

State of Colorado



HB14-1343 Peace Officer Post-Traumatic Stress Disorder Task Force Report

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Background

Within our nation, Colorado is ranked 31st in overall crime and 26th in Violent Crime.¹ It is interesting to note Colorado law enforcement and corrections professionals, who deal with crime victims and offenders, make up just 0.007% of our state's population, ages 18 to 64.² The majority of law enforcement professionals in Colorado are peace officers, certified by the Peace Officers Standards and Training Board (P.O.S.T. board). A peace officer's authority includes the enforcement of all laws of the state of Colorado. These peace officers also have the authority to carry firearms at all times, concealed or otherwise.³

Colorado peace officers staff a front line that confronts crime and violence in our society. No other occupation in our state requires an employee to don a bullet resistant vest, firearm, and state of mind in preparation for a potential lethal encounter each and every day. Our peace officers must acquire and retain the physical and psychological readiness to employ deadly force in defense of a citizen or themselves at any moment – whether on or off duty. Unlike any other profession in our state, the Colorado peace officers must maintain an appropriate level of vigilance (which can deteriorate into anxiety and hyper vigilance) for lethal encounters, physical and mental preparation for imminent, interpersonal violence, and critical thinking skills to respond appropriately to rapidly evolving events under life-and-death conditions.

The Centers for Disease Control and Prevention (CDC) defines interpersonal violence as "the intentional use of physical force or power, threatened or actual, against another person or against a group or community that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."⁴ No other occupation in Colorado immerses employees in the realm of interpersonal violence more than that of a peace officer. Of all the professions and occupations, only the peace officer has the legal authority and *obligation* to execute a segment of their duties by engaging in interpersonal violence. Furthermore, no

¹ 2011 FBI Uniform Crime Report at <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2011/crime-in-the-u.s.-2011>

² United States Census Bureau estimates Colorado's population, ages 18 to 64, at 3,382,292 at <http://quickfacts.census.gov/qfd/states/08000.html> The 2011 FBI Uniform Crime Report, specifically Table 77 concerning Full Time Law Enforcement Employees by State, identifies 235 agencies in Colorado with 16,700 employees (11,255 sworn officers and 5,445 civilian employees) at <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2011/crime-in-the-u.s.-2011/police-employee-data> The National Institute of Corrections states Colorado has 6,900 Department of Corrections employees (bringing the total of Law Enforcement and Corrections employees to 23,600) at <http://nicic.gov/statestats/?st=CO> Obtaining accurate numbers can be difficult, for instance the Bureau of Justice Statistics (July 2011, NCJ 233982) – during their 2008 Census – identified Colorado with 246 agencies employing a total of 17,989 personnel (12,069 identified as sworn personnel) at <http://www.bjs.gov/content/pub/pdf/csllea08.pdf>

³ Colorado Revised Statutes, 16-2.5-101, described within the Colorado Peace Officer Standards And Training, 2013 POST Manual at http://www.coloradoattorneygeneral.gov/sites/default/files/post/2013_Manual.pdf

⁴ The CDC uses the definition created by LL Dahlberg and EG Krug for the World Health Organization in a report in 2002 in Geneva at <http://www.cdc.gov/violenceprevention/youthviolence/definitions.html>

other profession in Colorado has a higher rate and frequency of exposure, as a recipient, of the intentional (threatened or actual) use of physical force. Finally, peace officers are among those very few occupations that witness the consequences and effects of interpersonal violence (an inevitable and frequent part of their tasks), and almost always as the first professionals to make contact with the victims.

Colorado peace officers are assigned to the forefront, to grapple with social indignity and the inhumane treatment of others within our society. The Law Enforcement Code of Ethics mandates peace officers provide service to mankind, to safeguard lives and property, to protect the innocent against deception, the weak against oppression or intimidation, and the peaceful against violence or disorder. This mandate exposes peace officers to immoral and malevolent predators, and to the immediate aftermath of their crimes when they victimize members of our communities. The peace officer must balance compassion and empathy while attending to his or her required duties – a difficult task, as peace officers are intimately exposed to human misery and suffering. When a person is killed at the hands of another, for instance, it is the peace officer who represents the deceased, whose voice replaces the departed to demand justice by way of a thorough, impartial investigation to seek the truth. The Code of Ethics does not allow personal feelings, prejudices, or animosity to influence their decisions during the course of their duties, yet peace officers must silently endure psychological harm.

It is difficult to identify a profession, in Colorado, that consistently challenges the physical and psychological wellbeing of a worker at the level and degree of a peace officer.

In the general population (the very society peace officers serve and protect), the prevalence of Post-Traumatic Stress Disorder (PTSD) at any given time is estimated to be at 7.8%.⁵ In comparison, 11% to 20% of our current Veterans, who served in Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF), have PTSD, and 12% of those who served in the Gulf War (Desert Storm) have had PTSD in a given year.⁶ PTSD can be caused by a wide range of events that can be grouped into three categories:

- 1) Intentional Human (Interpersonal Violence), such as combat, abuse, torture, rape, and assault;
- 2) Unintentional Human, such as vehicle accidents, industrial accidents, fire, and collapse of a structure; and
- 3) Acts of Nature / Natural Disasters, such as a tornado, hurricane, flood, earthquake, etc.⁷

It appears that the more severe, long-lasting, or dangerous a traumatic event, the more vulnerable a person is to developing PTSD. Interpersonal violence can have a greater impact than natural disasters and other types of traumatic events. For instance, 67% of people exposed to mass violence (such as Columbine High School and the Aurora Theater Shooting) have been

⁵ The National Comorbidity Survey Replication (February 2001 to April 2003), in Veteran's Affairs, National Center for PTSD at <http://www.ptsd.va.gov/professional/PTSD-overview/epidemiological-facts-ptsd.asp>

