



Maintaining Resiliency Among Peer Support Officers

Peer support teams consist of selection, training, confidentiality, the use of a clinical consultant and a host of other basic parameters.

IN RECENT YEARS, WE HAVE witnessed the growth of peer support officers (PSO) among law enforcement departments. While many departments have access to employee assistance programs, often these are not trusted and, as such, are underused. Police officers often choose not to seek counseling for a variety of reasons. However, as most know, there is a high incidence of depression, suicide, alcoholism and marital distress and dissolution among law enforcement members. In much the same way that Alcoholics Anonymous and Employee Assistance Programs started as a grass roots endeavor, “reaching out” to

other officers and dispatchers in distress has always been an informal aspect within most any department. However, recently, peer support has become more formalized and incorporated into many departments.

The International Association of Chiefs of Police (IACP) has developed guidelines for peer support teams describing, in general terms, selection, training, confidentiality, the use of a clinical consultant and a host of other basic parameters. However,

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as guidelines, they are just that: guidelines, with limited specificity. With respect to maintaining resiliency within the team, three critical aspects are: selection, training and clinical consultation. The IACP guidelines indicate that the candidates should be volunteers as well as “officers in good standing.” The training is rather open with a list of clinical topics to be included, but has limited parameters with respect to time allocation, content, etc. Other than indicating that a clinical consultant should be available 24/7, there is little suggestion with respect to qualifications or any other considerations for this relationship. These

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Choosing a Team

The PST for whom I am the clinical consultant had been in place with one member for some time. It had been a rather informal yet very useful program that was successful due to the personality of the individual officer. As a result, it was felt that the team should be expanded and developed. From the start, a priority to maintain the health and well-being of its team members was set. To that end, selection was handled as follows: the department recommended 12 possible candidates who were considered "officers in good standing." The positions were not open to anyone who volunteered as the thinking was that people may volunteer for their own personal motives. Instead, these candidates were chosen and asked to volunteer by senior officers. They were then interviewed by an independent panel of three outside consultants who were given the final decision with respect to selection for the team. This panel was composed of myself, another psychologist and a stress management consultant. Each candidate went through a confidential interview in which he/she was asked a variety of questions around life style, family pressures, substance involvement, physical fitness, their experience as a police officer as well as other determinants. A candidate was only chosen if all three felt positively and could endorse the individual.

This group then went through seven days of training. Four of these days were focused on clinical/critical incident training as well as administrative aspects and team operation. The other three days were conducted by the stress management consultant teaching them about the psycho-physiological aspects of the mind-body connection and methods of stress reduction. This training was punctuated by meditation exercises and group discussions as well as viewing educational videotapes.

At the completion of this training, each was asked if they wished to continue as members of the team, knowing now, full and well, what was required of them. When the list of team members was determined, it was sent back to the Chief for final endorsement.

Recently, at about the 1 1/2 year mark since the expansion of the team, the Chief is presenting each of the members with a certificate of appreciation. He will be attending the next peer officers meeting and making the presentations personally. Once again, this type of acknowledgement goes a long way toward maintaining resiliency.

three issues will be addressed in this article because they are critical to maintaining resiliency within the Peer Support Team (PST). While this article is focused on law enforcement, most of the suggestions would apply to any peer support team for all types of emergency service agencies.

Resiliency

Resiliency is the latest buzzword in a number of different work and clinical settings. In a nutshell, it connotes "the ability to spring back from and successfully adapt to adversity," or the ability to maintain productivity, performance and relationships in the aftermath of an unusually stressful event. It is an appropriate con-



