"Alms for an ex-leper" - Breaking Down the Barriers to the Recovery of Police with Psychological Injuries

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ABSTRACT

This paper explores the impact compensation entitlements can have on the treatment and recovery of police suffering from duty related psychological injuries, including Post Traumatic Stress Disorder (PTSD), Depression and Occupational Burnout. This paper is based on the author's extensive clinical experience over 4 decades, treating in excess of 3000 police.

An environment of potential, or unresolved, compensation issues is generally seen as adversely impacting on the successful rehabilitation of psychologically injured officers. Our experiences suggest that despite this a therapeutic approach based on cognitive behavioural therapy can assist police clients make significant clinical gains in terms of recovery and functioning. The key elements of clinical success depend on a sound therapist-client relationship, open and frank communication with police injury management and a commitment by all stakeholders to the so called "hierarchy of rehabilitation", in terms of any achievable return to work program.

[Scene from Life of Brian – Movie]

1. Background

The NSW Police Force (NSWPF) is one of the largest police agencies in the world with over 15,000 sworn officers, and a significant number of non-sworn officers who act in administrative roles. I would like to have provided a broader coverage of this intriguing organisation and how it delivers its services to the people of NSW, but time prohibits that. Specifically, in relation to any discussion today, it may be sufficient to say that the NSW Police confront traumatic circumstances that few of us will ever face and on a daily basis.

As a result of this and despite significant resilience as well as skills that assist them cope, many fall victim to a range of psychological conditions, the least of not which is Post Traumatic Stress Disorder (PTSD). Of course police, unlike their civilian counterparts who rarely experience traumatic circumstances, do so throughout their working life. I suppose most of us in this room can conjure up 4 or 5, or if you are as old as I am 6 or 7 events that would meet the criteria of a traumatic experience. Indeed our chances of suffering Post Traumatic Stress Disorder as a result remain typical of the general population at just 3% - 6%.

However most of us who work with emergency services understand the notion of the accumulative affects of trauma, this type of exposure is particularly seen among our war veteran population, refugees and of course emergency service personnel. Professor Sandy McFarlane, I think was the first to coin the term "creeping trauma". This is a form of PTSD

that is due to exposure to multiple traumatic events. This difference with civilians becomes critically important in any talk of treatment and recovery of police. Our treatment protocols especially the gold standard recommended by authorities in this area such as the Australian Centre for Post Traumatic Health, is based where a single event or at least several events over a relatively short period of time are the cause of PTSD, and specifically are the target of treatment. The first error regularly made in treatment is to simply apply a general protocol to police, I will return to this later in my presentation.

Many police experience PTSD, estimates in the western world are that 20% will suffer PTSD. In a police force of 15000 this will result in a substantial rate of injury indeed, one that has been the focus of my clinical practice for nearly 30 years.

There are other conditions that police suffer, and depression as well as substance abuse can also be prevalent co-morbid conditions of PTSD. Many police officers suffer occupational burnout, developing a sense of hopelessness, despair and depression that comes from their commitment to this demanding vocation. Of course this condition is not accepted in the psychiatric nomenclature and usually referred to within the DSMIV as "Chronic Adjustment Disorder".

However in this presentation I want to particularly focus on PTSD. Clinically I have taken the view that those with PTSD are best helped by removing them from the source of what caused the PTSD (as optimal therapeutic intervention would demand). Some do not support this rule, however when you consider that a person who has PTSD is then nine times more likely to suffer, if exposed to future trauma again, clinically at least I think there is a duty of care to make a recommendation that will provide the best prognostic outcome.

This imperative has been confirmed by the Supreme Court of NSW in Doherty vs. NSWPF [May 2010] indicating that a psychologically damaged officer even when "recovered" should not be put at any foreseeable risk. The NSWP by failing to address this risk were punished by a costly determination made against them. For us, as a profession, to ignore this determination could be risky, certainly this determination puts us on notice to be prudent in any recommendations we make when returning injured officers back to work.