⁶ Veteran's Affairs, National Center for PTSD at <http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp>

⁷ The Post-Traumatic Stress Disorder Sourcebook, Glenn R. Schiraldi, Ph.D., 2nd Ed 2009

shown to develop PTSD. People who have experienced previous traumatic events run a higher risk of developing PTSD as well.⁸

During the course of a career in law enforcement, which today often encompasses three decades, it is not surprising that some peace officers are diagnosed with duty-related PTSD. The reality, however, is their resilience. It is estimated that anywhere from 82% to 96% of our peace officers are *not* currently suffering from duty-related PTSD.⁹ An estimate must be arrived at, as we are not aware of any existing study that definitively determines the prevalence of duty-related PTSD in Colorado peace officers. For the purposes of our discussion, a 10% rate of duty-related PTSD is an acceptable estimate.

As mentioned at the beginning of this introduction, peace officers, corrections officers, and all law enforcement employees make up less than 1% of Colorado's population (ages 18 to 64). An estimated 10% rate of duty-related PTSD, among Colorado peace officers, is an even smaller number of our state's population. Psychologically healthy peace officers, however, translate to a public health, public order imperative. Mitigating psychological harm among our peace officer population is essential for the peace, health, and safety of our communities.

On June 6, 2014 Governor Hickenlooper signed House Bill 14-1343,¹⁰ which created the Peace Officer Post-Traumatic Stress Disorder Task Force. The task force was mandated to research work-related peace officer PTSD and other relevant topics, report findings, and make recommendations to include the best policies and practices for public employers of peace officers in Colorado concerning identification, prevention, treatment, covered workers'

⁸ PTSD Facts, Anxiety and Depression Association of America at <http://www.adaa.org/understanding-anxiety/posttraumatic-stress-disorder-ptsd>

⁹ The incidence of current duty-related PTSD in police officers can range from 4% all the way to 35% based on a study or source. For instance, 4% to 14% is often quoted, such as in the article "PTSD and suicide among law enforcement officers" at <http://sheilamyers.hubpages.com/hub/PTSD-and-suicide-among-law-enforcement-officers> and Picking Up The Peaces at <http://www.pickingupthepeaces.org.au/post-traumatic-stress-disorder-statistics>. It is calculated at 7% in the study "Risk factors for posttraumatic stress symptomatology in police officers: a prospective analysis" at <http://www.ncbi.nlm.nih.gov/pubmed/9284863>; 10% to 15% as the estimate of prevalence of PTSD in law enforcement in "Keeping Our Heroes Safe: A Comprehensive Approach to Destigmatizing Mental Health Issues in Law Enforcement" in *The Police Chief* at http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display&article_id=3354&issue_id=52014; 13% in the study "Duty-related stressors and PTSD symptoms in suburban police officers" at <http://www.ncbi.nlm.nih.gov/pubmed/9400075>; 7% to 19% in "Predictors of Posttraumatic Stress in Police and Other First Responders" by Charles R. Marmar at <http://deepblue.lib.umich.edu/bitstream/handle/2027.42/74485/annals.1364.001.pdf?sequence=1>; 15% to 18% of working police officers have undiagnosed symptoms of PTSD per Dr. John Violanti in ROCIC Special Research Report • Police Suicides: Dispelling the Myths. Causes, Prevention, and Intervention Strategies at http://undertheshield.org/wp-content/uploads/Police_Suicides_0214.pdf, and 12% to 35% in "Vulnerability to Psychological Disorder: Previous Trauma in Police Recruits" by Christine Stephens, Nigel Long, and Ross Flett (page 66) in *Police Trauma: Psychological Aftermath of Civilian Combat* edited by John Violanti and Douglas Paton (1999, Charles C Thomas Publisher), and again (12% to 35%) as the rate also used in "Workplace Strategies for Prevention of PTSD" by Christine Stephens (page 140) in *Policing and Stress* by Heith Copes (2005, Pearson Prentice Hall).

¹⁰ See Appendix A
2014 Peace Officer PTSD Task Force

compensation claims, standardized pre-employment psychological screenings, and education of both management and employees on this mental health illness. This bill directed the Department of Corrections to appoint one representative to the task force, thus including corrections officers among peace officers in work-related PTSD. The task force extended the scope of their research and recommendations to include law enforcement employees such as communications officers, crime scene investigators, victim assistance coordinators, and other support roles within Colorado law enforcement agencies staffed by non-sworn (civilian) employees. The report that follows has been prepared for the Public Health Care and Human Services Committee of the House of Representatives and the Health and Human Services Committee of the Senate.

Task Force Legislative Charge

The following is an excerpt from House Bill 14-1343:

29-5-113. Peace officers - post-traumatic stress disorder task force - creation - report - repeal. (1) THERE IS HEREBY CREATED THE PEACE OFFICER POST-TRAUMATIC STRESS DISORDER TASK FORCE, REFERRED TO IN THIS SECTION AS THE TASK FORCE. THE TASK FORCE SHALL RESEARCH WORK-RELATED PEACE OFFICER POST-TRAUMATIC STRESS DISORDER AND OTHER RELEVANT TOPICS AS DETERMINED BY THE TASK FORCE AND REPORT FINDINGS AND MAKE RECOMMENDATIONS THAT INCLUDE THE BEST POLICIES AND PRACTICES FOR PUBLIC EMPLOYERS OF PEACE OFFICERS IN COLORADO CONCERNING IDENTIFICATION, PREVENTION, TREATMENT, COVERED WORKERS' COMPENSATION CLAIMS, STANDARDIZED PREEMPLOYMENT PSYCHOLOGICAL SCREENINGS, AND EDUCATION OF BOTH MANAGEMENT AND EMPLOYEES ON THIS MENTAL HEALTH ILLNESS.¹¹

Based on this charge, the task force set out to explore a number of questions, including:

- To what extent does PTSD impact our law enforcement and corrections officers?
- What is the impact on their personal well-being, their performance at work?
- What is the impact on local and state government operations?
- What efforts are being made to educate / train officers in the prevention and or mitigation of PTSD?
- To what extent are officers responding with maladaptive behavior (i.e. self-medicating) versus healthy, proactive efforts?
- What resources are available to agencies and local government to prevent PTSD and, once an officer has been diagnosed, to treat it?

