The Jordan Elizabeth Harris Foundation

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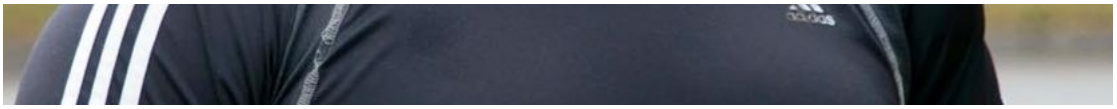
A CONVERSATION WITH FWPD PEER SUPPORT COORDINATOR BILLY MITCHELL (/BLOG/2019/10/1/A-CONVERSATION-WITH-BILLY-MITCHELL-PEER-SUPPORT-COORDINATOR-FOR-THE-FORT-WORTH-POLICE-DEPARTMENT)

We were deeply troubled by a recent article about an increase in suicides by New York City police officers of late, so we decided to reach out to local law enforcement officials and first responders here in Fort Worth to discuss what's being done to address their mental health and prevent suicides. First we spoke with Billy Mitchell, the Peer Support Coordinator for the Fort Worth Police Department. Billy's position revolves around watch-guarding the mental health of his fellow officers, and he offers a first person perspective on some of the unique stresses officers face.



What's your work background?

BILLY MITCHELL: I'm a 28 year veteran of the police department. I joined the peer support team in 2004 and became the Peer Support Coordinator in 2009. I've taken classes in Critical Incident Stress Management and I'm also an instructor in CISM.

What does it take to be considered for a position in Peer Support?

BM: So I don't have a degree or anything like that. I've gone through a couple years of college, but it's more about temperament. It's more about your willingness and your desire to help others. If you're not already assisting others in their times of need, then you're probably not a good fit for this job. It's something where you've already been recognized as someone useful to others facing intense stress.

As far as qualifications, you need to be a peer of the individuals you're trying to assist. For example, a police officer to help other police officers. But, of course, a police officer can also help a firefighter, or vice-versa, because they both understand certain aspects of emergency work. First responders are considered peers in those terms.

So you work in the Fort Worth Police Department, who all is under your umbrella?

BM: Everyone from the Chief down. Everyone. I've had the chief contact me. They contact me when they're concerned about an individual, or I've had Deputy Chiefs contact me with their own issues. Sometimes I go to the Chief and say hey, look, I know you're going through these stressful situations, what are you doing to take care of yourself?

I stay pretty busy. I get calls all the time. I sit at the front desk to stay visible so people can walk by and say "hey, Billy. I got something going on at home, can I talk to you for a sec?" and then we can just step into my office for a bit. Then I make followup phone calls to these individuals.

The truth is we all suffer from stress. And it can have an adverse effect if it's not dealt with properly. Even officers who've been fired, the very last thing I want is an officer to turn to suicide after losing his job. I don't care what he's been fired for, he's still an individual. So I don't want anybody to kill themself or spiral down the road to destruction if I can do anything about it. So I even meet with officers who have been fired.

> *Everyone from the chief down. Everyone.*

I'll sometimes do home visits. Yesterday I did a home visit with a young son of a recently deceased officer. His mother asked me to come by and talk with him.

My days vary. Before the end of the day I'm going to visit with an officer who retired and dealing with some lingering back issues, and he's home right now and I know he's depressed, so I just go see him for a while to make sure he doesn't feel forgotten. A lot of people don't realize, chronic pain goes hand in hand with depression. It's very common for people suffering from chronic pain to experience depression.

Anyone from the Chief on down, and then some. That's who's under my umbrella.

Is your position quite common among police departments?

BM: You ask is this common, but honestly, I am the only full-time peer support coordinator (for a police department) that I am aware of in the entire Metroplex. Maybe there are others doing full-time peer support work, but I'm not aware of them.

I'm good at what I do, but the difference is between first aid and surgery. What we do is considered "psychological first-aid", as opposed to surgery. A lot of times, all someone needs is a metaphorical band-aid. A quick follow up and addressing of potential mental issues. But I can't fix the mental equivalent of a compound fracture. That's work for a surgeon.

We do Critical Incident Stress Debriefings for groups of individuals who are involved in a traumatic incident. Primarily shootings, and suicides, and things of that sort. I call these "structured group discussions". These are similar to but NOT the same thing as group therapy.

One thing I should emphasize is that peer support team members are NOT technically therapists or counsellors, we are "peer support persons". So it's not a substitute for therapy, but often people going through a critical incident stress debriefing do not then require therapy. That's because these sessions help mitigate the harmful emotional effects while the incident is still in its infancy, stopping these problems from becoming entrenched and then more serious later on.

But the surgeon can't do anything if they don't know who needs help.

BM: Right. And an idea of how that works, if there were a shooting right now, I get a phone call and I'm out the door on my way. Research has found that people who have an initial visit with a CISM trained individual are more likely to seek needed psychological assistance. By being there, especially right after the incident, you're eroding the stigma of getting help emotionally.

Having the trust of these individuals is also key towards them seeking help. I've got a good reputation, and I thank God for that. People need to feel they can trust who they are talking to. Texas Health and Safety Code 784 establishes confidentiality between CISM trained personnel and first responders.

What are some of the unique stresses a uniformed officer faces which we may not be aware of?

BM: Hyper-vigilance is a big one that people don't think about. Hyper-vigilance is a constant readiness to act. You've heard of the fight or flight response? The flight or fight response is when an individual has to act, usually to preserve life, either his life or someone else's. And when that happens, their adrenaline levels are up, their cortisol levels are up, heart-rate increases. All those things gear the body toward action. And then...nothing happens. But all those chemicals are still in the body. So what do you do with that excess energy? This is why a lot of officers develop a gut. Those cortisol levels create belly fat if they're not burned off.