2. Getting Data

The most difficult task I had in preparing this paper was eliciting data from the NSW Police, i.e. just how many officers do suffer from Post Traumatic Stress Disorder. I was unable to obtain any data from the insurer or WorkCover. I am sure you understand why this information is well guarded or secret.
They claimed of course that it was "confidential", but how does a public utility lay claim to such a right in this age when being both transparent and accountable are the so called hall

marks of honest government? I would argue that if inordinate amounts of taxpayers' funds are being spent, then we have a right to know. From a political standpoint I can understand the sensitivity of the issue, but that should be secondary to probity and openness in government.

This practice has for the past 30 years has seen probably in excess of 3000 police officers (we stopped counting at 3000 some time ago. I am able to make some estimates ourselves that we derive from our clinical interventions. However as I said earlier, we take the position that an officer who suffers from PTSD, should be in most cases be medically discharged, so our sample will have some bias

The data I requested from the NSWPF was

1. How many police were diagnosed as suffering from suffering PTSD in the last two years? [That would simple enough by accessing the initial Workcover Certificates]. 2. How many returned to work after being diagnosed? a) to restricted duties, b) alternative duties (non operational) or c) full time duties
3. How many were discharged?
4. Of those initially returned to work in the first year 2008, how many continue to serve in 2010?
[This question is important because of the issue of predictable relapse raised earlier in this paper]
5. I sought statistical information in respect to gender differences, (consideration for separate data for heterosexual and homosexual police officers).

So in the absence of being able to gain any figures, we examined 200 police officers we have seen in the last 2 years.

The reason we have kept a record in particular of these officers as they took part in a study examining the trajectory of stress among police officers and I refer here to the paper "Identification and Measurement of Work-Related Psychological Injury: Piloting the Psychological Injury Risk Indicator Among Frontline Police"[1].

Of those 200 officers who participated in our study I have extracted the following information:

[1] Dollard, Maureen F., Peters, Roger Tuckey, Michele R., Winwood, Peter C. Journal Of Environmental Medicine. Volume 51, Number 9, September 2009 Pg 1057 - 1065

I diagnosed 60% as having burnout (adjustment disorder) However 85% were later diagnosed by a psychiatrist as having PTSD. The average number of treatment sessions was 13.
I diagnosed 22% as having PTSD (all confirmed)[2]
15% of police clients had their claims disputed – 100% were successful on appeal.
11% returned to full time work. 5% returned to work in restricted duty capacity.
84% were discharged
38% were discharged and now in employment
14% are currently completing training for employment outside police.[3]
7% decided to be a full time homemaker
7% were totally and permanently incapacitated for any work.
14% were of age for retirement from work

3. PTSD & Secondary Gain

So far I have simply provided background to establish the environment that we are operating in so that I can raise yet a critical consideration in recovery. This relates to issues of secondary gain. The first and foremost of these and the focus of this presentation is financial.

Let me see if I can confuse you first. The NSW Police has two sets of parameters for pensions. One is referred to as the Pre 1988 group of enlisted police officers who are entitled to on medical discharge 72.5% of their salary and have to simply demonstrate that they can no longer (due to their injuries) be operational police officers. This is obviously a shrinking group of officers with some estimates as low as 1200, again figures are difficult to obtain.

The second group are those police that were recruited between 1988 and 1992 and contribute to a different system of superannuation (SASS) and their entitlements allow an injured police officer on medical retirement to receive a substantial lump sum payment for partial, or a larger sum for total and permanent incapacity.
Those police recruited after 1992 receive virtually nothing through their superannuation fund, (First State Super) unless they are found totally and permanently incapacitated, but like all Post 1988 recruited officers have access to (D&D) an insurance scheme i.e. the Death and Disability Fund.
However all post 1988 officers in order to be medically discharged must demonstrate that they can't work within the NSW Police in any capacity, in either an operational or nonoperational role.

