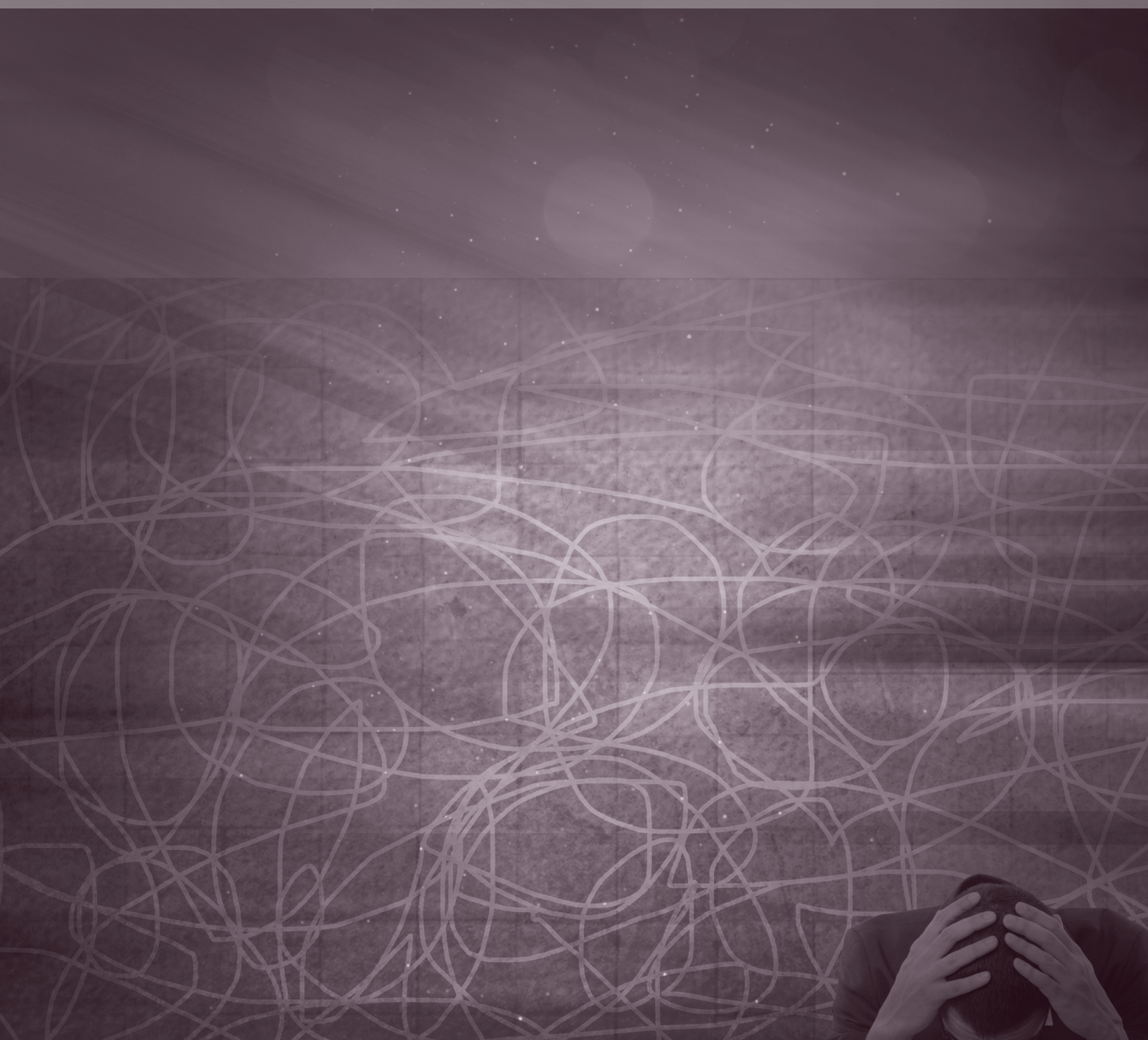
Law Enforcement Officer Suicide

2020 REPORT TO CONGRESS

COPS
Community Oriented Policing Services
U.S. Department of Justice

Law Enforcement Officer Suicide

2020 REPORT TO CONGRESS



The Internet references cited in this publication were valid as of the date of publication. Given that URLs and websites are in constant flux, neither the author(s), the contributor(s), nor the COPS Office can vouch for their current validity.

Recommended citation:

Spence, Deborah L., and Jessica Drake. 2021. *Law Enforcement Suicide: 2020 Report to Congress*. Washington, DC: U.S. Department of Justice.

Published 2021

This report responds to Senate Report 116–127 accompanying the Consolidated Appropriations Act, 2020 (P.L. 116–93). The Senate report language states the following:

> Review of Law Enforcement Mental Health and Wellness Programs.—The Committee recognizes the psychological and emotional impacts law enforcement face in responding to stressful and traumatic situations and is disturbed by increased reports of suicides by current and former law enforcement officers. The Committee directs the Department to provide a report within 90 days of enactment of this act assessing the availability of existing mental health resources for law enforcement agencies and should also include recommendations for increased access to, and utilization of, mental health counseling and programs focused on law enforcement suicide prevention efforts.
>
> This report shall also review the efficiency and effectiveness of peer responder programs for sworn and non-sworn law enforcement employees, including "train the trainer" models designed to support employees in the wake of a personal or professional crisis. This report should provide a review of the effectiveness of partnerships between peer responder programs and mental health service providers who specialize in clinical psychology services and behavioral sciences. The report should include any additional programs or resources needed to assist the Department in its efforts to aid State and local law enforcement agencies in developing and implementing law enforcement suicide prevention programs.
>
> [. . .]
>
> First Responders.—The Committee is concerned about the increasing number of suicides among first responders. Due to this increasing prevalence, the Committee directs the Department of Justice within 90 days of enactment of this Act to submit a report on the feasibility of establishing an evidence-based behavioral health program for police and fire departments and other first responders that provides adequate training to identify warning signs of depression, stress, Post Traumatic Stress Disorder, and other mental and behavioral health conditions that the specific population is experiencing. The report should specifically identify how peer-to peer assistance, mental health check-ups, time off after responding to a critical incident, and family training will help ensure the resiliency and health of first responders and police officers.

This report assesses the availability of existing mental health resources for law enforcement agencies; it provides a review of peer responder programs and makes recommendations for establishing evidence-based behavioral health and suicide prevention efforts for both law enforcement and other first responders as requested by the Committee.

Introduction

In the 2010s, suicide was the 10th leading cause of death in the United States.[1] In 2018, more than 48,000 Americans died by suicide, half of those using a firearm.[2] Although some segments of the population have higher rates of suicide than others, no part of our society is immune. In the 2017 National Survey on Drug Use and Health, 4.3 percent of adults reported serious thoughts of suicide in the past year.[3]

As part of the fiscal year (FY) 2020 appropriations process, the Senate report on the appropriations bill expressed that the Congress is "disturbed by increased reports of suicide by current and former law enforcement officers."[4] According to Blue H.E.L.P., a nonprofit dedicated to acknowledging "the service and sacrifice of law enforcement officers we lost to suicide,"[5] the last three years have seen an increase in reported cases of death by suicide in the law enforcement profession. Their data collection efforts reported 168 deaths in 2017, followed by 172 in 2018 and 228 in 2019.[6] In all cases, these numbers exceed the number of line-of-duty deaths for those same years.