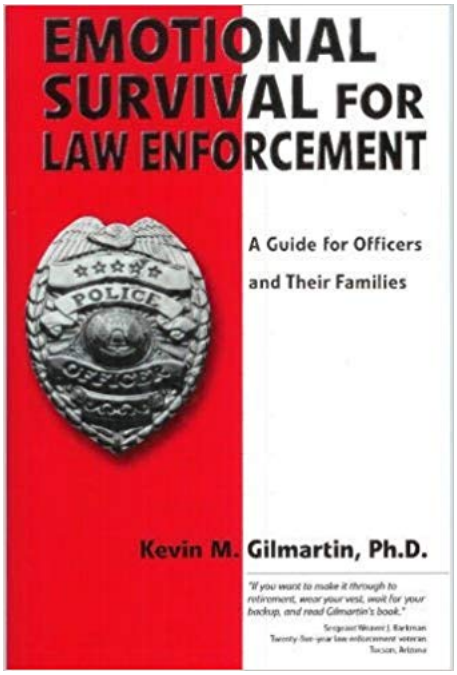
When we go to work, we may get dispatched out on the highway with heavy vehicles zooming by at 60 or 70 miles an hour. And we personally have known officers who have died or been severely injured on the freeway. So our necks are on the swivel all the time. We are constantly looking out for threats.

When I would get out of my truck, back when I was a uniformed officer, I'd constantly be looking for threats just walking to my door. Believe it or not, officers have been ambushed at their homes. And just because it doesn't happen often at all doesn't mean it's not constantly on my mind. And when we sit down at a restaurant we always sit with our backs to the wall, so that we can see every single person coming inside. We don't want our backs to the general public.

So that's what hyper-vigilance is, constantly looking for threats. This is one of the most debilitating things that officers face every single day we're in uniform.

And then we get home, so we're safe, right? You don't just hop out of hyper-vigilance. According to Dr. Kevin Gilmartin, author of *Emotional Survival for Law Enforcement*, it takes 18 to 22 hours for a person to fall out of hyper-vigilance.

And what's going on in that ~20 hours? Well, an officer is going back to work.



And what are some of the results on the body and mind from experiencing constant hyper-vigilance?

BM: Well, for starters, it can create anxiety disorders. It creates marital issues. Officers are more susceptible than the general population to alcohol issues, family issues, and suicide. Several studies show officers being twice as likely as the general population to abuse alcohol.

> *Of course, there are lots of positive feelings that can occur as well. The feeling that you're making a difference.*

More consequences: marital issues. It's not uncommon for officers to go through several marriages during their police career. Not uncommon for officers to experience heart disease when not exercising adequately. Being more prone to illness. Financial issues. Because you're constantly buying expensive things you don't really need in order to feel better. Also, there's a direct correlation between stress and police brutality. The more stressed an officer is, the more likely they are to lash out negatively in their dealings with the public.

Of course, there are lots of positive feelings that can occur as well. The feeling that you're making a difference. The esteem of being a police officer. It's a hard job to get, and then it's easy to lose. If you're not performing at the level you should be, if you make any mistakes or bad decisions, it's not hard to be fired, because so much is on the line.

Do you find that a stigma exists among officers in regards to seeking mental healthcare?

BM: Officers are less likely than civilians to seek mental health. And the reason for that is we fix everyone else's problems! We go to work and we go fix an accident, we go stop a burglary, we stop someone's violent argument. We fix peoples' problems. So the last thing we do is admit that we've got a problem ourselves. We don't want to be that person that needs somebody's help. We have a warrior mentality and that states 'don't worry about YOU, you've got a mission. Take care of the mission. Worry about YOU later.' So yes, officers are less likely to seek mental health assistance.

The old program for assisting an officer who dealt with a highly stressful situation: “ok, you and your buddies go out and get drunk tonight, then come back ready to work tomorrow.” That was the prescription, if you will, for officers

dealing with a stressful incident. If they saw someone killed, or their buddy got shot, you all go out and get drunk and come back to work tomorrow, maybe with a hangover. You 'man up'.

Yes, officers are less likely to seek mental health assistance than civilians, but that seems to be slowly eroding. And that's not by chance. It's because we're doing stuff to make people more receptive to getting help. And the more receptive they are the quicker that stigma will erode.

What improvements would you like to see in the future?

BM: I think the state needs to mandate mandatory training, at least on a yearly basis, about the importance of mental health checkups and education concerning our own stress. We've got a class called C.I.T. (Critical Intervention Training) which is for assisting the general public, but the fact is, we need more things focused on us and our own mental health needs. So I think it should be mandated that we receive competent training, every single year—I don't care whether you're a first year rookie or a 35 year veteran. I'd like to see four to eight hours a year dealing with attrition and psychological issues and their mitigation.

Also, I believe it should be mandated that every department have a peer support team, or in the least, that they're in concert with a regional support team. Officers need somebody that they can always feel comfortable talking with.

And I'll say one more thing, mental health checkups. Every officer, from the chief down, should be scheduled one hour a year with a true licensed mental health professional. He may never make the effort to on his own, but if he's got to be there, then heck, why not talk about the stuff that's been troubling him? I think that would be hugely beneficial.

Interview conducted by Dyar Bentz

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THE JORDAN ELIZABETH HARRIS FOUNDATION, 2830 SOUTH HULEN ST. #139, FORT WORTH, TX 76109, UNITED STATES (682) 207-5250 INFO@JEHFOUNDATIONFW.ORG (MAILTO:INFO@JEHFOUNDATIONFW.ORG)

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