[2] This is a very biased sample (with significant clinical pathology), despite this percentage seemingly more in accord with the literature, with the anticipated rate of PTSD among police is 20%, however the similarity is just co-incidence. The facts are though this condition is over diagnosed.
[3] Again we are in fact highly successful in returning our clients to work, even if outside the NSW Police.

Death and Disability payments are calculated by a multiplication factor dependent on their date of birth, which in most cases in the case of partial incapacity sees payments on average of $500K and of course more if the officer is found permanently and totally incapacitated. So in fact an officer who is under 30 years of age on medical retirement receives substantially more than an officer who is over 40 years of age. You might see an inducement for younger officers to quit earlier than ever before.

There has been some discussion that perhaps the change to the Death and Disability Fund in 2011 should see that reversed where in fact people are encouraged to serve longer and be rewarded. It is a matter still very much undecided. My main concern is not about the change to the Death and Disability, but abandoning it where police may remain at work despite being damaged, indeed then not "putting their hand up" because there was no alternative. Ceasing this benefit would only provide a superficial answer to what they think is an epidemic of officers leaving the NSW Police.

4. The Impact on Policing

I believe the attrition rate is somewhat coloured by the issue of entitlements but I think the failure to retain reflects morale, issues in relation to the quality of recruit, and simply how tough "the job has become. To ignore this and overly simplify to being caused simply by the so called "cash grab", (financial entitlements) is to ignore, at peril, some these significant challenges this organisation must face.

In my Region at the time of writing this just 55% of operational police officers were at work. You can only imagine the burden of the workload on those who are left to remain and quite obviously the consequences of that will be a higher burnout rate and more people taking time off. Peter Cotton certainly has indicated that rates of PTSD are inversely proportional to the morale or support agency, a point many in the NSWPF seemingly ignore.

5. Treating PTSD

If I was to ask you whether or not in all of this, especially in the last 10 years, whether there had been any scientific research studies that indicated the efficacy of any particular treatment of PTSD in police what would you say? Intuitively, if you didn't know your answer I think would be "of course".
Indeed you would think that a high risk group such as police would be up there with the most frequently studied population. While there are certainly studies on policing and the stress in policing, (literally thousands of them), there are no studies that have actually captured the results of any intervention in the police population.

In Australia, Richard Bryant who would be well known to all of you is presently testing a protocol via his Post Traumatic Stress Clinic which is using 12 sessions based on cognitive behavioural approach with exposure therapy. As I understand it he is not actually controlling for any variable such as workers compensation. He is just opening that clinic up to anyone who suffers from Post Traumatic Stress in the NSW Police. I will certainly be interested in his data. Of course one of the challenges for him and for that matter all of us who work with police is the multiplicity of variables, not just gender and age but in the case of NSW Police the state of morale. The fact that there are differences in terms of recruitment criteria in the last 20 years and certainly quite significant differences in work entitlements between those who were recruited prior to and post 1988 as indicated above. All of which need to be in the "mix" if we are to understand what works and why it does or doesn't.

So what works for us as a practice is a cognitive behavioural therapeutic approach, one that has been developed based on our own experiences but not validated, other than the anecdotal success we can report. It is interesting when challenged and asked if our intervention is based on a science practitioner model (which presumes that there is a hard body of evidence that has been peer reviewed and supported by the literature) the answer is "no" because asi have indicated, there isn't any. The fact is we simply use an intervention that seems to work for us.

6. Focus on Recovery

There are a significant number who do or could return to some work in the NSW Police but two difficulties need to be understood. The first is that Section 43a of the NSW Workers Compensation Act quite clearly identifies that an employee cannot be disadvantaged by their injury so taking a police officer from an operational role then say to a clerical role is first not in the best interests of the clients recovery (and in fact so often adds to their sense of despair). Secondly such a job is rarely commensurate with their pre-injury qualifications and training which a requirement of Section 43a of the Act is. I wrote a paper in 2008 "Punished for being injured"; you might get the flavour of that paper from simply the title.

