

COP-2-COP Hotlines: Programs to Address the Needs of First Responders and Their Families

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This article delineates the factors that have long contributed to the high rate of stress-related disorders in “first responders,” those frontline professionals responsible for the safety and security of the public (law enforcement officers, firefighters, and emergency service personnel). It covers the rationale for COP-2-COP, a unique program designed to address the mental health needs of a high-risk population, its history, its components, and outcomes. This state funded program is a crisis intervention “helpline” for first responders, and their families, providing peer support, clinical assessment, referrals to mental health practitioners with relevant experience, and Critical Incident Stress Management. We begin with two newspaper reports of actual cases and end with four fictional case studies that reflect a composite of typical symptoms experienced by clients contacting one of the COP-2-COP hotlines. These cases are presented along with the special programs that were designed to address the consequences of the terrorist attacks that occurred on September 11, 2001. Fortunately, COP-2-COP was already in place and prepared to act in response to the impact of a trauma of unprecedented magnitude. [*Brief Treatment and Crisis Intervention* 6:66–78 (2006)]

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Even before we experienced the traumatic events of September 11, 2001, there was sufficient evidence in medical and psychological journals to demonstrate that a strong relationship exists between stressful life events and the emergence of a broad range of physical and mental health disorders. The symptoms that

have already been studied include poor job performance, increased accidents, sleep disturbances, marital discord, alcoholism, substance abuse, digestive disorders, respiratory ailments, cardiovascular disease, cancer, and Posttraumatic Stress Disorder (PTSD). Higher rates of these symptoms are found in some segments of the population than in others (Waters, Irons, & Finkle, 1982).

This correlation is based on predisposing factors as well as on the daily experiences of these groups (Waters, 2002). There is no doubt that as an occupational category, “first responders” (e.g., law enforcement officers, firefighters, and emergency services personnel) constitute an occupation-at-risk group.

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Recent Newspaper Accounts

On July 25, 2004, the *New Jersey Star Ledger* (p. 15) reported that Alfred Ritzler, a 46-year-old corrections officer at the Southern State Correctional Facility with 20 years “on the job,” held his girlfriend, Donna Weigard, aged 41 years, hostage at her home for 6 hr. After a standoff with local police, he shot her and then committed suicide. He was described as “level headed” by his colleagues who were shocked at the event. This incident was the fourth time that a New Jersey corrections officer killed a girlfriend or wife in the previous 18 months, and the second suicide. On a national level, the rate of domestic violence among law enforcement families seems to be growing at a much faster rate than among the general population.

On July 12, 2002, almost 1 year after the World Trade Center (WTC) events, the *New York Post* reported that Daniel E. Stewart, aged 27 years, a respondent New York City Fire Department medical technician who was deeply affected by the emotional trauma of sifting through body parts and the wreckage of “Ground Zero,” hanged himself in the basement of his home on Long Island, New York. He left behind a disturbing suicide note that described his heartache after hauling out body after body from the ruins of the WTC. Stewart, who was single, spent almost 2 weeks after 9/11 assigned to removing bodies. However, he continued to go through the debris even on his days off until January of 2002. Eventually, he went to the site only once a week, but the emotional trauma had already taken its toll. Although voluntary counseling was made available to the first responders during the months following the disaster, Stewart only sought treatment on one occasion. Many people thought then and still think now that the counseling should have been mandatory. However,

not every professional agrees (Waters, 2002). Stewart did not give any of his concerned friends and coworkers a clue as to his plans.

Early Recognition of Police Stress

As early as the 1970s, Karl Goodin, Chief of the Cincinnati Police Department, during his opening remarks at one of the first seminars addressing police work and stress, observed that “policing . . . is one of the most stressful jobs in the occupational picture today” (cited in Benson, 1975, p. 275). Chief Goodin continued:

I have been a policeman for almost twenty years. During that time, I have seen many of my fellow police officers incapacitated by health problems, heart attacks, ulcers, chronic headaches, mental depression, and even suicide. They have been stricken in numbers that seem unduly large when compared to friends in the business world and in government service agencies other than police.

The situation is a paradoxical one because police officers begin their careers as healthy men and women. They enter the profession as the healthiest and most physically fit people in any single occupation, yet year after year they are struck down at comparatively young ages when early health history would seemingly point to above-average longevity.