¹¹ See Appendix A
2014 Peace Officer PTSD Task Force

Task Force Composition

The composition of the Peace Officer PTSD Task Force was designed to allow for geographic and role diversity for a myriad of perspectives, experiences, and expertise, including members from urban, suburban, and rural communities. The 20 voting members were appointed by their respective professional organizations, associations or government offices according to the enabling legislation.

Name	Title	Organization
Sean Harper	Sergeant	Fraternal Order of Police, Longmont Police Department
Danny Veith	Peace Officer	Fraternal Order of Police, Denver Police Department
Karl Wilmes	Deputy Director	Colorado Bureau of Investigations, Department of Public Safety
Timothy J. Martinez	Agent in Charge	Colorado Bureau of Investigations, Department of Public Safety (*replacement for Karl Wilmes)
Joseph D. Hoy	Sheriff	County Sheriffs of Colorado, Eagle County Sheriff's Office
Jim Crone	Sheriff	Colorado Sheriffs of Colorado, Morgan County Sheriff's Office
Ken Poncelow	Police Chief	Colorado Association of Chiefs of Police, Fort Upton Police Department
Tom Wickman	Police Chief	Colorado Association of Chiefs of Police, Frisco Police Department
Terry Campbell	ACSPP Legislative Lobbyist	Association of Colorado State Patrol Professionals (ACSPP)
Suzette Freidenberger	President CPPA	Colorado Police Protective Association
Ralph Trenary	Loveland City Council Member	Colorado Municipal League
Eric Bergman	CCI Policy & Research Supervisor	Colorado Counties, Inc.
Paul N. Fisher	Attorney, CBA Military and Veterans Liaison	Colorado Bar Association
Dr. George Hartlaub	M.D.	Colorado Psychiatric Society
Dr. John Nicoletti	Ph.D.	American Board of Professional Psychology, Colorado Psychological Association
Brenda Leffler	Lt. Colonel	Colorado State Patrol, Department of Public Safety

Rick Thompkins	Chief of Human Resources	Department of Corrections
Lenya Robinson	Director, Trauma Informed and Integrated Care	Department of Human Services
Dr. Kathryn Mueller	Medical Director, Division of Workers' Compensation	Department of Labor and Employment
Markie Davis	Manager, State Office of Risk Management	Department of Personnel and Administration
Jack Wylie	Legislative Liaison	Department of Personnel and Administration

Meetings and Sub-Committees

The full group met for a total of seven times between June 2014 and January 2015. These full-group meetings that were held on:

- June 30, 2014 at the Capitol
- July 31, 2014 at the Capitol
- August 14, 2014 at the Capitol
- October 7, 2014 at the Capitol
- November 12, 2014 at the Capitol
- December 10, 2014 at the Capitol
- January 5, 2015 at the Capitol

Sub-Committees were formed and met outside the full-group meeting times and reported back to the full group with recommendations. They were:

- **Advisory Legislative Sub-Committee** (Paul Fisher, Joseph Hoy, Jack Wylie, Markie Davis, and Brenda Leffler)
- **Advisory Policy Sub-Committee** (Dr. Kathryn Mueller, Danny Veith, Rick Thompkins, Jim Crone, Dr. George Hartlaub, Dr. John Nicoletti, and Suzette Freidenberger)
- **Planning and Technical Sub-Committee** (Ralph Trenary and Tom Wickman)

Subject Matter Expert Presentations

In order to set the foundation of a common knowledge base, several experts were brought in to present for the group. The presenters were:

- Brandon Bentley, retired Deputy from Spartanburg County Sheriff's Office (South Carolina)
- Steve Stowers, retired Sergeant Officer from Hutchinson Police Department (Kansas)
- Chief John Jackson, Greenwood Village Police Department (Colorado), President of the Colorado Association Chiefs of Police
- Marilyn J. Meyers, Psy. D., Licensed Psychologist – Health and Public Safety Psychology
- Kenneth M. Platt, Esq., Former Director of Colorado Workers' Compensation Department
- Ron Clark, Chairman of the Board – Badge of Life
- Steve Deal, retired Officer from Longmont, Colorado Police Department
- Nick Fogel, workers' compensation attorney specializing in representing peace officers at Burg Simpson Law Firm (Denver, Colorado)

What is Posttraumatic Stress Disorder?

Posttraumatic Stress Disorder (PTSD) is a term that is frequently heard on the news, in magazines, seen in movies and often in daily conversations. It is assumed that whomever you are speaking to knows what PTSD means. Yet when members were questioned about whether they understood what PTSD was at the first task force meeting concerning PTSD and peace officers, there were several members that volunteered they did not know and/or why an individual would develop PTSD.

The following definition of posttraumatic stress disorder is from the National Institute for Mental Health (NIMH), 2014:

PTSD develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers.

When in danger, it's natural to feel afraid. This fear triggers many split-second changes in the body to prepare to defend against the danger or to avoid it. This "fight-or-flight" response is a healthy reaction meant to protect a person from harm. But in post-traumatic stress disorder (PTSD), this reaction is changed or damaged. People who have PTSD may feel stressed or frightened even when they're no longer in danger.