But is this evidence of an increasing crisis in the law enforcement profession? Many commentators within law enforcement think even these numbers undercount the true extent of the problem; the increases Blue H.E.L.P. is reporting may actually be a function of improving awareness of that organization and the need not to hide these tragic deaths. As was discussed in the *Law Enforcement Mental Health and Wellness Act: Report to Congress (LEMHWA Report to Congress)* and in much of this other literature, most law enforcement officers are working-age men—a group known to have higher rates of death by suicide than the population at large. So it is important to remember that the extent to which suicide risk is a function of occupation is not yet known. A number of recent studies suggest that the national suicide rate has been increasing in the last 20 years. Since 1999, half of all states have seen 30 percent increases in suicide rates, and all but six had significant increases.[7] If officer deaths by suicide are increasing, it could be part of this general societal trend. However, given the high exposure to stress and trauma, the plethora of other conditions for which officers seem to be at high risk (including post-traumatic stress disorder [PTSD], depression, anxiety, cardiovascular disease, and addiction), and officer access to firearms, we cannot assume the occupational factors do not matter. At least one study has suggested that suicidal ideation is more prevalent among law enforcement officers than the general population.[8]

1. Jiaquan Xu et al., "Mortality in the United States, 2018." *NCHS Data Brief 355* (January 2020). http://www.cdc.gov/nchs/products/databriefs/db355.htm.
2. WISQARS (Web-based Injury Statistics Query and Reporting System), "Leading Causes of Death Reports, 1981–2018," Centers for Disease Control and Prevention, last modified February 20, 2020, https://webappa.cdc.gov/sasweb/ncipc/leadcause.html.
3. Jonaki Bose et al., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Mental Health* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018), https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf.
4. S. Rep. No. 116–127, Departments of Commerce and Justice, Science, and Related Agencies Appropriations Bill, 2020, at 121 (2020), https://www.congress.gov/116/crpt/srpt127/CRPT-116srpt127.pdf.
5. "About Blue H.E.L.P.," accessed June 12, 2020, https://bluehelp.org/about-us/.
6. "Blue H.E.L.P.: Honoring the Service of Law Enforcement Officers who Died by Suicide," accessed June 12, 2020, https://bluehelp.org/.
7. Deborah M. Stone et al., "Vital Signs: Trends in State Suicide Rates—United States, 1999–2016 and Circumstances Contributing to Suicide—27 states, 2015," *Morbidity and Mortality Weekly Report* 67, no. 22 (June 8, 2018), 617–624, https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a1.htm.
8. Ian H. Stanley, Melanie A. Hom, and Thomas E. Joiner, "A Systematic Review of Suicidal Thoughts and Behaviors among Police Officers, Firefighters, EMTs, and Paramedics," *Clinical Psychology Review* 44 (March 2016), 24–44, https://www.sciencedirect.com/science/article/abs/pii/S0272735815300684.

In the *LEMHWA Report to Congress*, the U.S. Department of Justice (DOJ) included a recommendation calling for the creation of a law enforcement suicide event surveillance system, calling attention to the U.S. Department of Defense's (DoD) *Suicide Event Report*.[9] And we are pleased to note the Congress's June 2020 passage of the Law Enforcement Suicide Data Collection Act. Once signed by the president, this law will start to make that recommendation a reality and improve our understanding of law enforcement suicide.

In the meantime, what is known is that there is a high rate of death by suicide among all the public safety occupations.[10] Two studies using the National Violent Death Reporting System (NVDRS) looked at deaths by occupational groups in 2015 and 2016 and found that the rates are higher than many other occupational groups for both male and female officers.[11] And a 2017 study in Australia found high suicide rates among emergency and protective services personnel through an analysis of retrospective mortality data.[12]

Officers are the most important resource agencies have, and every effort should be made to protect this investment made in our nation's safety and security. Healthy officers are necessary to healthy communities. We must do what we can to prevent those thoughts of suicide from becoming actions.

To help the Congress better understand what the profession is currently doing to prevent suicide and protect law enforcement officer mental health, as well as what more can or should be done, the authors researched some key areas, as requested in the Senate Report (and are grateful to Matthew Barge, Nola Joyce, and Sean Smoot for their assistance in conducting consultative interviews). First, this report adds to the *LEMHWA Report to Congress* in presenting what we know about peer responder programs in law enforcement—including train-the-trainer programs—and partnerships with behavioral health clinicians designed to support law enforcement agency employees in the wake of a crisis.

Second, it makes a good faith assessment of the availability of mental health resources for law enforcement personnel and the use of counseling and other programs focused on suicide prevention. This is not an easy task given more than 17,000 law enforcement agencies in the United States, each with widely varying budgets, staff sizes, and access to culturally competent behavioral health providers. A short time frame and a national public health emergency further complicated efforts to paint a fully accurate picture. The U.S. Census Bureau Household Pulse Survey suggests that in May 2020, up to one-quarter of Americans were showing symptoms of depression and one-third were showing symptoms of generalized anxiety.[13] COVID-19 may have an impact that should not be overlooked on officers' mental health—as likely will the sustained protests and calls to defund the police that have begun to take place around the country in the summer of 2020.

9. Deborah L. Spence et al., *Law Enforcement Mental Health and Wellness Act: Report to Congress* (Washington, DC: U.S. Department of Justice, 2019), 18, https://cops.usdoj.gov/RIC/ric.php?page=detail&id=COPS-P370.
10. John M. Violanti, Cynthia F. Robinson, and Rui Shen, "Law Enforcement Suicide: A National Analysis," *International Journal of Emergency Mental Health and Human Resilience* 15, no. 4 (2013), 289–297, https://pubmed.ncbi.nlm.nih.gov/24707591/.
11. Cora Peterson et al., "Suicide Rates by Major Occupational Group—17 States, 2012 and 2015," *Morbidity and Mortality Weekly Report* 67, no. 45 (November 16, 2018), 1253–1260, https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6745a1-H.pdf; Cora Peterson et al., "Suicide Rates by Industry and Occupation—National Violent Death Reporting System, 32 States, 2016," *Morbidity and Mortality Weekly Report* 69, no. 3 (January 24, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6903a1.htm.
12. Allison Milner et al., "Suicide among Emergency and Protective Service Workers: A Retrospective Mortality Study in Australia, 2001 to 2012," *Work* 57, no. 2 (2017), 281–287, https://content.iospress.com/articles/work/wor2554.
13. Alyssa Fowers and William Wan, "A Third of Americans Now Show Signs of Clinical Anxiety or Depression, Census Bureau Finds amid Coronavirus Pandemic," *Washington Post*, May 26, 2020, https://www.washingtonpost.com/health/2020/05/26/americans-with-depression-anxiety-pandemic/?arc404=true.

Last, the report includes a look at the efforts that have been initiated since the passage of the Law Enforcement Mental Health and Wellness Act and aims to identify the five key elements that are needed to assist the DOJ in its ongoing efforts to aid state and local agencies in implementing behavioral health and suicide prevention programs for first responders. These five foundational elements are summarized as recommendations at the end of the report.

Peer Support Programs and Behavioral Health Partnerships

Negative stress has a clear damaging effect on law enforcement officers.[14] Studies on first responders in a variety of fields have shown that frequent requirements for overtime work, shift work, night work, and working conditions that are physically challenging or dangerous all increase the risk of damaging effects on first responders' physical bodies and mental health and wellness.[15] Nationally, a conversation is underway about programs that would decrease the stressors that negatively impact officer safety and wellness, lower officer suicide rates, and take innovative approaches to building more resilient officers.

Unfortunately, there is limited analysis on the efficacy of mental health and wellness programs in a police department, resulting in the lack of a clear and concise pathway to preventing officer suicides that result from daily stressors and untreated trauma.[16] The following literature review seeks to summarize the key components—identified in a swath of research—that are said to influence a decrease in suicide, including gatekeeper training, peer-to-peer support programs that intentionally engage with psychologists who specialize in law enforcement, and improved confidentiality statutes and policies.