Figures showed that career police officers, both active and retired, die younger than those in most other occupational groups and suffer a particular high incidence of health problems. Why? The work is relatively clean; there are no poisonous industrial fumes to breathe or noxious chemicals to handle; it is certainly not monotonous compared to assembly-line work. Even though police officers run the risk of being killed in the line of duty, that is a relatively minimal

risk. Their job is actually safer than a good number of others, such as iron workers or farmers. (Benson, 1975, p. 275)

The fact that most first responders begin their careers in excellent health (as assessed by thorough physical examinations) and end with some job-related stress disorder demonstrates the cost of continuous exposure to stressful life events. Although not everyone in a hazardous profession exhibits discernable symptoms immediately, in the long run, the cumulative effect exacts a high price. Fortunately, there are strategies that will reduce the cost of facing danger and being responsible for the lives of others. Such individuals that exhibit fewer symptoms are those who are free to ventilate their reactions to a crisis. Hiding emotions or internalizing stress and anger are precursors to the development of stress-related disorders. Obviously, the inherent nature of police work precludes the immediate discharge of fears and apprehensions. Displaying emotions is not considered to be appropriate behavior for an individual who by profession, is mandated to protect others and to maintain safety and stability. "Police Culture leads officers to believe that they are a special population that has superhuman abilities and no weaknesses" ("Mental Health and Mental Illness," 2003, p. 358). This stoic persona is a self-expectation that is permeated by public beliefs fueled by the media. On the positive side, there are indications that strong support systems and effective coping skills can improve the officer's ability function effectively on the job and reduce tension at home.

There have always been requirements that police officers be strong enough to handle the job, but very little attention has been paid to mental health and resiliency, proven tools for survival. Although physical testing has long been emphasized and was the only prerequisite of the early "Bobbies" of Robert Peele during

the early 1800s in London, psychiatric examinations were not available at that time. Current testing procedures either have been underutilized or have been misinterpreted. The most widely utilized screening instruments include the Minnesota Multi-Phasic Personality Inventory that was originally designed to assess willing patients for treatment and not as an indicator of proficient police work. Complicated and expensive assessment centers have been compared to killing a fly with a hammer.

Black (2000) has found an interesting and valid corollary in the "Big Five" for law enforcement officers:

These 'big five' have traditionally been labeled Neuroticism (vs. emotional stability), Extraversion (or "surgency"), Openness to experience (alternatively viewed as culture or intellect), Agreeableness, and Conscientiousness (or dependability). In brief, Neuroticism is the inclination towards expressing anxiety, anger, depression, and other negative affects. Extraversion is marked by sociability, energy, and a buoyant frame of mind. Openness is characterized by objectivity, need for variety, and curiosity. Agreeableness is a tendency towards altruism, trust, and sympathy. And, conscientiousness is characterized by self-discipline, order, reliability, and foresight. These five factors have been proven as modes for survival in the police field, contrary to popular belief (Black, 2000, p. 2).

Black has truly captured the essence of successful policing. Too many people conceptualize police work based on how law enforcement is depicted in "sitcoms."

There are several inherent factors that are relatively unique to police work. For example, many individuals in the general population have the option of leaving their occupational challenges in the office. Police officers remain police officers even when not officially on duty.

In a restaurant, they may sit with their backs to the wall, scanning the room for signs of danger. Next, the public images and the job descriptions for the police are confusing. Moreover, law enforcement officers are alternatively admired and resented, delegated power and authority, and then given restrictions on the exercise of that power. The mass media depict more of the negative images of officers than images of officers as heroes. Finally, police officers are aware that there can be a “phantom assailant” behind every door or at every motor vehicle stop. Firefighters do not know what to expect when they rush into a burning building. Over 400 firefighters including New York’s chaplain were killed on September 11, 2001.

Another serious concern of the COP-2-COP program, in addition to the impact of terrorism, continues to be the suicide rate of officers. Unfortunately, many law enforcement professionals are not aware of the seriousness of the problem. More of the law enforcement budget is allocated to firearms training than to mental health needs.

Hackett and Violante (2003) wrote in their recent book:

Anecdotal evidence suggests that rates of alcohol abuse, depression and divorce are higher among police officers than the general public. Though statistics have not been compiled nationally, most law enforcement experts believe the police suicide rate is also higher, perhaps by as much as 50 percent. Because suicides among police officers are often reported as accidents or met with official silence, definitive numbers are hard to come by.