PTSD was brought to public attention in relation to war veterans, but it can result from a variety of traumatic incidents, such as mugging, rape, torture, being kidnapped or held captive, child abuse, car accidents, train wrecks, plane crashes, bombings, or natural disasters such as floods or earthquakes.

A traumatic situation involves an individual either being the victim of or a responder to an incident that involves either death, a significant injury, or the potential of those outcomes. A person who develops PTSD is an individual that was never able to move the experience of a traumatic situation from an intrusive thought related to that experience to a memory of a difficult event in their life. PTSD is characterized by two major symptoms: Intrusions (continuing to hear, see, smell or think about the event) and Flashbacks (returning thoughts back in time to the traumatic event, due to a reminder such as a similar event or an anniversary of the event). Co-occurring symptoms can include alcohol abuse, suicidal thoughts, or other significant emotional problems. PTSD can be prevented if the victim or responder is able to receive timely mental health treatment.

Understanding what happens when an individual develops symptoms of PTSD requires some knowledge of the brain and how the brain works when we are under stress. In order to provide more detailed information about PTSD, the following information is from two books written by Bessel A. van der Kolk, M.D., who is an internationally known expert on PTSD. Currently, he is the medical director at the Trauma Center at JRI in Brookline, Massachusetts. He is the author of: Traumatic Stress, The Effects of Overwhelming Experience on Mind, Body and Society,

Bessel A. van der Kolk, Alexander C. McFarlane, & Lars Weisaeth, New York, Guilford Press, 1996 and The Body Keeps the Score, Brain, Mind, and Body in the Healing of Trauma, Bessel A. van der Kolk, M.D., New York, Penguin Books, 2014.

Traumatic Experiences

“Experiencing trauma is an essential part of being human...Throughout evolution humans have been exposed to terrible events; yet most people who are exposed to dreadful experiences survive without developing psychiatric disorders...Most people who have been exposed to traumatic stressors are somehow able to go on with their lives without becoming haunted by the memories of what has happened to them. That does not mean that the traumatic events go unnoticed. After exposure to a trauma, most individuals become preoccupied with the event; having involuntary intrusive memories is a normal way of responding to a traumatic experience. This repeated replaying of upsetting memories serves the function of modifying the emotions associated with the trauma, and in most cases creates the ability to emotionally manage the content of the memories” (1996, p.3).

“However, with the passage of time, some people are unable to integrate the awful experience and start developing the specific patterns of avoidance and hyperarousal that are associated with PTSD. What distinguishes people who develop PTSD from people who are merely temporarily stressed is that they start organizing their lives around the trauma. Thus, it is the persistence of intrusive and distressing recollections, and not the direct experience of the traumatic event itself, that actually drives the biological and psychological dimensions of PTSD...Although most people who develop PTSD have considerable interpersonal and occupational problems, the degree to which the symptoms of PTSD come to affect overall functioning varies a great deal from person to person” (1996, p. 5-6).

Why does this happen?

“The most important job of the brain is to ensure our survival, even under the most miserable conditions. Everything else is secondary. The following provides basic information about the brain and how it functions in a traumatic situation.

1. The rational cognitive brain is primarily concerned with the world outside of us; understanding how things and people work, figuring out our goals, and managing our time.
2. Beneath the rational brain lie two evolutionarily older, and to some degree separate brains which are in charge of everything else; the moment-by-moment registration and management of our body’s physiology and the identification of comfort, safety, hunger, fatigue, desire, longing, excitement, pleasure and pain.
 - a. The most primitive part of the brain is often called the reptilian brain and it is located in the brain stem, just above where our spinal cord enters the skull. This part of the brain is responsible for; eating, sleeping, breathing, temperature regulation, hunger, etc.
 - b. The brain stem and the hypothalamus (which are directly above the brain stem), together control the energy levels of the body. They coordinate the functioning of the

heart and lungs and the endocrine and immune systems, ensuring that these, basic life-sustaining systems are maintained within the relatively stable internal balance known as homeostasis.”

3. Right above the reptilian brain is the limbic system also known as the mammalian brain. It is the seat of the emotions, the monitor of danger, the judge of what is pleasurable or scary, and the arbiter of what is or is not important for survival... Taken together the reptilian and limbic system make up what van der Kolk calls the emotional brain. **“The emotional brain is the heart of the central nervous system and its key task is to look out for your welfare.** It detects danger and alerts you by releasing hormones. The resulting physical sensations (ranging from mild-queasiness to the grip of panic in your chest) will interfere with whatever your mind is currently focused on and gets you moving—physically and mentally—in a different direction ” (2014, p.5).

“The emotional brain’s organization and biochemistry are simpler than our rational brain. It assesses incoming information in a more global way and as a result, it jumps to conclusions based on rough similarities of a situation. In contrast, the rational brain is organized to sort through a complex set of options. The textbook example is leaping back in terror when you see a snake—only to realize that it’s just a coiled rope.

The emotional brain initiates escape plans, like the fight-or-flight responses. These muscular and physiological reactions are automatic, set in motion without any thought or planning on our part, leaving our rational capacities to catch up later, often well after the threat is over.

The rational cognitive part of the brain (frontal lobes) gives us the ability to absorb and integrate vast amounts of information and attach meaning to it. The frontal lobes help us predict what will happen if we take one action or neglect another. But, it is exactly on that edge between impulse and acceptable behavior where troubles can begin.

The more intense the visceral, sensory input from the emotional brain, the less capacity the rational brain has to put a damper on it” (2014, p. 60).

What changes with PTSD?

“Danger is a normal part of life, and the brain is in charge of detecting it and organizing our response.