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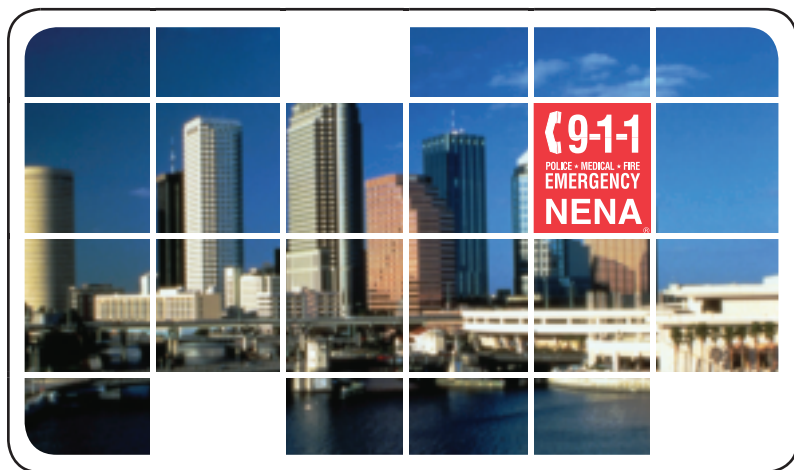
cern when developing a PST, because the members of the team have the regular duties and responsibilities, which may involve a fair amount of trauma and turmoil. To make ends meet, individuals may work overtime, which could subject them to the sleep deprivation as well. As a peer support officer, now they add the responsibility of assisting others with many of the same issues they

themselves must contend. Often, the peer support officer does this work “on his/her own time.” Therefore, it should be a critical priority to keep the peer support team and the officers within functioning in a healthy mode in order to avoid “burnout” or “compassion fatigue.”

Efforts must be made to shield team members from pressure they may receive

from command staff to divulge information regarding contact they may have with certain officers. In addition, another source of stress for the PSO can be the perception of other officers that they are a “tool” of the department “higher ups” and not to be trusted.

One means of facilitating resiliency is to establish a sense of rapport and relationships among the team members and with the clinical consultant. The following are recommendations: for the first year, the consultant should meet with the team on a monthly basis for a two-hour training/consultation session. In addition to team building, the agenda of these meetings should be 1) “case” discussions; 2) concerns with respect to policies and procedures; 3) additional training; and 4) team management issues. Run these meetings informally and involve an informal “check in” to determine how each team member is doing. After the first year, the frequency may be moved to every six weeks.



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Even if your department does not have its own team, become aware of what CISM services are available within your area. Talk with other departments to determine what, if any, programs they may have.

A Clinical Consultant

In addition to these regular meetings, make available to the team a clinical consultant who is available on a 24/7 basis for phone consultation. One concern may be that the peer officer may get involved with a situation that propels him/her beyond his/her training or emotional capacity. In addition, recognize that peer officers are people too and may face some of their own difficulties. Make the consultant available to the members to provide them with guidance and support.

Another component of the consultation relationship is working with the team to educate the department as a whole regarding stress, law enforcement and the use of the PST. This can be done through PST cards,

posters, department newsletter articles and Web sites as well as presentations at in-service training. This type of “reaching out” is done for three primary reasons: 1) it is a proactive intervention and may make it easier for officers to use the team; 2) provides support for the team by “promoting” it and including them in the presentations; and 3) may generate interest on the part of others to become members of the PST. A critical issue for most teams is whether they maintain confidentiality. It takes time for trust to develop, but usually within a year or so, the department begins to feel that the team is a valuable asset.

Finally, if there is a critical incident that requires a debriefing, have the consultant participate in that intervention. By doing so, the team does not feel like they are out there on their own, and should things get a bit tense, the consultant is there to mitigate some of the rough spots of the debriefing.

A Work in Progress

Emergency service agencies have a culture that is not quick to change. Often, these types of programs may be met with resistance from above or from rank and file. Unfortunately, what often “gets the ball rolling” is a bad incident within a department such as a suicide of an employee or a serious critical incident. Even if your department does not have its own team, become aware of what CISM services are available within your area. Talk with other departments to determine what, if any, programs they may have.

Setting up a team is a relatively easy endeavor. However, it should be viewed as “a work of art in progress” that requires ongoing support. Often this does not come from the department and, therefore, must generate from the team as well as the clinical consultant. Peer Support Officers have chosen to go above and beyond and this must be acknowledged ... and respected.

ENPM

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