A police officer commits suicide every 24 hr. Data indicate that a police officer has at least a 3:1 chance of committing suicide than being killed in the line of duty. Evidence has also shown that rates of depression, alcohol abuse,

and family problems tend to be higher amongst law enforcement professionals than the general public. These factors have already been related to suicidal ideation and actual attempts (Hackett & Violante, 2003).

Some new evidence is also beginning to surface that shows that the aforementioned issues may be even more important for the police, Emergency Medical Services (EMS) and firemen who were involved in the September 11 tragedy. The call rate for COP-2-COP has increased drastically with respect to marital conflict and substance abuse since 9/11.

Obtaining information on suicide from police sources is difficult. Suicide is not openly discussed by police personnel. Officers tend to view suicide as dishonorable both to the officer and the profession. Departmental statistics on police suicide are rare, and police agencies are sometimes reluctant to allow researchers access to existing data. Another problem with studying police suicides is the lack of research across geographical and departmental variables. Most studies focus on one department and are conducted in large cities, and very little is known about suicides in small or rural departments. Although epidemiological data indicate that police officers are at higher risk for suicide than the general population, such results may not be applicable to every area of the entire country.

The History and Philosophy of COP-2-COP

After a series of police suicides in New Jersey in 1996–1998, a group of community leaders lobbied the legislature to create Bill 1801, which funded a helpline for law enforcement officers known as COP-2-COP. After 4 years of existence, this program has already answered over 12,000 phone calls and was a primary resource for the first responders and the families who were directly impacted by the tragedy of

9/11. The need for this program was based not only on the incidence of suicides and other stress-related symptoms but also on the inherent resistance of this population to seek treatment.

COP-2-COP provides clinical assessment, peer support, referrals, and Critical Incident Stress Management sessions. It utilizes both volunteer peer counselors (retired officers trained in the "Crisis Model") and screened professionals with relevant experience. Due to the unexpected success of the COP-2-COP program, it has become a model for other emergency service crisis intervention programs that provide education and supportive resources to first responders.

COP-2-COP is the first program of its kind in the country to be funded by legislative law. The COP-2-COP program established a toll-free "Law Enforcement Officer Crisis Intervention Services" telephone hotline. In July of 2000, an agreement was signed between the New Jersey Department of Personnel and the University of Medicine and Dentistry, University Behavioral Healthcare. The program "went live" on November 1, 2000, and by December of 2005 it had answered 16,500 phone calls. In April 2002, COP-2-COP became the first and only law enforcement crisis intervention program to be certified by the American Association of Suicidology. In its first year, prior to 9/11, COP-2-COP received over 1,700 phone calls. In the first few months immediately following 9/11, a 300% increase in calls was recorded, thus eliciting attention to the program from the New Jersey Governor's Office, the New Jersey Attorney General's Office, the *New York Times*, The New York Police Department, the Port Authority Police Department of New York and New Jersey, the Federal Bureau of Investigation, and the Secret Service as well as similar national and international organizations.

Marketing of the COP-2-COP program is accomplished by having the staff give presentations at union meetings, police and

firefighters academies, chiefs' association conferences, countywide training sessions supported by the county prosecutors, and even appearances at roll calls at the various shift changes. We have used every means possible to the public of our program including giving out hats with our logo and phone number (COP-2-COP; 1-866-267-2267, the last seven digits are COP-2-COP). We had pens, wallet cards, and posters made and distributed. We continue to attend all police conferences and, finally, we find that word of mouth endorsements or a stern admonishment from a ranking officer has encouraged clients to seek our help.

Our success has been attributed to the alliance between the population served and the peer counselors who are all retired officers. Another factor is the quality of providers that COP-2-COP recommends. Originally, 200 police departments were polled for names of successful therapists and psychiatrists who had been used in the past. This call for professionals resulted in over 150 providers with expertise and interest in working with the law enforcement community. We need not worry about any of these therapists running into the hallway screaming, "Oh my God, she's got a gun!" Furthermore, we offered training for this group in issues such as the Police Personality, PTSD, and Critical Incident Stress Debriefing. The training is an ongoing process and includes nationally acclaimed experts in the field.