The authors of a recent issue brief produced by the National Consortium on Preventing Law Enforcement Suicide drew attention to the continuing gap in our understanding of what exactly works in the law enforcement setting.[17] They noted that most published articles focused on the topic were not evaluations but case studies, surveys, literature reviews, or expert opinion pieces. A 2012 literature review of critical incident stress management noted that "although current evidence suggests that employers have a duty of care for employees in high risk occupations . . . confusion abounds about the most appropriate forms of intervention."[18] And a 2017 meta-analysis of six studies that provided quantitative data on suicide deaths in the emergency and protective services concluded that "there is currently a lack of firm evidence on which to ground occupational policy with respect to the prevention of suicide in these occupational groups."[19]

A number of reasons explain why the evidence for efficacy is so thin. First, there will always be challenges in detecting a statistically significant impact on the suicide rate within any population group and attributing any observable change to a particular program or activity. In addition, there are ethical concerns associated in studying this topic; it is not reasonable to withhold treatment or services from any officer in the interest of having a control group of individuals not receiving the experimental treatment. Integrated program models are also difficult to systematically evaluate, requiring research expertise and funding that is not typically available to a law enforcement agency.

Last, there is not always clear agreement on what different terms mean. In 2003, Devilly and Cotton noted that "frequently and particularly in applied contexts, terms are being used without operational

14. John Marx, "Blue Trauma Syndrome," Cops Alive, March 22, 2014, http://www.copsalive.com/blue-trauma-syndrome/.
15. Jens Baumert et al., "Adverse Conditions at the Workplace are Associated with Increased Suicide Risk," *Journal of Psychiatric Research* 57 (October 2014), 90–95, https://www.sciencedirect.com/science/article/abs/pii/S0022395614001757.
16. Katrina Witt et al., "Effectiveness of Suicide Prevention Programs for Emergency and Protective Services Employees: A Systematic Review and Meta-Analysis," *American Journal of Industrial Medicine* 60, no. 4 (April 2017), 394–407, https://onlinelibrary.wiley.com/doi/10.1002/ajim.22676.
17. National Consortium on Preventing Law Enforcement Suicide, *Preventing Suicide among Law Enforcement Officers: An Issue Brief* (Washington, DC: Bureau of Justice Assistance, 2020), https://www.edc.org/preventing-suicide-among-law-enforcement-officers-issue-brief.NOSI Issue Brief.
18. Margaret Jane Pack, "Critical Incident Stress Management: A Review of the Literature with Implications for Social Work," *International Social Work* 56, no. 5 (September 2013), 608–627, https://journals.sagepub.com/doi/full/10.1177/0020872811435371.
19. Witt et al., "Effectiveness of Suicide Prevention Programs," 405 (see note 16).

definitions and are often used interchangeably. This makes inspecting the evidence behind claims a murky and very difficult task."[20] The continued challenge of poorly defined terms is borne out in numerous discussions by the DOJ's Officer Safety and Wellness Group since its establishment in 2011, with practitioners and clinicians noting that the lack of broadly accepted, layperson definitions of clinical diagnoses and practices makes it challenging for the law enforcement profession to be clear about what programs are working under what conditions. For example, in a 2019 meeting discussing coping strategies for stress management, "[a]ttendees felt that there was a lack of uniformity in the way that [post-traumatic stress] is defined and interpreted. . . . Meeting participants believe there is a need for a common, accessible definition that can be consistently applied and understood by both lay persons and professionals."[21]

These barriers to building a robust body of evidence lead to a number of gaps in what is known to be effective. The National Consortium on Preventing Law Enforcement Suicide, created in 2018 with funding from the Bureau of Justice Assistance, identified a number of knowledge gaps that persist even as greater attention is given to the problem of law enforcement suicide. These gaps include a lack of assessments on the quality of care provided by in-house behavioral health professionals, the role of resilience training in reducing suicide risk, and the role of families as both risk and protective factors.[22]

In police departments, stigma around mental health and wellness can be the most challenging barrier to overcome in a police department's attempt to change the culture surrounding officer suicide. Dr. John Violanti has published exhaustively on the effects of stress on the physical and mental health and wellness of law enforcement officers. He stresses there is a culture of silence in law enforcement that comes with suicide. In his book, *Under the Blue Shadow: Clinical and Behavioral Perspectives on Police Suicide*, Violanti reflects on a general feeling that command in most police departments views trauma with a "Suck it up and deal with it, like I had to" approach to officers in crisis.[23] In the past, it was not uncommon that an officer showing visible signs of being under duress or succumbing to stress would have their guns and gun ID card taken away, thus removing them from the streets and labeling them as unfit in their own perception or that of the entire agency. This fear has led to long-held privacy concerns for many officers seeking help.[24]

One thing that is clear is that all discussion and research into improving and protecting the mental well-being of law enforcement officers constantly circles back to the importance of peer support and behavioral health partnerships. Law enforcement officers are willing to talk to their peers before anyone else, making peer support programs supported by a partnership with a clinician a critical tool for increasing the use of behavioral health programs and services. This is not unique to law enforcement officers; research has documented that people of all walks of life report that their most common way of coping with a disaster is to talk about it with trusted peers.[25] But it is always brought up as being particularly important in the law enforcement context, where many officers

20. Grant J. Devilly and Peter Cotton, "Psychological Debriefing and the Workplace: Defining a Concept, Controversies and Guidelines for Intervention," *Australian Psychologist* 38, no. 2 (July 2003), 144–150, https://aps.onlinelibrary.wiley.com/doi/abs/10.1080/00050060310001707147.
21. Kelly D. Bradley, *Promoting Positive Coping Strategies in Law Enforcement: Emerging Issues and Recommendations*, Officer Safety and Wellness Group Meeting Summary (Washington, DC: Office of Community Oriented Policing Services, 2020), 10, https://cops.usdoj.gov/RIC/ric.php?page=detail&id=COPS-P375.
22. National Consortium on Preventing Law Enforcement Suicide, Preventing Suicide (see note 17).
23. John M. Violanti and Stephanie Samuels, *Under the Blue Shadow: Clinical and Behavioral Perspectives on Police Suicide* (Springfield, IL: Charles C. Thomas Ltd., 2007), 118.
24. Violanti and Samuels, *Under the Blue Shadow*, 119 (see note 23).
25. Carol S. North and Elizabeth Terry Westerhaus, "Applications from Previous Disaster Research to Guide Mental Health Interventions after the September 11 Attacks," in *Terrorism and Disaster: Individual and Community Mental Health Interventions*, ed. Robert J. Ursano, Carol S. Fullerton, and Ann E. Nerwood (Cambridge, UK: Cambridge University Press), 93–106.

feel that individuals who have not experienced the reality of the job cannot possibly understand the effect it has on them.

Some of the earliest research in first responder–related stress found that the most helpful coping behavior in the aftermath of a traumatic event was talking to others about the incident.[26] More recent studies have continued to bear this out. In late 2018, the National Fraternal Order of Police (National FOP) undertook a national survey of active and retired law enforcement officers in partnership with NBC New York. In the more than 8,000 responses received, the survey showed that three out of four officers prefer trained peer support as an intervention in a time of crisis. This is in contrast to employer-provided services such as employee assistance programs (EAP), about which a majority of the respondents said they have not used them and believe those services would not be effective.[27]

This belief in the power of peers to help individual officers cope with stress and trauma is not an accident. Community resiliency is important to individual mental health, and "sharing one's difficulties and struggles with close friends in times of hardship can actually be nourishing."[28] The close-knit community of law enforcement can actually be an important protective factor for officer mental health if it is allowed to set aside a culture of stoicism and emphasis on personal strength. This cultural shift is happening in the law enforcement profession and is to be celebrated and further encouraged through partnerships with clinicians who can note and affirm the existing group structures in their work.

Training is also critically important to supporting officer mental health and suicide prevention. Colleagues, supervisors, and managers are all important players in suicide prevention efforts, as they are the ones who may see the signs that an individual is struggling. But if they do not have the knowledge and skills to help them intervene—or if they believe intervention may further hurt their co-worker in crisis—they may not take steps that could otherwise prevent a death by suicide.