The second issue for police with PTSD who then work in non operational duties is that they may still be exposed to traumatic events. For instance communications is recommended but if researchers want to study stressed people, they recruit call centres or communications units. Again quite often police officers with PTSD are recommended to work in exhibits. You might imagine what that job entails, in fact it involves the daily handling artefacts and objects and material that relates to some of the most awful crimes that have been committed.

Further recommendations for work as say "brief handling manager" means that the officer who may be damaged is then exposed to material that one can only assume would cause

distress, heightened anxiety and thus exacerbate PTSD (which after all is a condition of arousal). Again these can be poor choices for rehabilitation.

So the options for police returning back to police work are mostly poor. However, given the fact there is such an inducement to leave by the substantial payout of either the Death and Disability, or 72.5% salary for life, from an administrative and economic point of view, the answer is pretty straight forward for many police. From a vocational point of view it is a bit more difficult, because I would say at least half of the police officers I see do not want to leave the NSW Police. Yes they are jaded, yes they are angry often with the system but mostly they feel a sense of loss and this is a grieving for something that they have yearned to do all of their life, this leads to ambivalence, and not to be taken lightly, especially by the treating therapist.

The principle issue in working with anyone who has felt unsafe through a traumatic experience is the restoration of safety. For instance if you are working clinically with someone today who has been involved in a very traumatic event, part of what your exposure desensitisation therapy does is assist the client to feel safe again.

The key to recovery comes to restoring our client's sense of safety. For instance if you have been in a motor vehicle crash it may be the fact that you rationalise the event by thinking of the statistical number of miles travelled and the chances of you having any kind of crash ever again are so remote and of course with several trips without incident you are again able to feel safe, i.e. the extinguishing of this fear driven response. However in treating police it needs to be understood that when a police officer returns to the front line not only can they expect to return to an environment that is unsafe, but whatever happened in first 10 years of their career will probably happen again in the next. So you might see therapy that may work with clients who have been exposed to a single traumatic and extraordinary event is patently not appropriate in treating police.

7. Getting Better

The first question an officer may ask themselves is how I get a discharge if I don't have any symptoms and I am not "sick". Secondly how do I get well again? Thus therapeutically there is a barrier to getting completely well and that looks like a secondary gain.
Invariably it is not, reasonable but inaccurate thinking. In other words, police seem to think they need at least "a bit of a limp" to be able to make exit.

In therapy we encourage officers to understand that it is not just the fact that they are "sick" that they will be medically discharged. It is that they have been injured and that the organisation should not be willing to take the risk of damaging them further, or injuring them again.

In about the third month that an officer will plateau, or have made the best recovery they will for a while, [see Graph]. This means that they have some time before they reach optimal or final recovery. With most police there is a period of probably six months where they will recovery sufficiently to be functioning well enough, but not sufficiently to say that treatment is complete.

As I say, the important period of therapeutic part of the engagement is probably the first 4-6 sessions; thereafter it's often a case of treading water.

8. Conclusion

Efforts in returning police clients back into meaningful and dignified work but outside the NSW Police Force and maintaining remission is mostly successful. I believe that despite using a therapeutic model that we developed ourselves, the dodo effect applies. That is that the best therapist will achieve the best result irrespective of the model that is used. However, there is a substantial need for quality research to validate not just our intervention but all treatments currently applied to this unique population.

Thankyou very much

A Case Study: Doherty Vs The State of New South Wales [2010] NSWSC450 (20 May 2010) before Justice Price

Background

Barry Doherty was retired in 2005 as a Sergeant of Forensic Services Group. For most of his police life he had been exposed to a range of incidents and as a result of those incidents suffered from PTSD and was subsequently medically discharged.

As a result of his Post Traumatic Stress Disorder, he sued the NSW Police for negligence and was successful.