COP-2-COP's original mission remains a mandate to "serve those who serve us" by providing a 24-hr behavioral healthcare hotline service to law enforcement officers throughout the State of New Jersey. Although confidentiality and integrity are the cornerstones of COP-2-COP's efforts, the staff follows the State guidelines to ensure the safety of the officers and the communities in acute circumstances. It strives to maintain its commitment to the law enforcement community in New Jersey and aspires to tailor the program to law enforcement behavioral

healthcare services. To meet its goal, “Crisis Call Model” training is provided to all individuals who answer the phones. This process is a combination of a class taught by Nagdomen, a crisis and suicide line trainer of national acclaim, and the ABC model, first conceptualized by Caplan and Lindemann in the 1940s and further defined by Jones in 1968 (cited Kanel, 2003). Basically, the system is in three parts: “A, achieving contact; B, boiling the problem down to basics; and C, coping” (Kanel, 2003, p. 29).

The volunteers and staff have also been taught Basic, Peer, and Advanced Critical Incident Stress Management, primarily by Everly and Mitchell, cofounders of the International Critical Incident Stress Foundation and original presenters of the Critical Incident Stress Debriefing model. About 15 months ago, the COP-2-COP staff were taught how to apply the Roberts’ Seven Step Crisis Intervention model to suicide-prone police officers who called the hotline and their families.

The COP-2-COP Model

The COP-2-COP models are very similar and apply the first three and fifth stages in Roberts’ Seven Step Crisis Intervention Model. A review of Roberts’ model (Roberts, 2000, 2005; Roberts & Yeager, 2005) will enable the reader to see the common factors and some differences.

1. Plan and conduct a crisis assessment (including lethality measures).
2. Establish rapport and rapidly establish a relationship.
3. Identify major problems (including “last straw” or crisis precipitants).
4. Deal with feelings and emotions (including active listening and validation).
5. Generate and explore alternative coping strategies and skills.
6. Develop and formulate an action plan.
7. Establish a follow-up plan and agreement.

Because COP-2-COP comprises law enforcement officers helping other law enforcement officers, establishing rapport is easier than for other hotline operators. Through the use of common terms and similar backgrounds, an implicit connection is experienced, indicating that the client and the counselor speak the same language and are on the same track. Consequently, a working relationship is quickly established. Our assessment follows a protocol that is attached to the clinical page and visible to the agent. The check list requests answers to:

1. The nature of the presenting problem.
2. The severity and length of time that the problem has existed.
3. The actual impact on functioning.
4. Precipitants or the immediate cause of the problem.
5. Past history of substance abuse.
6. Other relevant aspects of past history.
7. Past inpatient and/or outpatient psychiatric history.
8. Current Medical problems and medical history.

Another section of the initial interview asks questions about suicidal or homicidal ideations and whether or not the officer has access to his/her duty weapon or any other firearms or method (assessment of lethality). All of our clinicians and most volunteers have been trained and certified as trainers by Violante using Quinnett’s prevention tool, “QPR.” The simplicity of this process is remarkable:

1. Question anyone exhibiting suicidal tendencies or depressive symptoms.
2. Persuade that person to seek assistance.
3. Refer that person to a mental health professional.

Concerns about feelings, “The last straw,” is a very important component of the assessment

and are addressed among several of the above questions (e.g., “presenting problem” and “precipitants or cause of the problem”). The “listening and hearing” phase exists throughout the telephone interview. The clinical staff of COP-2-COP are very attentive to what the client is really saying and the important issues the client has left unsaid. In order to develop viable action plans, the counselors must explore and assess past coping mechanisms. Of course, the challenge in this phase is to learn about the client’s skills and successful prior coping attempts. It is critical at this point that we avoid interjecting our own suggestions. We have had numerous requests from clients that we solve their problems (typical of many counseling clients). During this stage, we also search for depressive symptoms. When we ask, “What do you do for fun or entertainment?” if the client’s response is, “Well I used to . . . , but I don’t even want to do that any more,” the clinician has an indication of anhedonia (a symptom of depression) and the loss of a prior coping skill, which needs to be addressed.