1. Sensory information about the outside world arrives through our eyes, nose, ears, and skin. These sensations converge in the thalamus, an area inside the limbic system (emotional brain). The thalamus utilizes the input from our perceptions into an experience of ‘this is what is happening to me.’
2. The sensations are then passed on in two directions:
 - a. to the amygdala in the limbic, unconscious part of the brain.
 - b. and up to the frontal lobes, where they reach conscious awareness.

The pathway to the amygdala (emotions) is extremely fast. The pathway to the frontal cortex (thinking) takes several milliseconds longer, in the midst of an overwhelming threatening experience.

The central function of the amygdala, which van der Kolk calls the brain's smoke detector, is to identify whether incoming information is relevant for our survival. It does so quickly and automatically, with help from the hippocampus (memory), a structure that relates the new input to past experiences. If the amygdala senses a threat—a potential collision with an on-coming vehicle—it sends an instant message to the reptilian brain to orchestrate a whole body response.

Because the amygdala processes the information faster than the rational cognitive (frontal lobes) part of the brain does, it decides whether incoming information is a threat to our survival even before we are consciously aware of the danger. By the time we realize what is happening, our body may already be on the move” (2014, p.61).

“The amygdala’s danger signal triggers the release of powerful stress hormones, including cortisol and adrenaline, which increases heart rate, blood pressure, and rate of breathing, preparing us to fight back or run away. Once the danger is past, the body returns to its normal state fairly quickly. But when recovery is blocked, the body is triggered to defend itself, which makes people feel agitated and aroused.

If the amygdala is the smoke detector in the brain, the medial pre-frontal cortex (MPFC) located directly above our eyes is the watchtower... If you smell smoke it may be a sign that your house is on fire and you need to get out fast—or is it from a steak you put on too high a flame? The amygdala does not make these judgments, it just gets you ready to fight back or escape, even before the frontal lobes get a chance to make an assessment. As long as you are not too upset, your frontal lobes can restore your balance by helping you realize that you are responding to a false alarm and you can stop the stress response” (2014 p. 61).

“Ordinarily, the executive capacities of the pre-frontal cortex enable people to observe what is going on, predict what will happen if they take a certain action, and make a conscious choice. Being able to calmly and objectively evaluate our thoughts, feelings and emotions we can take our time in deciding on how we are going to respond to a situation. This allows the executive brain to inhibit, organize and modulate the hardwired automatic reactions programmed into the emotional brain. This capacity is crucial in our relationships and regulating our emotional responses. When this system breaks down, we become ‘conditioned animals.’ The moment we detect danger we automatically go into fight or flight mode.

In PTSD the critical balance between the amygdala (the smoke detector) and the MPFC (watchtower) shifts radically, which makes it harder to control emotions and impulses. Neuroimaging of human beings in highly emotional states reveal that intense fear, sadness, and anger all increase the activation of the brain regions involved in emotions and significantly reduce the activity in various areas in the frontal lobes (rational-cognitive), particularly in the MPFC. When that occurs, the inhibitory capacities of the frontal lobes break down, and people ‘take leave of their senses.’ They may startle in response to any loud sound, become enraged by small frustrations, or freeze when someone touches them.

When these two systems are in balance, we ‘feel like ourselves.’ However, when our survival is at stake, these systems can function relatively independently.

The following is an example that may help in understanding what happens in the brain when someone is experiencing a traumatic event. ‘The neuroscientist Paul McLean, developed the three part description of the brain, comparing the relationship between the rational brain and the emotional brain to that between a more or less competent rider and his unruly horse. As long as the weather is calm and the path is smooth, the rider can feel in excellent control. But unexpected sounds or threats from other animals can make the horse bolt, forcing the rider to hold on for dear life. Likewise, when people feel their survival is at stake or they are seized by rages, longings, or fear, they stop listening to the voice of reason, and it makes little sense to argue with them. Whenever the limbic system decides that something is a question of life or death, the pathways between the frontal lobes and the limbic system become extremely tenuous. Our self-experience is the product of the balance between our rational and our emotional brains”’ (2014, p. 64).

Posttraumatic Stress Disorder

“Unlike other forms of psychological disorders, the core issue in trauma is reality: It is indeed the truth of the traumatic experience that forms the center of the psychopathology; it is not a pathology of falsehood or displacement of meaning, but of history itself.” However, the critical element that makes an event traumatic is the subjective assessment by survivors of how threatened and helpless they feel. So, although the reality of extraordinary events is at the core of PTSD, the meaning that survivors attach to these events is as fundamental as the trauma itself. An individual’s interpretation of the meaning of the trauma continue to evolve well after the trauma itself has ceased” (1996, p. 5).

For example, a peace officer who was involved in a shooting did not develop PTSD symptoms until a few months after the shooting. At the time of the critical incident, his rifle malfunctioned. Due to his extensive training, he was able to maintain his focus, clear his rifle, all the while the suspect was shooting at him. A couple months following this incident, this peace officer went to the shooting range. At the range he went to shoot his back-up weapon and found that it had a defective spring. If he had not been able to clear his rifle, at the time of the shooting, he would have had only one shot available with his back-up weapon. When he realized that his back-up weapon was defective, and how vulnerable he was at the time of the shooting, was when he developed PTSD.

“Immediately after a traumatic event almost all people suffer from intrusive thoughts about what happened. These intrusions help them either to learn from the experience and plan for restorative actions (accommodations), or to gradually accept what has happened and readjust their expectations (assimilation). One way or another, the passage of time modifies the ways in which the brain processes the trauma-related information. Either it is integrated into memory and stored as an unfortunate event belonging to the past, or the sensations and emotions belonging to the event start leading a life of their own.

When an individual develops PTSD, the replaying of the trauma leads to sensitization; with every replay of the trauma, there is an increasing level of distress. In those individuals, the traumatic event, which started out as a social and interpersonal process, comes to have secondary biological consequences that are hard to reverse once they have become entrenched. Repetitive exposure etches the memory more and more powerfully into the brain” (1996, p. 8).