In 2015, RAND conducted a study to address the impact of so-called gatekeeper training and its efficacy in preventing suicides among law enforcement personnel. The study notes that "gatekeepers are individuals in a community who have face to face contact with large numbers of community members as part of their usual routine."[29] In the context of a police department, common gatekeepers would be command staff, chaplains, departmental psychological service staff, and others such as administrative staff and sergeants. The study found that trained gatekeepers are more able to recognize the warning signs of suicide and to respond with effective intervention strategies.[30] These findings are in line with similar studies conducted with a focus on gatekeeper training in the military.[31]

Absent training and support, potential gatekeepers may feel reluctant to address officer mental health and wellness because they do not feel equipped to responsibly handle the intervention.[32] Reluctance

26. Kathy R. Jambois-Rakin, "Critical Incident Stress Debriefing: An Examination of Public Services Personnel and Their Responses to Critical Incident Stress," *Illness, Crisis and Loss* 8, no 1 (January 2000), 71–90; 76, https://journals.sagepub.com/doi/pdf/10.1177/105413730000800106.
27. Officer Wellness Committee, *Report on FOP/NBC Survey of Police Office Mental and Behavioral Health* (Nashville, TN: Fraternal Order of Police, 2019), https://www.fop.net/NewsArticle.aspx?news_article_id=6548.
28. Al Dueck and Katie Byron, "Community, Spiritual Traditions, and Disasters in Collective Societies," *Journal of Psychology and Theology* 39, no. 3 (2011), 244–254, https://journals.sagepub.com/doi/10.1177/009164711103900307.
29. Crystal Burnette, Rajeev Ramchand, and Lynsay Ayer, *Gatekeeper Training for Suicide Prevention: A Theoretical Model and Review of the Empirical Literature* (Santa Monica, CA: RAND Corporation, 2015), 16, https://www.rand.org/pubs/research_reports/RR1002.html.
30. Burnette, Ramchand, and Ayer, *Gatekeeper Training* (see note 29).
31. Burnette, Ramchand, and Ayer, *Gatekeeper Training* (see note 29).
32. Patrick Corrigan, "How Stigma Interferes With Mental Health Care," *American Psychologist* 59, no. 7 (2004), 614–625, https://psycnet.apa.org/record/2004-19091-003.

to intervene was a common thread among most literature on officer suicides in the United States. Specifically, there is strong evidence supporting the idea that gatekeeper training improves knowledge and adaptive beliefs about suicide prevention and that these adaptive beliefs were associated with fewer suicide attempts in agencies three months following the training.[33] In the RAND report, researchers found across three studies that training reduced the reluctance of leadership to intervene compared to the control group.[34]

According to RAND, gatekeeper training results in the following changes in behaviors, beliefs, and response:

- Knowledge about suicide, including declarative and perceived knowledge about suicide, depression, and resources available for at-risk individuals.
- Beliefs and attitudes about suicide prevention, referring to whether individuals believe suicide is considered preventable, whether it is important or appropriate to intervene with at-risk individuals, and whether seeking help for mental illness is a form of self-care.
- Reluctance to intervene, including perceptions individuals may have that it is not their responsibility or that it is inappropriate to intervene, noting that the stigma surrounding mental illness is one reason for gatekeeper reluctance.
- Self-efficacy to intervene, reflecting the extent to which the individual feels comfortable and competent to identify, care for, and facilitate referral for a person at risk of suicide.[35]

Implementing training programs for gatekeepers can result in a significant reduction in suicide rates. Work looking at emergency and protective service workers found that suicide rates declined from 32.26 per 100,000 to 16.7 per 100,000 in a 12-year period following the training.[36] Assorted case studies reveal that the common themes in departments that have lowered suicide rates continue to be education and training of individuals, the creation of a support networks such as peer to peer programs, and cooperation from internal and external resources like departmental psychological services or a robust EAP program, as well as education and training of managers and staff.[37]

Peer-to-peer programs can similarly train peers to recognize and respond to signs of suicide risk by connecting officers to appropriate resources for help, including crisis lines and mental health professionals.[38] Thomas Barker first wrote about the importance of peers in law enforcement in 1977, highlighting the influence that peers can have not only on rule violation and deviant behaviors but also in support for trauma through shared experience.[39] Barker's work focused more on pathways to criminal behavior in law enforcement but still shed a new light on the common choice of officers to rely on their peers for emotional support and coping in a variety of situations. It also carved out the idea that the most influential people to an officer could very well be the peers they served with daily, placing great value on creating positive relationships in departments. The practice of peer-to-peer support started to emerge in police departments across the U.S. in the 1980s and grew more common following the events of September

33. Robert H. Aseltine, Jr. and Robert DeMartino, "An Outcome Evaluation of the SOS Suicide Prevention Program," *American Journal of Public Health* 94, no. 3 (March 2004), 446–451, https://pubmed.ncbi.nlm.nih.gov/14998812/.
34. Burnette, Ramchand, and Ayer, *Gatekeeper Training* (see note 29).
35. Burnette, Ramchand, and Ayer, *Gatekeeper Training* (see note 29).
36. Witt et al., "Effectiveness of Suicide Prevention Programs" (see note 16).
37. Misato Takada and Satoru Shima, "Characteristics and Effects of Suicide Prevention Programs: Comparison between Workplace and Other Settings," *Industrial Health* 48, no. 4 (2010), 416–426, https://pubmed.ncbi.nlm.nih.gov/20720333/.
38. National Consortium on Preventing Law Enforcement Suicide, *Preventing Suicide* (see note 17).
39. Thomas Barker, "Peer Group Support for Police Occupational Deviance," *Criminology* 15, no. 3 (November 1977), 353–366, https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1745-9125.1977.tb00071.x.

11, 2001.[40] Since then, agencies across the nation have deepened their investments in having trained peer support staff on hand to help manage the myriad problems that police officers face from the traumatic nature of their employment.

In 2011, the DoD Centers for Excellence identified four ways to build and support effective peer support programs: (1) adequate planning and preparation, (2) clearly articulated policies, (3) systemic screening, and (4) defined selection criteria for peer support counselors.[41] Military personnel who had access to peer support experienced improved social networking and quality of life and exhibited increased wellness and improved coping skills. In fact, most research to date on peer support programs indicates that peer support programs improve quality of life and foster mental health and wellness resiliency.

At University Behavioral Health Care at Rutgers University, the Cop2Cop Program has regularly demonstrated the value of reciprocal peer support (RPS). RPS involves connection and pure presence, information gathering and risk assessment, case management and goal setting, resilience affirmation, and praise.[42] The model, which was featured in the *Law Enforcement Mental Health and Wellness Programs: Eleven Case Studies (LEMHWA Case Studies)*, presented to Congress in 2019, is a hybrid of traditional peer support programs and clinician supervised crisis intervention programs. It seeks to train peers to repeat the RPS model tasks to address trauma and build relationships of trust and experience to connect a peer to a trained clinician for continuum of care. Follow-ups with peers in RPS-modeled programs have shown repeated success where officers seeking help can see a clinician, reach out to the Cop2Cop peer for relational development, and build resiliency tools to heal and grow.

