

The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@columbia.edu) or Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (steve007my@aol.com).

A Confidential Peer-Based Assistance Program for Police Officers

Posttraumatic stress is an understandable complication of police work. Despite stereotypes that portray police officers as heroic and invincible, about one-third of police officers who are exposed to diverse work-related traumatic events develop significant posttraumatic stress symptoms. Many suffer from additional complications, including high rates of alcohol abuse, marital and family problems, domestic violence, and suicide.

Police officers with psychological or personal problems are reluctant to seek assistance from internal departmental services. Fears of stigmatization, adverse job consequences (such as modified work assignments, altered career paths, or loss of one's weapon), and perceptions of personal weakness or failure prevent police officers from seeking help. As a closed group, police officers are unwilling to share their problems with mental health professionals, who are seen as outsiders who cannot understand police culture.

After 26 suicides in the New York Police Department (NYPD) over two years (1994 and 1995), it was determined that a confidential, nondepartmental assistance program was needed to assist NYPD officers. In addition, peers would be needed to help

officers overcome the personal and cultural barriers to seeking professional assistance. With the endorsement of the NYPD and Police Unions, the Police Organization Providing Peer Assistance (POPPA) was created.

POPPA is a confidential, voluntary, independent, nondepartmental assistance program for the NYPD that uses trained volunteer NYPD officers as peer support officers. Volunteers have been recruited and trained from all ranks and backgrounds of the NYPD. Since 1995 POPPA has run a 24-hour help line. An officer can call any time about any personal or job-related stress problem and talk to a trained volunteer peer support officer. Calls are self-referred, and all assistance is voluntary. Within 24 hours (the same day if necessary), the peer support officer will meet with the officer face to face. About 75 percent of calls to the help line result in a face-to-face peer meeting.

To protect privacy, such meetings take place outside departmental facilities, and no records are maintained. The peer support officer provides an empathic ear and screens for major safety issues, such as suicidal or homicidal ideation, alcohol abuse, and risk of violence. The peer support officer also helps the officer accept that a personal or stress-related problem is not a sign of weakness or personal failure. Asking for help is discussed as a sign of strength. Often this peer meeting provides the support that officers need to be able to use their own personal resources to cope more effectively.

When necessary, the officer is provided with a referral to a mental health professional who is trained and experienced in working with police officers. Peer support officers do not provide ongoing counseling. Their role is to screen, support, and act as a bridge toward professional assistance. Clients who need further assistance are advised to see a professional. The responding peer support officer discusses each call and referral with a senior peer team coordinator who has several years of experience working

with POPPA. All at-risk or questionable cases are reviewed with the clinical director, a retired police officer and C.S.W., and, when needed, with the medical advisor, a psychiatric physician.

POPPA has developed and trained a panel of more than 110 independent mental health professionals in New York City and the surrounding counties. Alleviating fears of job-related consequences, all assistance provided is confidential and is not reported to the NYPD. Officers of the NYPD have gradually accepted POPPA's peer support officers and the reality that sometimes even they need assistance for personal problems. In the first year, there were about 250 calls to the help line. Since 2001, the number of calls has increased to between 900 and 1,200 per year. The proportion of callers who accept a referral for professional assistance has also increased, from about 30 percent to 45 percent of callers. Because of confidentiality issues, detailed information is unavailable. However, the primary reasons for calls over the years 2003 and 2004 were in the areas of stress or anxiety (34 percent), alcohol problem (26 percent), marital problem (24 percent), traumatic stress (18 percent), depression (14 percent), and bereavement issues (7 percent).

It is encouraging to see that many police officers can overcome stigmatization issues and view mental health problems as normal complications of their work that can be addressed. Other emergency services and professional organizations whose members also fear the consequences of seeking assistance—such as physicians, nurses, and other mental health professionals—may also benefit from a similar independent, voluntary, confidential peer-based assistance program.