During the process of setting up an action plan, the clients need to participate actively because it restores control and improves cognitive functioning. However, we do not leave them with too many choices. Our program has follow up built into the process. We call back our clients every 10 days until we are convinced that they are stabilized. We will call more often if we deem it necessary. The call-backs are highly valued by the clients, have generated very few problems, and are rewarding to our staff and to the volunteers. We hear comments regarding continuous progress and appreciation for our efforts.

COP-2-COP Programs Following September 11, 2001

The COP-2-COP program has been very successful in intervening in a variety of difficult individual cases and has also provided support

on a mass scale to major departments after 9/11. Our involvement was extensive and an invaluable learning experience in itself. No Crisis Intervention Unit had ever been presented with the gravity and enormity of this event. For example, we learned that an extremely important addition to all disaster responses must be a dedicated helpline for all personnel involved, including survivors and families.

Phase I: We provided clinical support to the large numbers of Crisis Intervention Teams that responded from all over the nation and Canada. Some of them were attached to the Federal Emergency Management Agency teams at Javits Center. We also assisted the New York City Police Department Early Intervention Unit in debriefing their first responders.

Phase II: This stage consisted of stress management training for all affected police commands over a 10-week period while they were still participating in the recovery operation and were making huge personal sacrifices of time and energy. Officers later said that they had 15 or 20 weeks of their lives stolen, never to be regained. The predominant early reaction was anger (a well-known component of the grief process).

Phase III: Phase III involved large seminars with first responders and the last groups to leave the site. Noted speakers were invited from all over the country, including Violante, author of the *Blue Epidemic* and an expert on police suicide; Everly, cofounder of the International Critical Incident Stress Foundation; and Reese, former director of the Behavioral Science Unit at the Federal Bureau of Investigation Academy in Quantico.

Phase IV: The activities of Phase IV continue to this day with a therapeutic presence on the anniversary of 9/11 and the 3 or 4 days, both before and after that anniversary. On the second anniversary, we provided a remembrance service at a memorial site to the victims of 9/11 and for all survivors of EMS personnel.

Ancillary Programs

As a result of our experience, and recognition of need, several programs were developed with a similar format to COP-2-COP. A hotline (1-866 “WTC-RSVP”) was put in place for all emergency service personnel impacted by 9/11 including fire, police, and EMS. They were viewed as “victims of a crime” and our services were funded accordingly. As time passed and the need for the WTC response decreased, another program was implemented (1-866-NJFDEMS) that responds to the needs of fire and EMS personnel with a realistic goal of establishing a model program at the University of Medicine and Dentistry of New Jersey Emergency Response Squad and dissemination of this program to all other units when the requisite legislation is completed and signed into law.

Case Studies

The mandate of COP-2-COP to serve the needs of the individual is best understood in the typical case studies that we will present here. However, in order to maintain the confidentiality of our clients, we have created the names of each case and combined the presenting symptoms so that no individual can be identified. Each case is a fictional account.

Case Study I: Officer “Brenda Morgan”

The client is a 37-year-old, single, Black, female officer who is seeking counseling. She lives alone and has no children. She is a police officer with a large department. Officer Morgan responded to duty at the WTC for 5 weeks but has been reassigned to a special unit. However, she feels this unit is not receptive to female officers. She reports sleep disturbances, eating problems, and difficulties in concentrating and in coping. Officer Morgan has started to isolate herself from family and friends. In par-

ticular, she states that she has lost 50 lb in a 5-month period without dieting. She also reports severe chest pains and feels that at one time, she was having a heart attack. The client responded to her primary care physician and was given a stress test. The stress test proved negative. The psychiatrist assigned to Officer Morgan prescribed Xanax and Ambien for her anxiety. The client reports that although she was treated by a psychiatrist for over 2 months, her issues remain unresolved. The client now speaks about killing herself (suicidal ideation) and states that she has had some fleeting thoughts about suicide in the previous 2 weeks. Officer Morgan also states that all her weapons have been removed from her home. However, she says that, if she decided to “take her life, she wouldn’t use a gun.” When the client was asked if she had a plan or if she intended to take her life, she replied that if she wanted to commit suicide she had enough pills in the house to do the job.