Other data address the critical nature of being able to debrief following a critical incident with a trusted peer, supervisor, or clinician. One study found that the debriefing process was seen as useful by the subjects regardless of measurable impacts or quantifiable data to associate with suicide prevention.[43] Participants perceived that investments in their mental health and well-being are a critical step in healing. Another found that peer-to-peer models with standardized role-play exercises, especially ones that train on Question, Persuade, and Refer (QPR), helped officers in crisis and provided framework for trained peer support officers to directly ask about suicide and persuade the at-risk individual to accept help.[44]

So it should not be surprising that one of the most well-known post-event protocol used in law enforcement settings is what is known as critical incident stress debriefing (CISD)—a structured group discussion process "designed to mitigate acute symptoms, assess the need for follow-up, and if possible provide a sense of post-crisis psychological closure."[45]

In a 1993 look at critical incident stress debriefings, researchers found that the debriefing process was seen as useful by the subjects regardless of more traditionally measurable impacts. Participants "perceived the CISD team members as caring for them."[46] Among departments featured in the

40. Cherie Castellano, "'Reciprocal Peer Support' (RPS): A Decade of Not So Random Acts of Kindness," *International Journal of Emergency Mental Health* 14, no. 2 (2012), 137–142, https://ubhc.rutgers.edu/documents/Clinical/Call%20Center/Recipricol-Peer-Support-Article-Cherie-Castellano.pdf.
41. Castellano, "Reciprocal Peer Support" (see note 40).
42. Castellano, "Reciprocal Peer Support" (see note 40).
43. Ogden Willis Rogers, "An Examination of Critical Incident Stress Debriefing for Emergency Service Providers: A Quasi-Experimental Field Survey," PhD dissertation, University of Maryland, College Park, MD, 1993, https://archive.hshsl.umaryland.edu/handle/10713/1636.
44. Wendi Cross et al., "Proximate Outcomes of Gatekeeper Training for Suicide Prevention in the Workplace," *Suicide and Life-Threatening Behavior* 37, no. 6 (December 2007), 659–670, https://onlinelibrary.wiley.com/doi/abs/10.1521/suli.2007.37.6.659.
45. George S. Everly, Jr., and Jeffrey T. Mitchell, "A Primer on Critical Incident Stress Management (CISM)," International Critical Incident Stress Foundation, Inc., accessed June 12, 2020, https://icisf.org/a-primer-on-critical-incident-stress-management-cism/.
46. Rogers, "An Examination of Critical Incident Stress Debriefing" (see note 43).

LEMHWA Case Studies, a number stated they have used the Everly and Mitchell Critical Incident Stress Management (CISM) model. According to the International Critical Incident Stress Foundation,

> "CISM is a comprehensive, integrative, multicomponent crisis intervention system. CISM is considered comprehensive because it consists of multiple crisis intervention components, which functionally span the entire temporal spectrum of a crisis. CISM interventions range from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. CISM is also considered comprehensive in that it consists of interventions which may be applied to individuals, small functional groups, large groups, families, organizations, and even communities."[47]

The U.S. Department of Homeland Security (DHS) is another example of a law enforcement agency that uses CISM and further trains select personnel in leadership skills such as supporting team members, running a team, and working the political side of the response. Other agencies report a less formal organization and response to critical incidents. While maintaining CISM-certified trainers is outside the budget constraints of many departments, its basic principles are well known and frequently practiced in the law enforcement profession.

One limitation to programs like CISM is that they are designed for application after a critical incident. Researchers examining agency offered suicide prevention and wellness programs in 2019 noted that there is "a difference between whether offered programming was proactive or reactive. Reactive programs (e.g., critical incident stress management, crisis intervention team) were often required of officers following a critical incident, but rarely was participation in any other programming required outside of these incidents."[48]

When considering programs to improve the mental health and wellness of law enforcement officers and reduce the incidence of suicide, it is important to consider that some are designed to be universally applied where others are meant to be applied selectively or when indicated. In the *LEMHWA Report to Congress*, it was noted that "In the preventive services world, interventions are generally classified as universal, selective, or indicated. The first applies to everyone in the population, the second to a group identified as being at greater risk, and the third to individuals who are symptomatic."[49] All three are important to a successful effort to reduce death by suicide.

It is not enough to just have plans and programs in place to help people cope in the aftermath of a crisis. In the law enforcement context, this means that programs are needed that not only universally train and prepare officers for managing the stress and trauma that they will inevitably face in their careers but also provide intervention services to those who are at greater risk or who are already symptomatic because of their involvement at critical incidents. This is doubly important because critical incidents are not the sole cause of stress and trauma for law enforcement personnel. The daily realities of the job can lead to cumulative stress and trauma even without the critical incidents that officers anticipate and accept when they choose this profession. Even the less sensational aspects of the job can be stressful and have long-term negative effects on officers' mental well-being.

47. Everly and Mitchell, "A Primer on Critical Incident Stress Management" (see note 45).

48. Megan A. Thoen et al., "Agency-Offered and Officer-Utilized Suicide Prevention and Wellness Programs: A National Study," *Psychological Services* 17, no. 2 (2020), 129–140. https://psycnet.apa.org/record/2019-22923-001.

49. Spence et al., *Law Enforcement Mental Health and Wellness Act*, 38 (see note 9).

A growing body of evidence shows that developing stress resilience and self-regulation skills in officers can mitigate the negative effects of stress on decision-making.[50] In addition to learning to quickly regain their physiological and psychological balance after intense moments on the job, officers can be given tools that help them manage the thoughts and emotions that come up long after incidents have passed. Data suggest that "training in resilience building and self-regulation skills could significantly benefit police organizations by improving judgment and decision-making"[51] and decreasing the frequency of on-the-job errors that can result in injuries or death. One example pointed out by DHS is the Penn Resilience Program and PERMA Workshops, which is also used by the U.S. Army and the Pennsylvania State Police. Based on empirical studies to build resilience, well-being, and optimism, it is a strength-based approach that has been advocated for law enforcement.[52] Another well-known program is Performance and Recovery Optimization (PRO) program, developed at the San Antonio (Texas) Police Department and replicated by others as far away as Australia. PRO is an integrated stress management program that helps officers reframe thinking about stress management to thinking about performance enhancement.[53]

Access to and use of mental health resources by officers

Two important questions are how widely available mental health support resources are and how widely they are used by law enforcement. Unfortunately, they are not easily answered. The Bureau of Justice Statistics (BJS) *Law Enforcement Management and Administrative Statistics* series is one of the most comprehensive data collection efforts about state and local law enforcement, but it does not include questions about suicide prevention or other mental health resources that are available in departments.

One of the most commonly noted sources of assistance for law enforcement is their agency's EAP; but the ubiquity of these programs is hard to establish in law enforcement, particularly as many are part of city or county benefits packages and not specifically law enforcement–focused. While common, not every employer offers such a program. In a small survey conducted in 2018 as part of the effort to draft the *LEMHWA Case Studies*, the authors found that of the agencies who responded, 79 percent offered peer-to-peer programs, 58 percent offered EAPs, 58 percent offered in-house psychological services, and 50 percent offered referral-based psychological services to the private sector.[54] The survey conducted by the National FOP found that 82 percent of participants are aware that behavioral health services are offered by their employer, although they did not note specifically what those services were.[55] And in 2019, a survey of city and county agencies found that EAPs or counseling services were the most common programs offered but that at the officer level almost 25 percent of respondents did not know whether their agency had suicide prevention programming and 35 percent did not feel their agency supports its officers' mental wellness.[56]

All employee support programs come with costs, which can unfortunately lead to a focus on use as the most important metric. But a high rate of use does not speak to measurable results (positive or