“In PTSD, the past is relived with an immediate sensory and emotional intensity that makes survivor’s feel as if the event was occurring all over again. The ‘Grant Study,’ a longitudinal study of the psychological and physical health of 200 Harvard undergraduates, who participated in World War II, is a good illustration of how people process traumatic events. When these men were re-interviewed about their experiences, 45 years later, those who did not have PTSD had considerably altered their original accounts; the most intense horror of the events had been diluted. In contrast, time had not modified the memories of the minority of subjects who developed PTSD. Thus, paradoxically, the ability to transform memory is the norm, whereas in PTSD, the full brunt of the experience does not fade with time” (1996, p. 9).

“There are six critical issues that affect how people with PTSD process information:

1. They experience persistent intrusions of memories related to the trauma, which interferes with attending to other incoming information.
2. They sometimes compulsively expose themselves to situations reminiscent of the trauma. Examples of this behavior would be harming others, self-destructiveness, and re-victimization.
3. They actively attempt to avoid specific triggers of trauma-related emotions, and experience a generalized numbing of responsiveness; many people with PTSD not only actively avoid emotional arousal, but experience a progressive decline and withdrawal in which any stimulation (whether it is potentially pleasurable or aversive) provokes further detachment. To feel nothing seems to be better than feeling irritable and upset.
4. They lose the ability to modulate their physiological responses to stress in general, which leads to decreased capacity to utilize bodily signals as guides for action; they suffer from hypervigilance, exaggerated startle response and restlessness.
5. They suffer from generalized problems with attention, distractibility, and stimulus discrimination.
6. They have alterations in their psychological defense mechanisms and in their personal identity. This changes what new information is selected as relevant...Trauma is usually accompanied by intense feelings of humiliation; to feel threatened, helpless, and out of control is a vital attack on the capacity to be able to count on oneself. Shame is the emotion related to having let oneself down” (1996, p. 9-15).

The feelings of shame and humiliation are very destructive for peace officers. They have received extensive training and place very high expectations upon themselves. This feeling of shame is very harmful and can lead to self-destructive behavior, including suicide.

The Brain and PTSD

“After trauma, the world is experienced with a different nervous system. The survivor’s energy is now focused on suppressing inner chaos, at the expense of spontaneous involvement in their lives. These attempts to maintain control over unbearable physiological reactions can result in a whole range of physical symptoms, including fibromyalgia, chronic fatigue, and other autoimmune diseases... Long after the actual event has passed, the brain may keep sending signals to the body to escape a threat that no longer exists. Being able to move and do something to protect oneself is a critical factor in determining whether or not a horrible experience will leave long-lasting scars.”

An example is a postal carrier who was attacked by a Rottweiler. In the therapy office, she appeared calm and she was able to joke and chat. One day, I walked with her outdoors to another building. As soon as we were outside, she immediately began scanning the environment. She was looking from side to side and her expression was tense and scared. When she was outdoors, she was always prepared for another attack. The sound of leaves, the jangle of keys, and the sight of a dog in the distance or even inside another car—she re-experienced being attacked.

“As long as the trauma is not resolved, the stress hormones that the body secretes to protect itself keep circulating, and the defensive movements and emotional responses keep getting replayed. Many people may not be aware of the connection between their “crazy” feelings and reactions and the traumatic events that are being replayed. They have no idea why they respond to some minor irritation as if they were about to be annihilated.

“Flashbacks and reliving are in some ways worse than the trauma itself. A traumatic event has a beginning and an end—at some point it is over. But for people with PTSD, a flashback can occur at any time, whether they are awake or asleep. There is no way of knowing when it’s going to occur again or how long it will last. People who suffer from flashbacks often organize their lives around trying to protect against them. They may compulsively go the gym to pump iron (but finding that they are never strong enough), numb themselves with drugs or alcohol, or try to cultivate an illusory sense of control in highly dangerous situations (like motorcycle riding, bungee jumping, or working as an ambulance driver.) Constantly, fighting unseen dangers is exhausting and leaves them fatigued, depressed, and weary.

If the elements of the trauma are replayed again and again, the accompanying stress hormones engrave those memories ever more deeply in the mind. Ordinary day-to-day events become less and less compelling. Not being able to deeply take in what is going on around them makes it impossible to feel fully alive. It becomes harder to feel the joys and aggravations of ordinary life, harder to concentrate on the tasks at hand. Not being fully alive in the present keeps them more imprisoned in the past.

These reactions are irrational and largely outside people’s control. Intense and barely controllable urges and emotions make people feel crazy—and makes them feel don’t belong to the human race. Feeling numb during birthday parties for your kids or in response to the death of a loved one makes people feel like monsters. As a result, shame becomes the dominant emotion and hiding the truth the central preoccupation... The bottom line is that the threat-perception

system of the brain has changed, and people's physical reactions are dictated by the imprint of the past" (2014, p. 67).

So how do we prevent PTSD from developing?

Peace Officers are in an occupation that exposes them to numerous traumatic events. Providing education and psychological services from the Academy through retirement can significantly decrease the risk of an officer developing PTSD. There is a need for accepting, supportive environments throughout each department for mental health services, just as there is for other medical services. Peer Support Services play a significant role in identifying officers in the field who may need additional assistance. The Peace Officer PTSD Task Force has provided recommendations that may significantly decrease the risk of a peace officer developing PTSD, a mental-mental injury.