Officer Morgan stated that she “has had enough,” and “cannot take it anymore.” She feels that she is being harassed at work by her supervisors. She also reported experiencing severe shoulder pain from a gunshot wound that she had previously received when making an arrest. During the assessment, she stated, “I think that I will end it.” The counselor asked if there is anyone that she trusts who could be called to transport her to a screening center in order to safeguard her. The client agreed to allow the staff to call her partner while she remained on the line. Her partner was located and agreed to go the home of the client. While the client was still on the phone, the screening center in her municipality was notified and promised to respond to her home and assess the situation. Screeners arrived at the client’s home and, assisted by her partner, made the necessary arrangements to transport her to the hospital for further psychiatric testing. Once the assessment at the center was complete,

Officer Morgan gave her permission for voluntary admission to a mental health unit.

This COP-2-COP intervention actually comprised only the first two stages of Roberts' model, crisis assessment (lethality) and establishment of rapport. It was clear that this client needed inpatient care. Talking to the police counselor enabled her to take the next step toward recovery rather than engage in a self-destructive act. The helpline counselor did not underestimate the danger and contacted the assessment center immediately and the client's partner for assistance in moving to the next stage. Despite her call for help, she did have a plan and the means to carry out a suicide plan.

The assessment center staff came to the conclusion that Officer Morgan needed to be hospitalized for a short period of time. She agreed to a voluntary commitment.

During her hospital stay, Officer Morgan had the opportunity to review the major precipitants including her experiences at Ground Zero and her shooting injury. In a safe environment, she was able to finally express her fears and explore alternatives that she had previously ignored. When she was released from the hospital, she had the beginning of an action plan and was having fewer difficulties in concentrating and problem solving. She agreed to outpatient treatment during which she could continue to formulate her plans. The COP-2-COP counselors called her and found that she was making progress.

From time to time, she calls the line to let the counselors know how much help they provided.

Case Study II: Officer "Brian Casey"

Officer Casey had 7 years on the force when he called the COP-2-COP line seeking advice. His third and current marriage has lasted 3 years with one child. He also has three children from his previous two marriages living at home with

his family. He admits to consuming a six-pack of beer every day after work but denies having an alcohol abuse problem. His presenting problems are feelings of helplessness and hopelessness due, he thinks, to marital difficulties that have persisted for more than 6 months. He states that he has contacted the COP-2-COP line because the arguments have escalated and the previous night, his wife filed a domestic violence complaint against him. The police department was involved and Internal Affairs took away his gun. Officer Casey admits that he has been drinking all day and has been living in his car due to a protection order forbidding contact with his family. He reports that life is not worth living and has had some thoughts of committing suicide.

Officer Casey was directly involved with the September 11 events. Furthermore, he states that his marital problems escalated after his return from volunteer work at the morgue for 16 weeks in addition to his normal 10-hr shifts, 6 days a week, necessitated by special assignments during the aftermath of the WTC disaster.

Although there were several problems, some of which predate his 9/11 involvement, the primary issue with this client appeared to be a need to establish rapport and assist him in recognizing his alcoholism. The alcoholism was a particularly delicate issue and could not be easily addressed with screening center participation due to the client's suicidal ideation and difficulties in establishing his actual location (he was using a cellular phone). After several phone calls and lengthy dialogue, he was referred to a local rehabilitation center that has a special residential program for law enforcement officers. Subsequently, this officer was returned to his family, reinstated on the job, and reports doing well. He has continued outpatient counseling for the trauma issues.

Once the alcoholism and domestic violence issues were addressed, the counselors in the

residential facility were able to help him examine his previous marital problems, his relationship difficulties, and the trauma associated with 9/11. This is a long-term case that will require follow-up by both the residential facility and the COP-2-COP counselors. Alcoholism is a constantly relapsing disorder that cannot be handled by crisis intervention strategies alone. Utilizing Roberts' model, it is clear that assessing lethality and establishing rapport were critical issues for the COP-2-COP counselors. The evaluation of previous coping skills and plans for the future became the responsibility of the alcohol and substance abuse residential program.

Case Study III: Mrs. "Ellen Winters"

The wife of a law enforcement officer called COP-2-COP in order to get help because she reports that she is afraid of her husband. She fears his angry outbursts and is also concerned about his own safety because he has made statements alluding to committing suicide. For example, he has said that, "If it wasn't for the kid, I'd kill myself." The wife has had a restraining order taken out against him. Officer Winters has tried to coerce his wife into dismissing the restraining order, claiming that he will lose his job if she does not comply with his demands. Mrs. Winters fully understands the implicit threat in this claim because it would mean a loss or significant decrease in income for her and their two children aged 6 and 8 years. Mrs. Winters is also pregnant and is concerned about food bills and the mortgage. Officer Winters has succeeded in frightening his wife, leaving her uncertain of what course to take.