50. Evelyn-Rose Saus et al., "The Effect of Brief Situational Awareness Training in a Police Shooting Simulator: An Experimental Study," *Military Psychology* 18, Supplement (2006), S3–S21, https://www.tandfonline.com/doi/abs/10.1207/s15327876mp1803s_2.
51. Rollin Mccraty and Mike Atkinson, "Resilience Training Program Reduces Physiological and Psychological Stress in Police Officers," *Global Advances in Health and Medicine* 1, no. 5 (2012), 42–64, http://journals.sagepub.com/doi/10.7453/gahmj.2012.1.5.013.
52. Positive Psychology Center, "Penn Resilience Program and PERMA Workshops," The Trustees of the University of Pennsylvania, accessed June 12, 2020, https://ppc.sas.upenn.edu/services/penn-resilience-training.
53. Colleen Copple et al., *Law Enforcement Mental Health and Wellness Programs: Eleven Case Studies* (Washington, DC: Office of Community Oriented Policing Services, 2019), 65–66, https://cops.usdoj.gov/RIC/ric.php?page=detail&id=COPS-P371.
54. Copple et al., *Law Enforcement Mental Health and Wellness Programs: Eleven Case Studies* (see note 53).
55. Officer Wellness Committee, *Report on FOP/NBC Survey* (see note 27).
56. Thoen et al., "Agency-Offered and Officer-Utilized Suicide Prevention" (see note 48).

otherwise). The rate of use does not tell us what happened to the people who used the service and whether they got the assistance they required. It does not speak to program quality or to whether employees have reason to distrust or be skeptical of the program's offerings. As the International Employee Assistance Professionals Association has noted, "there is no standard definition of EAP utilization, yet employers see utilization as one of the most critical measurements in determining the effectiveness of the EAP services for which they are paying. External EAP vendors are selected and evaluated and internal EAP effectiveness is measured on the basis of program utilization, yet there is no standard definition by which the profession operates."[57]

What is clear is that many programs appear to be underused. Understanding why employees do or do not access services is therefore the more important question than rate of use.

Challenges to access

One of the biggest challenges to suicide prevention programs for law enforcement professionals is well discussed and largely agreed upon: culture. "It should come as no surprise that a western psychology which emerges in an individualistic culture might propose or assume that the individual possesses the resources necessary to adapt to disasters or that the goal of interventions would be able to empower individuals."[58] This cultural expectation—that the individual will manage their own reactions to trauma and to seek specialized help when necessary—has largely failed law enforcement officers. As the *LEMHWA Report to Congress* noted, the cultural expectation of behavior that is most valued by the law enforcement profession can be among the main barriers to ensuring not only that there are programs and services to address the unique health and wellness needs of the workforce but also that those programs and services are accessed and used by that workforce.[59]

This stigma surrounding mental health in the law enforcement community is one of the most significant barriers facing officers in crisis and department culture. Officers themselves are problem solvers, so they do not want to present themselves as someone who also has a problem.[60] The National Consortium's issue brief best describes the ingrained culture in officers by stating that "seeking treatment for mental health problems runs contrary to police socialization training. This training tends to instill in officers a sense of superhuman emotional and survival strength to deal with adversity."[61] Yet the nature of law enforcement jobs regularly exposes officers to trauma, which left untreated can result in unmanaged negative coping mechanism such as drug and alcohol abuse.[62]

A lack of awareness of the basic risks to officer mental health inherent in the job, what services exist, or how they might work also can not be underestimated as a barrier to use. Recent surveys point to a lack of awareness on the part of both the public and the profession that critical stress is a significant effect of work in law enforcement. The National FOP survey showed that only one-third of the respondents had ever been trained on behavior health awareness at any point in their career.[63] This is why the first recommendation in the *LEMHWA Report to Congress* was to "support the creation of a public services campaign around law enforcement officer mental health and wellness."[64] One of the biggest barriers to anyone seeking mental health services is fear of the unknown

57. International Employee Assistance Professionals Association, *EAP Utilization* (Arlington, VA: International Employee Assistance Professionals Association, n.d.), https://www.eapassn.org/Portals/11/Docs/HOME/Utilization.pdf.
58. Dueck and Byron, "Community, Spiritual Traditions, and Disasters" (see note 28).
59. Spence et al., *Law Enforcement Mental Health and Wellness Act*, 8 (see note 9).
60. Violanti and Samuels, *Under the Blue Shadow*, 3–6 (see note 23).
61. National Consortium on Preventing Law Enforcement Suicide, *Preventing Suicide* (see note 17).
62. Violanti and Samuels, *Under the Blue Shadow* (see note 23).
63. Officer Wellness Committee, *Report on FOP/NBC Survey* (see note 27).
64. Spence et al., *Law Enforcement Mental Health and Wellness Act*, 10 (see note 9).

or that there is no one who can help. Resources produced on what to expect when talking to behavioral health professionals and both academy and in-service training that covers risks, signs, and services can help break down this barrier.

Several researchers have also found that officers regularly express skepticism about what levels of privacy would be maintained and if they would be able to continue their jobs if they shared their true feelings with peers.[65] They fear that admitting they were suicidal or in crisis could result in apathy, ridicule, and job-related consequences.[66] In addition, officers often feel a divide between themselves and the average clinician, reporting that they could not connect to someone who had limited understanding of their specialized field.

Individual privacy in behavioral health is protected through law and policy that provide for confidentiality and privilege. Confidentiality between a therapist or psychologist is protected both by state law and the Health Insurance Portability and Accountability Act (HIPAA).[67] As discussed in the *LEMHWA Report to Congress*, HIPAA is what most people assume protects personal health information from any type of public disclosure. Clergy-penitent privilege similarly prevents clergy from being required to disclose confidential communications in a court proceeding. But peer-run crisis lines or in-agency peer support programs are not HIPAA-covered providers, and not all are staffed exclusively with chaplains. If law enforcement officers are going to seek help from peers, they need to have the confidence that what they say in that session will not be subject to disclosure or discovery in judicial proceedings. Such disclosure could jeopardize both them and their agencies.

As a result, many states are passing resolutions to fill this gap. For instance, Colorado law provides that peer support team members who are trained in a model program with certified trainers may receive confidentiality protections similar to those a psychologist would have when engaging in peer support service.[68] But despite efforts like these, officers still regularly cite fear of gossip or reporting as a consequence of seeking help. When confronted with this problem, one study found that relationships built on trust were critical to bridge the divide between an officer and mental health services.[69]

In addition, statutory privacy protections also need to be bolstered by agency policy and practices that reinforce those protections and promote a culture where seeking help is never discouraged. The *LEMHWA Case Studies* covered several law enforcement agencies' confidentiality policies, including the Las Vegas (Nevada) Metropolitan Police Department's policy that their psychological services be located offsite so officers seeking help may be more confident in their anonymity.[70]

65. Bradley, *Promoting Positive Coping Strategies in Law Enforcement* (see note 21).
66. National Consortium on Preventing Law Enforcement Suicide, *Preventing Suicide* (see note 17).
67. American Psychological Association, "Protecting Your Privacy: Understanding Confidentiality," last modified October 19, 2019, https://www.apa.org/topics/ethics-confidentiality.
68. Colo. Rev. Stat. § 13-90-107 (2016), https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=997bd659-2fae-4bb3-8771-79920756747c.
69. Castellano, "'Reciprocal Peer Support" (see note 40).
70. Copple et al., *Law Enforcement Mental Health and Wellness Programs: Eleven Case Studies* (see note 53).

Current Efforts

To fully understand what additional programs and resources are needed to assist the DOJ in its efforts to aid state and local law enforcement in implementing suicide prevention efforts, it is important to understand what activities are already underway. This is particularly important given that this is an ever-changing landscape as DOJ's grant-making components strive to adapt and meet the emerging needs of the profession.

The primary DOJ components invested in addressing suicide prevention programming for state and local law enforcement are the COPS Office and the Office of Justice Programs (OJP). Within OJP, BJA has the most extensive portfolio, although work by the National Institute of Justice and the Office for Victims of Crime has also contributed significantly to the field. The following summarizes some of the significant work that has taken place since the publication of the *LEMHWA Report to Congress* and highlights the efforts that are already underway to support and establish evidence-based behavioral health programs for police and other first responders.

