterans' support groups, law enforcement peer support groups, employee assistance programs, or behavioral health services.
- Departments should raise supervisors' awareness of potential problems that returning officers may face and train supervisors in early identification and in appropriate interventions.

Recommendations for Research and Policy Development

Police organizations should partner with the Department of Defense and the Department of Veterans Affairs and convene a special working group to develop additional recommendations. The group should identify specific areas of mutual concern in program development, training, and research. Potential funding for joint projects should be explored, and a plan for follow-up should be developed and implemented.



Partnerships among police organizations, agencies like the National Institute of Justice and IACP Psychological Services Section, as well as relevant associations of mental health professionals, the National Center for PTSD, and other organizations should be established to identify research priorities related to policing and combat zone duty, natural disasters, and other events with mass casualties. Research questions to consider include the following:

- What are the implications of military service in combat zones for the psychological screening of police recruits? What influence, if any, should the current shortage of applicants for police work have on the screening process?
- What do police officers who have served in combat zones identify as unmet needs? What do they believe their agencies might do to better assist them and their families? Confidential interviews or surveys should be conducted.
- What specific issues are police agencies facing related to police officers who return from combat zone deployments? More extensive research is needed to answer this question.
- What are the differences, if any, between the mental health needs and concerns of returning police officers and those of reservists returning to other occupations?
- Are police officers and other emergency responders at reduced risk, compared to reservists in other occupations, of PTSD and other combat-related mental health problems? Conversely, are police officer reservists at equal or greater risk for certain problems (for example, stress related to long periods of separation from their spouses, children, or jobs)?
- What protective factors are most important for reducing the risk of PTSD or for reducing the risk of other mental health problems associated with combat and disasters? How can this knowledge be translated into practical, effective police agency practices?
- Are police agencies nationwide implementing a broader range of proactive programs to assist returning officers than those identified in this study? Are the programs meeting their objectives? Can a matrix of best practices be developed?



Law enforcement officers are being deployed to war zones in significant numbers. In addition, law enforcement agencies have a long history of recruiting new police officers with military backgrounds and will continue to do so. While it is not clear how many current police officers are returning to work with unresolved combat-related problems, most will face stressful and potentially dangerous situations back on the job. At a minimum, they should be brought up to date about training and policies, and they and their families should be assured that confidential sources of help are available if needed upon their return or in the future. Our preliminary study indicated that while some departments are responding in special ways, many are not. Only a concerted effort among law enforcement, mental health, and veterans' organizations can have a significant impact on the safety of returning officers, their families, and their communities.



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Selected Resources

Professional Associations and Research Organizations

American Psychiatric Association (APA) (www.psych.org). Founded in 1884, the APA represents 36,000 psychiatrists and operates several web sites and subsidiaries. See www.healthyminds.org for fact sheets and other resources. Select “contact APA” from the HealthyMinds home page to learn more about other APA activities and information sources. Also see the association’s web page on disaster psychiatry at www.psych.org/Resources/DisasterPsychiatry.aspx.

Anxiety Disorders Association of America (www.adaa.org). A national, nonprofit organization solely dedicated to informing the public, health care professionals, and legislators about anxiety disorders, and to promoting their early diagnosis, treatment, and cure.

International Association of Chiefs of Police (IACP) Police Psychological Services Section. See www.theiacp.org/div_sec_com/sections/psych.htm. *Peer Support Guidelines* (2006). Available on www.theiacp.org/div_sec_com/sections/PeerSupportGuidelines.pdf. *Pre-Employment Psychological Evaluation Services Guidelines* (2004). Available on www.theiacp.org/div_sec_com/sections/Pre-employmentPsychologicalEvaluation.pdf.

International Critical Incident Stress Management Foundation. (www.icisf.org). A nonprofit foundation that provides education, training, and support services for all emergency services professions; training in emergency mental health services for psychologists and other professionals; and consultation in establishing crisis and disaster response programs for various organizations and communities worldwide.

International Society of Traumatic Stress Studies. (www.istss.org). Founded in 1985, the organization’s web site includes fact sheets and links to other resources on PTSD, terrorism and disasters, children and trauma, and related topics.