The determination by his Honour should be read thoroughly (78 pages) if we are all to move forward with respect to the issue of PTSD and rehabilitation.

The facts of the matter are that Barry Doherty was returned to work, after he clearly had Post Traumatic Stress Disorder. While his symptoms had ameliorated sufficiently to allow the police doctor Dr Li (PMO) to give a certification that he was fit to work, this was "unsafe". As this determination proves it was a dangerous action and was also negligent and as a result exposed the NSWP to an action at Common Law.

What this judgement clearly demonstrates is that police with PTSD, even when they are symptom free should not be returned to an operational role due to the higher chance of relapse, worse of course for police who still retain symptoms who are then extremely vulnerable to triggering events, even simply by being in the police environment.

There is a significant tension between the aims and ambitions of the NSW Police in returning officers back to work. After all they are charged with maintaining a fully functioning operational police force while at the same time avoiding any unnecessary wastage that comes with premature retirement, including of course protecting the Death and Disability Benefits paid to police on medical discharge with hurt on duty claims.

On another side, there are those officers who are so committed to their work they underreport their symptoms and in fact fake positive in order to maintain their employment, with concerns of fear for being seen as fake. This misplaced loyalty cost Doherty 1/3 of the settlement which was originally over $1million.[4]

[4] Any psychologist working with police officers understand this loyalty (at other times fear) that drives injured officers back to work; it is a sentiment that is readily capitalised on by the organization. However Doherty did technically contribute to his own injury and it's an insightful decision by His Honour, that otherwise would have undoubtedly led to an appeal by the NSWP

The facts of the matter are though that there are yet another group of officers who suffer these symptoms and who desperately try to escape but have to go through a number of hoops in order to establish their entitlements and any kind of exit with dignity.

The point I am making here is that if the hurdles and challenges that face officers who should make a claim but for whatever reasons go back to work, then the potential to create more and more cases like Doherty seems never ending. So an officer who is clearly symptomatic but returned to an operational environment where upon they became worse, then there is clearly an occupational health and safety issue for all concerned.

It should be kept in mind that if Death and Disability and entitlement which is claimed to seduce officers into taking medical discharge, is abandoned (in 2011 as proposed) then I suspect that while on the one hand while the cash incentive to leave will be removed, the incentive to stay and maintain ones income base (to pay a mortgage) will see more and more officers who are damaged return to the workplace.

Health and Well-being vs. An Adversarial system

The Doherty determination clearly highlights the role of advocacy in these types of cases, i.e. how the views based on an adversarial stance muddies reality. On the one hand in this case Professor Tennant, a professor of psychiatry arguing that all was done that could have been done and it was going to happen in any case, versus Professor McFarlane who talks about the kindling effect and how negligent it was for this person having been identified as suffering from Post Traumatic Stress Disorder and then returned to work at all. Both positions were predictable and both were "hired guns" and cash for comment professionals.

In the meantime, the PMO Dr Li had the invidious task of trying to work out whether this police officer should go back to work when quite clearly he didn't have a consensus of opinion and didn't have the medical or psychological expertise to be able to make such a judgement. He was dependant upon instead a group of psychiatrists and psychologists who are either employed by the NSWPF, or outside, and again as I say, these opinions tend to be based on adversarial grounds rather than good therapeutic sense.

[At least in this judgement, His Honour regarded the MMPI II which is regularly used psychiatric assessment as being ineffectual as a screening tool]

This judgement cost the people of NSW over $2Million. In addition Doherty's condition has not fully remitted and he will require treatment for some time, I suspect this says as much about the tortuous path of litigation as it does about the path toward recovery from PTSD.

Conclusion.

This determination validates an opinion, one that I have argued for years, that suggests that an officer having suffered PTSD should by virtue of that injury be medically retired and is certainly not fit for further operational duties. This judgement demonstrates that failing to recognise this principle is to fail in respect to their clear duty of care. This decision again has some major ramifications in respect to the rehabilitation and management of psychologically damaged police.

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