Law Enforcement Mental Health and Wellness grants

In FY 2019, the COPS Office launched a new Law Enforcement Mental Health and Wellness Act (LEMHWA) grant program. The program awarded $1.7 million to develop knowledge, increase awareness of effective mental health and wellness strategies, increase the skills and abilities of law enforcement, and increase the number of law enforcement agencies and relevant stakeholders using peer mentoring programs. This funding included awards directly to 15 law enforcement agencies focusing on enhancing or expanding their peer support programs as well as to the National FOP to develop a national peer support training program that would aid in standardization in knowledge, skills, and abilities across the country.

This program was implemented in the wake of the two reports published by the COPS Office in 2019: the *LEMHWA Report to Congress* and the *LEMHWA Case Studies*. These reports were drafted in response to the Law Enforcement Mental Health and Wellness Act that was signed into law in January 2018. The public reports offered Congress 22 recommendations and 11 case studies and extensively address suicide prevention as part of a holistic wellness approach. Nearly 10,000 copies of the reports have been distributed since their release, and their content heavily influenced the design of the LEMHWA grant program.

Congress expanded the LEMHWA grant program in FY 2020, and the COPS Office expects to award approximately $4.3 million in grants directly to state and local law enforcement agencies this year—approximately 40 agencies will receive awards to help them increase their ability to provide peer support, access to behavioral health professionals, and suicide prevention training and programs to their officers. These grants are approximately $125,000 each; this amount may not seem substantial, but it is sometimes a critically needed federal investment for local agencies. It helps them train personnel; partner and contract with behavior health specialists; promote the availability of services in their departments; expand programs to correctional officers, dispatchers, and other civilians in the agency; collaborate on efforts to support police, fire, emergency medical services, and other first responders through multidisciplinary programs; and even allow larger agencies to offer their services and experience to surrounding smaller jurisdictions that may lack the infrastructure to support a confidential peer support or crisis intervention program on their own.

The challenge of a grant program like LEMHWA is that the demand generally far exceeds the need. In FY 2020, the COPS Office received more than twice as many applications as it can realistically fund. And as state and local budgets are affected by the expenses and lost revenue caused by the COVID-19 pandemic, the ability of agencies to provide these types of programs on their own will be significantly curtailed. In the wake of the economic downturn in 2008, the COPS Office looked at the impact of that economic contraction on public safety and found that police policies and practices were undergoing a transformation to adapt to the economic changes. Surveys conducted by the Police Executive Research Forum, the Major Cities Chiefs Association, and the International Association of Chiefs of Police (IACP) at that time found that "two-thirds of their responding departments reported that they had reduced or discontinued training programs because of their limited budgets."[71]

Given that policing during a pandemic brings unique stressors on top of the general risks of exposure to trauma and stressful working conditions, the need for programs that address officer mental well-being in 2020 and onwards is expected to increase.

VALOR Initiative

The Officer Robert Wilson III Preventing Violence Against Law Enforcement Officers and Ensuring Officer Resilience and Survivability (VALOR) Initiative is a collection of programs providing training, research, partnerships, and other resources to benefit law enforcement officers' short and long-term safety, wellness, and resilience. The suite of programs includes research and programs on resilience and other mental health and wellness concepts.

As part of the VALOR Initiative, BJA launched the National Suicide Awareness for Law Enforcement Officers (SAFLEO) Program, which "provides training, technical assistance, and resources to law enforcement agencies, staff, and families, to raise awareness, smash the stigma, and reduce and prevent law enforcement suicide."[72] With strategic partners including the American Association of Suicidology, SAFLEO delivers in-person and online training, resources, and technical assistance focused on education, awareness, recognition, and prevention of law enforcement suicide for law enforcement agencies and officers. SAFLEO's comprehensive approach focuses on occupational and life risks and emphasizes the need for support from law enforcement agencies, colleagues, families, and friends. Its training and resources address all of these factors and also provide tailored information specific to the different audiences (family, colleagues, friends, agency administration, officers, etc.).

Since FY 2018, BJA has awarded one grant to the Institute for Intergovernmental Research (IIR) for this initiative with funding from the VALOR program. In FY 2020, because of COVID-19 related safety precautions, in-person training was restricted. Therefore, the SAFLEO program was only able to conduct one of its newly developed in-person trainings on two separate occasions in the spring of 2020, training 65 law enforcement executives. Once in-person training resumes, the program will deliver in-person trainings throughout the nation. In the interim, as COVID-19 safety precautions continue, the SAFLEO program is prioritizing development of more online resources. The program has published a multitude of information resources on the SAFLEO web page and will continue to do so. In addition, the first of a series of four webinars was delivered in July 2020 to 326 participants.

71. Matthew C. Scheider et al., *The Impact of the Economic Downturn on American Police Agencies* (Washington, DC: Office of Community Oriented Policing Services, 2011), https://cops.usdoj.gov/RIC/ric.php?page=detail&id=COPS-W0713.

72. "About SAFLEO," National Suicide Awareness for Law Enforcement Officers Program, accessed June 15, 2020, https://www.valorforblue.org/SAFLEO.

Further, BJA's Law Enforcement Agency and Officer Resilience Training Program provides training and technical assistance to build more resilient officers and agencies.[73] Enhancing officers' knowledge and skills in resiliency can strengthen their resolve and resilience during and in the aftermath of critical incidents such as terrorist incidents, active shooter events, officer-involved shootings, line-of-duty deaths, and repeated exposure to traumatic events, as well as other day-to-day challenges they face in the course of their duties. Since FY 2017, BJA has awarded one grant to the IACP for this initiative with funding from the VALOR program. The program has successfully developed a comprehensive resilience skills training and a train-the-trainer resilience training. The program piloted the trainings in three law enforcement agencies, delivering 107 law enforcement participants the skills training and 28 participants the train-the-trainer training. The program is currently prioritizing development of more online resources as COVID-19 restrictions continue. Once in-person training resumes, the program will deliver in-person training throughout the nation.

Trainings like these are critical to helping break the stigma that exists around help-seeking behaviors. SAFLEO also advertises two important national resources for officers who may be in crisis: (1) the National Suicide Prevention Lifeline and (2) the Crisis Text Line.

Collaborative Reform Initiative

The COPS Office also supports a technical assistance center, the Collaborative Reform Initiative Technical Assistance Center (CRI-TAC). The program provides critical and tailored technical assistance resources to state, local, territorial, and tribal law enforcement agencies on a wide variety of topics. It features a "by the field, for the field" approach while delivering individualized technical assistance in a range of public safety, crime reduction, and community policing topics. Nine national law enforcement organizations partner on CRI-TAC, helping to ensure requesting agencies are connected to leading experts no matter the issue. In 2018 and 2019, more than 300 agencies have sought assistance on developing wellness and mental health programs for their officers.

The COPS Office also offers technical assistance specifically for agencies experiencing a crisis event that could precipitate mental health issues among officers, helping them to work through what resources and expertise they need to help ensure officers have access to services that will help them. Customized blueprints can help agencies better navigate local systems and services, and successfully manage plethora of donation and volunteer offers that can appear in the wake of a critical incident.

National Consortium on Preventing Law Enforcement Suicide

In 2018, BJA launched the National Officer Safety Initiative (NOSI) in support of the President's February 9, 2017, officer safety–focused executive order.[74] NOSI is funding innovative approaches to augment law enforcement safety in three key areas: (1) law enforcement suicide, (2) traffic safety, and (3) a national public awareness and education campaign. This included standing up the National Consortium on Preventing Law Enforcement Suicide.

The consortium convenes a group of national subject matter experts in the field of mental health, wellness, suicide, and law enforcement. The main goal of the consortium is to produce a report on the current state of law enforcement suicide by focusing on challenges, successes, and gaps it has

73. "Program Providers," BJA VALOR Initiative, accessed August 25, 2020, https://bja.ojp.gov/program/valor/program-providers.