National Institute of Mental Health/Anxiety Disorders Education Program. For information and resources on anxiety disorders, including PTSD, see www.nimh.nih.gov/healthinformation/anxietymenu.cfm.

National Center for Post Traumatic Stress Disorder (PTSD). (www.ncptsd.org). Part of the Department of Veterans Affairs, the National Center for PTSD offers a wealth of resources, including fact sheets, articles, research reports, links to other information sources, and tips for accessing Veterans Affairs services.

Partnership for Workplace Mental Health. Sponsored by the American Psychiatric Foundation and its partners, this organization seeks to advance effective employer approaches to mental health. See www.workplacementalhealth.org for brochures on depression, anxiety, and other mental health concerns; and the partnership's quarterly publication, "Mental Health Works," which focuses on actions that employers are taking and research related to mental health and the workplace.

Posttraumatic Stress Disorder Alliance (www.ptsdalliance.org). The group's purpose is to provide "educational resources to individuals diagnosed with PTSD and their loved ones; those at risk for developing PTSD; and medical, health care and other frontline professionals." Alliance members are the International Society for Traumatic Stress Studies, Anxiety Disorders Association of America, Sidran Institute, and the American College of Obstetricians and Gynecologists.

Military and Veterans' Organizations

Mental Health Advisory Team (MHAT) Reports. The Office of the Surgeon General, United States Army Medical Command, issues periodic reports on mental health issues among military service members in Iraq and Afghanistan. The reports can be downloaded from www.armymedicine.army.mil.

Military One Source (www.militaryonesource.com/skins/MOS/home.aspx). A Department of Defense service that is provided at no cost to active duty, Guard, and Reserve service members (regardless of activation status) and their families. Includes counseling and information on a range of issues, including combat stress.



Iraq and Afghanistan Veterans of America (www.iava.org/index.php). Founded in 2004 to support Iraq and Afghanistan Veterans. See “For OEF/OIF Vets” (www.iava.org/index.php?option=com_content&task=view&id=16&Itemid=174) for information and resources related to PTSD and other concerns.

Vietnam Veterans of America (VVA) (www.vva.org). A nonprofit corporation founded in 1978, VVA is the only congressionally chartered, national Vietnam veterans’ organization. The VVA PTSD/Substance Abuse Committee page (<http://vva.org/Committees/PTSD/index.html>) includes links to other valuable resources on mental health and substance abuse among veterans; and the “VVA’s Guide to PTSD” (<http://vva.org/ptsd.html>) provides details on filing claims for benefits based on exposure to traumatic events resulting in PTSD.

Videos, Broadcast Media

The Ground Truth (2006). Patricia Foulkrod, Director/ Producer. The video features interviews with 13 soldiers and Marines who served in combat in Iraq and Afghanistan, and with the parents of one soldier who took his own life several months after his return. For more information and a brief synopsis of each person’s story, see www.thegroundtruth.net.

The Soldier’s Heart (2005). Public Broadcasting Service. The documentary and a transcript are available for viewing at www.pbs.org/wgbh/pages/frontline/shows/heart.

Combat Stress Reactions: Normal Responses to Abnormal Conditions. A video CD produced by the U. S. Navy Combat Stress program, narrated by Captain Jennifer Berg, M.D., with segments geared to service members, their families, and command personnel. Available for viewing on line at <http://deploymentlink.osd.mil/movies/videoPopUp.html>.

Battlemind. A training video developed by the Walter Reed Army Institute of Research-Psychiatry and Neuroscience. It can be viewed or downloaded at www.battlemind.org/#.

The War Tapes (2005). Filmed by National Guard unit members on the front lines in Iraq. See www.thewartapes.com/the_film/about.shtml.



FOR MORE INFORMATION

U.S. Department of Justice
Office of Community Oriented Policing Services
1100 Vermont Avenue, N.W.
Washington, DC 20530

To obtain details on COPS programs, call the
COPS Office Response Center at 800.421.6770.
Visit COPS Online at www.cops.usdoj.gov.

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