The COP-2-COP staff informs Mrs. Winters that as long as her husband does not violate the restraining order, he will not lose his job. The staff explains that a restraining order is a civil procedure, not a criminal charge, but Officer Winters must take some kind of corrective action. Mrs. Winters is advised to maintain the

restraining order for her safety and for the protection of the children. According to policy, Officer Winters has had his duty weapon removed and he has been suspended from duty due to the domestic violence complaint. This is standard operating procedure in all departments, usually followed by a psychiatric evaluation and a "fit for duty" report. Counseling and anger management are the usual treatments in such cases. During the initial intake with Officer Winters, the information is uncovered that he has been using "a lot" of oxycontin in the past 18 months since returning to work following disability leave for 6 months. It was during his disability leave that the treating physician prescribed oxycontin. In the time since he returned to work, Officer Winters has increased his use of oxycontin and gone to several doctors in order to obtain separate prescriptions. The officer's job is at risk because of the drug problem. He needs to get treatment for this addiction as soon as possible. If his problem were alcohol, there might be some tolerance, but misuse of drugs, whether they are "street drugs" or prescribed, will result in termination. This could be the lever that would get him into contact with COP-2-COP and into treatment.

Officer Winters' recent behavior involves angry attacks on family and coworkers. There have already been disciplinary actions at work based on his behavior. He has been away from home for days at a time and his wife has no idea where he goes. When he does come home, the arguments begin again and he leaves. According to Mrs. Winters, he has been removing items from the house, but, again, she has no idea what he is doing with them. At this moment, Mrs. Winters is the actual presenting client. The staff agrees that this is a complicated case, typical of many of the COP-2-COP calls. The first issue is the safety of the wife and children. Domestic violence cases can escalate rapidly from verbal threats to homicide. Restraining orders do not always work and perpetrators often feel

a sense of entitlement to “punish” their spouses. Suicide can also follow. The second issue concerns the safety of the officer who has substance abuse problems and has expressed suicidal threats. Because the wife has made the initial contact, she remains our responsibility. The wife needs to be protected from the batterer because of imminent danger. Great care must be taken to refer her to an appropriate facility. She must be a part of this decision. One of the resources that COP-2-COP uses is Women Aware, a program for abused women in Metuchen, New Jersey (there are similar programs around the country). Women Aware offers support, safe houses (refuge), and practical advice to abused women. The next goal is to establish contact with Officer Winters, preferably, to have Officer Winters call the hotline. As every mental health professional knows, each family has three stories: His, hers, and the TRUTH (if it proves true). Officer Winters could be referred for treatment for abusing a prescription drug. Other law enforcement officers who are involved with alcoholic anonymous can serve as sponsors and be supportive. There are Alcoholic Anonymous meetings designated for police officers. Rapport has already been established with Mrs. Winters. However, her situation could still prove lethal. The first reaction is to send her to a shelter, but this is not always the safest place. Police officers usually know where the shelters are located, often in close proximity to police headquarters. Mrs. Winters’ health is an issue because she is pregnant. The counselors must assess not only her coping skills but also her resources. They must discover her support group (e.g., family and friends) and her financial status and immediate needs. Clearly, practical problems can interfere with the development of a viable action plan. Eventually, a plan is developed that involves going to the shelter where there will be assistance with caring for the children and where with the shelters counselors, she can decide what she wants to do with her life. The

COP-2-COP staff will continue to contact and have hopes that Officer Winters supervisors will influence him to seek help. This is a case in progress.

Case Study IV: Officer “Robert Jones”

Robert Jones called the COP-2-COP helpline in March of 2002. He was 34 years old and had worked for a major urban police department for 12 years. He has been married twice and has two children from his first marriage who live with his ex-wife. His visitation rights specify that he can spend every other weekend and every other holiday with his children. Officer Jones was easily engaged and rapport was established despite his state of morbid depression. He reported sleep disturbances, irritability, inability to concentrate or focus, and inability to engage in normal social activities or to enjoy anything other than staying home alone and playing video games. An old back injury had put him on temporary disability for the 6 months prior to his first call to COP-2-COP. Officer Jones’ primary complaint was his depressed mood and the rapidly disintegrating relationship with his current wife. He stated that it is very difficult for him to establish and maintain any lasting relationship and that he feels that he will never change.