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Clinical Neurophysiology Services in Psychiatry Departments

In general, the clinical neurophysiology needs of psychiatry departments are currently provided by clinical neurophysiology laboratories housed in neurology departments for electroencephalography (EEG), medicine for electrocardiography (ECG), and either medicine or neurology for sleep studies. This arrangement has a number of significant drawbacks. First, a majority of studies of the use of EEG among patients with psychiatric disorders are published in psychiatry or psychophysiology journals, which are not commonly read by internists or neurologists. Second, most neurologists and internists lack psychiatric training. This training gap is a serious problem, because interpretation of tests must be performed within the differential diagnostic process for the patient.

Psychiatry-based clinical neurophysiology laboratories could remedy both these problems. Moreover, the proximity of the laboratory to the clinical population will allow psychiatry trainees and faculty members to be more exposed to this area of knowledge. Such exposure is important, because the current underutilization of EEG by psychiatrists is largely a result of the psychiatrists' distance from the field and consequent poor understanding of psychiatric indications for EEG assessment. The value of EEG in the diagnostic evaluation of psychiatric patients is well documented (1). Polysomnography has a limited but definite place in the work up of nocturnal episodes. Finally, the use of EEG in psychiatry has recently increased as a result of the adverse effects of a number of new psychotropic agents.

In this report we describe the experience at the department of psychiatry at the Ludwig-Maximilians-University of Munich, Germany, where clinical neurophysiology services are

provided within the department.

The division of clinical neurophysiology provides all clinical EEG and ECG studies for inpatients and outpatients in all age groups. Patients receive a routine EEG recording, usually within the first week after admission, before they receive medication. Further recordings for monitoring are performed on request, if clinically necessary. In cases of suspected epilepsy or epileptic seizures, serial EEGs are recorded. All ECG recordings are also provided by this unit.

The clinical neurophysiology laboratory is an autonomous working group managed by physicians who are trained in psychiatry, neurology, and neurophysiology. These physicians are responsible for the supervision and training of staff, quality assurance of the technical devices, analyses of neurophysiologic data, preparation of the written EEG reports, and contact and cooperation with clinicians.

Personnel training includes continuing clinical education—for example, psychopathology and differential diagnoses of neuropsychiatric disorders, technical practice and tutorials, and discussion of important EEG findings and specific EEG patterns.

After the routine admission workup, further assessments are performed as needed. It has been estimated that, on average, more than 3,000 routine and research EEGs and more than 4,000 routine ECGs are recorded in the laboratory each year.

Because the unit is integrated within the psychiatric hospital, there is a close cooperation between neurophysiologists and clinicians. The neurophysiologic assessments are requested by using a standardized form and are usually handled within three days in cases of emergency (delirium, confusional states, and suspected nonconvulsive epileptic states) without any delay. On the same day of the respective recordings, the data are analyzed, and a report is sent back to the ward. There are weekly demonstrations of EEG recordings with relevant findings for all clinicians.

The average cost of a routine EEG as covered by health insurance ranges between \$30 and \$80, depending on

the complexity of the case. However, up until now the diagnostic and therapeutic procedures have been part of the daily fixed costs of a hospital stay. The routine EEG and ECG recordings are included in the general diagnostic services and are covered by the hospital budget (included in the total cost of stay in hospital).

This model of a psychiatry-based clinical neurophysiology laboratory exemplifies the many benefits such a service can provide for the discipline of psychiatry. The laboratory provides a teaching service that is currently lacking from a majority of psychiatry training programs. The laboratory also provides an opportunity to conduct clinical studies or derive publishable data from ongoing service records—for example, pharmacoelectroencephalographic studies.

Regarding cost, an important point to be emphasized is the significantly lower charge for a routine EEG compared with the current charges in the United States (from \$400 to \$600). If the charges for routine EEG were significantly lower (below \$100), they could be covered by third-party payers or can be included in the overall cost of hospital stay.

A directory for training sites for psychiatrists is available from the EEG and Clinical Neurosciences Society (ECNS; www.ecnsweb.com). Board certification in clinical neurophysiology is also available for psychiatrists at the American Board of EEG and Neurophysiology (ABEN).

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Reference

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