Findings and Recommendations

In addition to hearing from subject matter experts, the task force reviewed other state programs and statutes. The Legislative Sub-Committee of the task force conducted extensive research and did not identify any single solution from another state. Rather, the research demonstrates that any legislative solution should be combined with non-legislative alternatives.^{12 13}

Amidst the diversity of thought and perspectives of task force members, it was still possible to reach agreement on many findings and recommendations. The task force provides the following non-binding, programmatic recommendations for consideration.¹⁴

1) Training Recommendations

- a) Academy/Basic Training
 - i) Initial cadet basic training should incorporate trauma awareness education that includes: basic training in stress management, stress inoculation, critical incidents, and posttraumatic stress disorder (PTSD).
 - ii) Mental trauma awareness education should be included during training scenarios and didactics.
 - iii) Spouse/family education, including information on vicarious trauma and symptoms and police family dynamics should be made available.
- b) Continuing Education within Each Department
 - i) Reinforcement should be placed on stress management and education, to include signs and symptoms of posttraumatic stress, vicarious trauma, substance abuse and addiction, and warning signs of depression and suicide.
 - ii) Tactical scenarios should include psychological response strategies to train officers to prepare for the psychological impact of a critical incident.
 - iii) Attention should be paid to providing information on vicarious trauma and signs and symptoms of stress, with emphasis placed on those officers assigned to particularly disturbing assignments, such as child pornography units.

¹² See Appendix F for the Advisory Policy Sub-Committee Report and Appendix G for the Advisory Legislative Sub-Committee Report

¹³ See Appendix M for the Advisory Policy Sub-Committee Findings for Best Policies and Practices for PTSD Prevention

¹⁴ While the term “officer” is used throughout the recommendations, the intent of the task force is to ensure the recommendations apply to all employees of law enforcement agencies, where applicable.

- iv) First line supervisors and commanding officers should receive additional training on identifying signs of stress and trauma in employees and methods to use Peer Support and psychological services.
- v) As technology becomes available, academies and continuing education curriculum may benefit from simulations that utilize virtual reality for stress inoculation, similar to the military, utilizing immersion training for soldiers. This allows peace officers to experience a critical incident in a safe environment and practice both tactical and emotional response.
- vi) Spouse/family education should be provided on stress management, signs and symptoms of PTSD, vicarious trauma, and police family dynamics. Agencies may explore the option of recommending literature, relevant speakers, and/or online training and interactive web seminars as an avenue to provide spouse/family ongoing education.
- vii) Explore the possibility of incorporating a certain number of hours of mental wellness/suicide prevention for law enforcement officers through the Peace Officer Standards and Training Board (P.O.S.T.).

2) Pre-Employment Psychological Evaluation Recommendations

- a) The current statute for pre-employment evaluations reads:
 “C.R.S. Authority for Appointment: S 16-2.5- This appointed individual has undergone both a physical and psychological evaluation to determine such person’s fitness to serve as a provisionally authorized peace officer, certified peace officer or a reserve peace officer. Such evaluations shall have been performed within one year prior to the date of appointment by a physician and either a psychologist or psychiatrist licensed by the state of Colorado per S 24-31-303(5) (b), C.R.S. Psych/Medical evaluations are only required prior to the first appointment after academy graduation. Evaluations are at agency’s discretion after the first appointment.”
- b) In regards to the above statute, the task force recommends that psychologists/psychiatrists follow the most current version of the International Association of Chiefs of Police (IACP) Psychological Pre-Employment Evaluation Guidelines (2009).¹⁵ These guidelines include examiner qualifications, job analysis, testing, validity, interviews, background information, reports and use of the evaluation.
- c) The task force supports and encourages that a pre-employment psychological evaluation be performed on every new hire to a department, even if the employee is a lateral transfer from another law enforcement agency.

3) Peer Support Recommendations

- a) Continue resource development for Peer Support options.

¹⁵ See Appendix C
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- b) Ensure that officers are aware of Peer Support, and ensure that Peer Support maintains visibility throughout the department (i.e. occasional e-mail reminders, posters, etc.). Ensure understanding of departmental policy regarding confidentiality of Peer Support, if applicable.
- c) Ensure credible training for members of Peer Support and provide members with appropriate referrals and resources. Peer Support programs should be consistent with the most current version of IACP guidelines.
- d) For agencies unable to have a Peer Support program due to lack of funding or size, Mutual Aid or a Regional Peer Support Program may be viable options.
- e) Peer Support should be utilized to help identify officers who may need additional help and facilitate them connecting to the appropriate resources.

4) Psychological Services Recommendations

- a) Each department should have psychological services available for their employees. If an Employee Assistance Program (EAP) is utilized, ideally, there would be clinicians in the EAP with specialized training and knowledge of law enforcement and trauma.
- b) Psychological services are encouraged to maintain visibility at an agency and employees should be informed on how to contact and utilize these services. If an officer is experiencing high stress levels in his/her everyday life, he/she may be more likely to experience more severe trauma reactions following a critical incident.
- c) Law enforcement administrators should encourage officers to engage in psychological support services. Administrators should provide their staff information about the confidentiality and availability of psychological support resources.
- d) Law enforcement administrators are encouraged to provide psychological interventions following a critical incident.
- e) Department programs should focus on early identification and treatment, particularly in cases of cumulative PTSD.
- f) Department programs may offer a proactive annual wellness check-in with a department mental health provider, a member of the Peer Support Team or other available support resources. This is a confidential meeting that does not initiate any records unless major concerns about an officer's fitness for duty arise, in which case a plan of action will be developed with the officer in accordance with the department's policy. A wellness check-in is not an evaluation. Participation in the program should be encouraged and is voluntary.