Officer Jones police normal assignment was patrol and he was among the first responders to the WTC tragedy, arriving just after the first tower went down. He said, in describing the event:

We were up next to a building to avoid the falling bodies. It was terrible. I saw a man or maybe a woman, I don’t know which, split in half by a flagpole. I know now that they don’t die or pass out before they hit the ground. I could see them trying to break their falls with their arms and legs outstretched, just before they hit the asphalt.

Further discussion about his 9/11 duty disclosed persistent symptoms of PTSD. He said that he had missed being debriefed after the detail because he took 3 weeks vacation immediately and went to Puerto Rico. Officer Jones still has flashbacks, nightmares, reexperiences the event, and recalls the smell of death while he was digging in mud that was part human remains.

The first time he called, Officer Jones was not willing to seek individual treatment with a licensed clinician. However, after several phone calls over a period of 3 weeks with the COP-2-COP peer counselor, it was suggested to him that he was actually reporting some relief just from the telephone contact. He was told that this improvement was a clear indication that "talk therapy" is effective and that he would get even more relief by speaking to his own private therapist. A therapist would be provided from the network of providers that specialize in working with law enforcement personnel and trauma. He agreed and spent 6 months in treatment that resulted in marked improvement.

Following Roberts' Seven Stage Model of Crisis Intervention, we begin with an assessment of the lethality of Officer Jones' condition during the first conversation. He was not evaluated as being in immediate danger of a self-destructive act. The stage of building rapport was significantly shortened because callers are aware that they are speaking to retired officers or clinicians with specific experience in addressing the issues that face law enforcement officers, firefighters and EMTs. However, it still took several calls before he was willing to contact a therapist. During those calls, Officer Jones' prior concerns and previous coping strategies were examined. When he began to work with the licensed professional, they made plans for the future and periodically assessed Officer Jones' progress. Although he has already made significant changes in his life and reduced the severity of his symptoms, he has been made aware that he is free to return to

counseling and that he should check in with his counselor from time to time. If he does not follow up with his counselor, the counselor will call him because maintenance of contact is an integral component of the COP-2-COP process. One should not forget the nature of the 9/11 trauma for first responders. Images such as the ones of falling bodies that filled Officer Jones' dreams are likely to recur periodically and he will need continued support. It would be wise for spouses programs to be established to share information about PTSD and effective coping techniques.

Family therapy is, indeed, the way of the future.

Conclusions

It takes very little imagination to read the above cases and to see how easily our interview schedule can be integrated into Roberts' Seven Step Crisis Intervention Model (Roberts, 2005). The establishment of rapport has been the key to our process and is an integral part of all our programs. Assuming that the police profession (the first group that we addressed) is a culture unto itself, a program that considers and integrates the norms and the language of that profession into its program, especially during difficult times, shortens the assessment and therapeutic process and increases the probability of successful outcomes. Callers seem universally relieved to find another person on the hotline who has "been there," speaks the same language, and instantly recognizes their problems. Those of us who answer the phones, often hear the comment, "you really know how it is," and we accept that as a compliment. Due to the resistance of law enforcement officers and other first responders to seek treatment, it seemed logical that they would find it easier to take that difficult first step if they knew that they would be speaking to a brother or sister officer. The overwhelming success of the program supports that

assumption. Hopefully, a longitudinal study will indicate that the COP-2-COP program has actually improved the overall wellness of first responders and their families in this state. We know that we have saved some lives and certainly made a difference with many individuals.

Before September 11, 2001, there was an awareness of the differential impact of traumatic life events on those individuals most responsible for the safety and security of the public. Now that this nation and others have faced terrorism, we are even more sensitive to the debt that we owe our first responders and that there are actually viable programs that can reduce the costs of doing their jobs. Courses and training programs already exist and should serve as models to our nation. We need to teach crisis theory and practice to everyone who is responsible for the well-being of others from childhood to old age. COP-2-COP is only the beginning.

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