5) Critical Incident Response Recommendations

- a) Departments should follow the most current version of the IACP Guidelines for Officer-Involved Shootings (2013)¹⁶. These guidelines include: immediate psychological first aid (usually from Peer Support), connection with Peer Support and/or another officer who has previously experienced something similar to help normalize reactions, and follow-ups from a mental health professional at one and four months post-incident.
- b) Both Peer Support and Critical Incident Stress Management (CISM) are encouraged to be onsite during prolonged, larger scale incidents (i.e. Century 16 shooting). In cases where there are multiple departments and agencies responding, there should be a clear chain-of-command and limited-access credentialing for outside psychological services offering assistance.
- c) Departments should consider assessing any critical incident, regardless of whether a weapon is fired, for the need of psychological intervention.
- d) Mental health practitioners who were involved in the psychological intervention should follow up with officers at both one- and four-month intervals post-incident, at a minimum, as delayed reactions can occur. This should be in accordance with the most current version of the IACP Guidelines for Officer-Involved Shootings (2013). Peer Support can assist in identifying the need for further psychological intervention.
- e) Follow-ups with affected officers and support personnel should also occur on anniversaries, especially of larger scale incidents, and during any meaningful times during trial (i.e. public release of response report, mistrial, etc.). The department should consider having a Peer Support member with the involved officer throughout the trial as well as on anniversaries, if requested by the involved officers.
- f) Supervisors should be aware of less significant incidents that could potentially trigger a stress response as part of a cumulative trauma. Supervisors should consider modifying agency “Injury, Illness or Exposure” forms to allow for documentation of these events. This could be done by adding a simple check box to department forms, which would allow supervisors to easily document exposure to a psychologically traumatic event.

6) Media Recommendations

- a) Command staff, Peer Support, and/or Psychological Services should caution officers that there will be news articles, internet blogs, and comments on social media that may trigger an emotional response (anger, sadness, etc.)
- b) Peer Support members and/or command staff should communicate with officers as media reports arise, as these sometimes include inaccurate information that may trigger a response or create negative public opinion.
- c) Departments should be judicious in the disclosure of personal information of officers to the public and understand the potential risks of doing so. The IACP Officer-Involved

¹⁶ See Appendix D
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Shooting Guidelines (2013) suggest waiting at least 48 hours to release information specific to officers involved in an incident. The officer should be informed beforehand so that he or she has time to both process the incident and to make any security decisions. The department should consider having a Peer Support member with the involved officer throughout the trial as well as on anniversaries, if requested by the involved officers.

- d) A well-structured and standardized media campaign to the public should be considered to bring awareness to PTSD, suicide, and other mental impairment issues, particularly as they relate to law enforcement officers.

7) Resource Development and Utilization Recommendations

- a) Ensure that resources are readily available to all employees. Utilize the U.S. Department of Veteran Affairs PTSD website and South Carolina program as models.¹⁷ For example, the US Department of Veterans Affairs (VA) operates the Veterans Crisis Line, 1-800-273-8255, with the parallel online confidential chat function at VeteransCrisisLine.net and with text message service connection at 838255.
- b) Rural communities should engage in increased communication and resource sharing to ensure that officers have access to necessary services, trainings, peer support groups, etc.
- c) The focus on PTSD among officers should live past the adjournment of the Peace Officer PTSD Task Force, and the discussion should continue with law enforcement and other executives that focus on prevention, identification and treatment options. Current groups, such as the County Sheriffs of Colorado and the Colorado Chiefs of Police, may be used to further discussions on “best practices” (i.e., shared resources, peer support groups, and regional support teams).

8) Workers’ Compensation Recommendations

- a) Any legislative solution should include all employees that fall under “Law Enforcement Personnel” (i.e. corrections officers, communication officers, victims’ advocates, etc.). Care should be taken to assess which individuals qualify in order to be inclusive.
- b) C.R.S. 8-41-301.(2)(a) reads:
 - “A claim of mental impairment must be proven by evidence supported by the testimony of a licensed physician or psychologist. For purposes of this subsection (2), "mental impairment" means a recognized, permanent disability arising from an accidental injury arising out of and in the course of employment when the accidental injury involves no physical injury and consists of a psychologically traumatic event that is generally outside of a worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances. A mental impairment shall not be considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, lay-off, demotion,

¹⁷ See Appendix E
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promotion, termination, retirement, or similar action taken in good faith by the employer. The mental impairment that is the basis of the claim shall have arisen primarily from the claimant's then occupation and place of employment in order to be compensable.”

- c) The task force has found through testimony and other sources that the language in the above statute is problematic and needs to be reviewed by the legislature and considered for modification to ensure consistency in application. This recommendation has the full support of the Fraternal Order of Police (FOP), Colorado Police Protective Agency (CPPA), Association of Colorado State Patrol Professionals (ACSPP), Colorado Association of Chiefs of Police (CACP), the County Sheriffs Of Colorado (CSOC), Colorado Municipal League (CML), Colorado Counties INC. (CCI), Colorado Bar Association (CBA), Colorado Psychiatric Society (CPS) and Colorado Psychological Association (CPA). Representatives from State agencies provided technical assistance only in regard to legislative modifications during the meetings and abstained from the task force vote.
- d) The above statute already addresses claims in disciplinary actions, terminations, and other situations that could encourage abuse by employees, therefore it is not necessary to address this issue specifically.
- e) Off-duty incidents and on-duty incidents should be covered equally. Workers’ Compensation and insurance already cover officers acting under the color of authority while off duty.
- f) The task force finds it would be highly beneficial for Independent Medical Evaluations (IME) and treatment providers to have skill sets in both trauma and law enforcement duties. The task force recommends examination of this factor by the legislature and law enforcement agencies.

Appreciation and Recognition

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- Adeline E. Hodge, Master of Social Work candidate at the University of Denver and Legislative Intern to Colorado State Representative Jonathan Singer
- Marilyn J. Meyers, Psy.D., Licensed Psychologist – Health and Public Safety Psychology

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