74. The White House, Presidential Executive Order on Preventing Violence against Federal, State, Tribal, and Local Law Enforcement Officers, Executive Order 13774, February 9, 2017, https://www.whitehouse.gov/presidential-actions/presidential-executive-order-preventing-violence-federal-state-tribal-local-law-enforcement-officers/.

identified. The report will provide recommendations on policy and procedure updates, effective messaging strategies, and best practice programs as well as how to engage families in suicide awareness and prevention at all phases of an officer's career, including retirement.

The consortium will also develop and provide other informative resources for the field. Since FY 2018, BJA has awarded one grant to the IACP for this initiative with funding from the VALOR program and Byrne Justice Assistance Grants training and technical assistance authority. The consortium has convened four meetings of its 31 members and developed various tools and guides related to law enforcement suicide that will be published by September 2020.

In February 2020, the consortium released *Preventing Suicide Among Law Enforcement Officers: An Issue Brief*. The issue brief summarizes what is known about risk and protective factors, the challenges associated with prevention programs, and identified strategies and promising practices.[75] The consortium continues to work on building recommendations for suicide prevention for first responders and will have additional public releases of information over the coming months, including a framework for suicide prevention as well as a toolkit to assist agencies in developing custom programs. The consortium is currently prioritizing development of more online resources as COVID-19 restrictions continue, including webinars and additional online guides and tools.

Officer Safety and Wellness Group

BJA and the COPS Office formed the national Officer Safety and Wellness (OSW) Group in 2011 to bring attention to the safety and wellness needs of law enforcement officers. The OSW Group convenes regularly and brings together law enforcement practitioners, researchers, and subject matter experts to help amplify efforts to improve officer safety and wellness in the field.

While previous meetings of the OSW Group discussed line-of-duty deaths, suicide in law enforcement, and career-ending post-traumatic stress, for the July 2019 meeting attendees were asked to pivot from potential worst-case outcomes. Not everyone who struggles with the stressors of the job reaches a point of suicidal ideation or suffers a heart attack or finds themselves no longer capable of working. But they still are faced with a variety of threats to their overall wellness and require systems, strategies, and social networks that support their capacity for resilience. With a variety of positive coping strategies and protective factors in place, officers can successfully manage their careers in ways that allow them not only to survive but also to thrive. But without the right tools and skills, they may turn to antisocial coping strategies that risk damaging their health, career success, family and personal relationships, and general enjoyment of life. Meeting attendees were unanimous in the belief that early intervention is always best. As one participant said, "You don't wait for cancer to metastasize before seeking treatment."[76]

The group met again in March 2020 and looked holistically at the challenges and opportunities for supporting officer safety and wellness in smaller and rural agencies—the 80 to 85 percent of agencies that do not have large civilian support staff, easy access to anonymous peer support within their own agencies, or in many cases even local access to culturally competent behavioral health specialists. Conversation also covered the interrelatedness of physical and mental health, the importance of leading by example, and the reality that clear and comprehensive rules around privacy, confidentiality, and privilege are crucial to the success of any program. More than one attendee

75. National Consortium on Preventing Law Enforcement Suicide, *Preventing Suicide* (see note 17).

76. Bradley, *Promoting Positive Coping Strategies in Law Enforcement* (see note 21).

noted that there needs to be an acknowledgement that the men and women who are taking their lives are taking their lives because of job-related trauma exposure. Fear of backlash from risk management, human resources, and the financial aspect of health care should not deter officers or agencies from striving to reduce officer susceptibility to the mental health issues underlying suicidal ideation.

President's Commission on Law Enforcement and the Administration of Justice

In October 2019, President Trump signed an executive order creating a new commission on law enforcement and the administration of justice. Chaired by Director Phil Keith of the COPS Office, the commissioners represent the breadth of law enforcement in this country and are supported by dozens of working group members and federal staff working to ensure critical topics are thoroughly discussed. One of the 13 topic areas being examined by the commission is "the physical safety, health, and wellness of law enforcement officers."[77] Speaking to its critical importance, this was the topic of the first hearing held in February 2020.

As the hearing opened, the commissioners noted that officers' jobs have grown more difficult in the last few decades, and there are more stressors and increased scrutiny. One commissioner asked, "How can we expect them to take care of others if they are not taken care of?"[78] Testimony at that hearing captured many of the critical issues in officer safety and wellness, and death by suicide was noted as a significant concern by many who spoke. Other speakers also noted how officers value access to peer support and how such programs are integral to officer well-being.[79]

The commission report includes recommendations that specifically speak to ideas for continuing to improve the programs and resources available to law enforcement officers at all levels of government who are struggling with their mental health.[80]

Nonfederal efforts

Efforts are also underway that are not directly led by the DOJ but that both inform and are informed by DOJ's efforts. For example, the Action Alliance has established a public safety task force with the aim of developing a "comprehensive, national response to suicide among public safety professionals."[81] The Action Alliance is the nation's public-private partnership for suicide prevention and observed that many of the other public safety professions are facing the same questions and challenges as law enforcement. This task force brings together representatives of law enforcement, the fire service, emergency medical services, and epidemiological researchers and includes representatives from DHS as well as DOJ. It is working to facilitate collaboration across the public safety spectrum in improving messaging about suicide and seeking help when an individual is experiencing signs of depression and suicidal

77. Executive Office of the President, "Commission on Law Enforcement and the Administration of Justice," Executive Order 13896, October 28, 2019, https://www.federalregister.gov/documents/2019/11/01/2019-24040/commission-on-law-enforcement-and-the-administration-of-justice.
78. President's Commission on Law Enforcement and the Administration of Justice, "Hearing One: Officer Safety and Wellness," U.S. Department of Justice, February 27, 2020, https://www.justice.gov/ag/page/file/1259216/download.
79. President's Commission on Law Enforcement and the Administration of Justice, "Hearing One" (see note 78).
80. President's Commission on Law Enforcement and the Administration of Justice, Final Report (Washington, DC: U.S. Department of Justice, 2020), https://www.justice.gov/file/1347866/download.
81. National Action Alliance for Suicide Prevention Public Safety Task Force, "Request to Metropolitan Fire Chiefs Association/Urban Fire Forum Chiefs," National Action Alliance for Suicide Prevention, accessed June 15, 2020, https://www.nfpa.org/-/media/Files/Membership/member-sections/Metro-Chiefs/Urban-Fire-Forum/2019/2019UFFStatementSuicidePrevention.ashx.

ideation. This effort has been endorsed by the National Fire Protection Association (NFPA) Urban Fire Forum (UFF).[82]

Efforts like this to work across the public safety professions could prove beneficial in a variety of ways. Fire department employees are also first responders who experience occupational trauma and increased rates of death by suicide similar to law enforcement. This is not to suggest that a firefighter understands the culture of law enforcement any more than an officer understands the culture of the fire house, but as first responder agencies organized at the smallest units of government, often with the same limitations on health care providers and insurance coverage, they may contribute ideas to the conversation. And there are successful crisis intervention efforts in the country that serve all first responders, recognizing that for many, the similarities in what they face outweigh the differences of their professional cultures.

The *Standard on Fire Department Occupational Safety, Health, and Wellness Program*,[83] issued by NFPA and updated in 2018, establishes that fire departments

> "shall provide access to a behavioral health program for its members and their immediate families. [This will] include the capability to provide assessment, basic counseling, and crisis intervention assistance for stress, alcohol and substance abuse, anxiety, depression, traumatic exposure, suicidality, and personal problems that could adversely affect the member as well as fire department work performance."[84]

It goes on to say that departments will adopt and follow written policies concerning confidentiality and the protection of privileged information related to those programs and that departments "shall maintain a relationship with an appropriately licensed and/or certified behavioral health specialist [who] . . . shall have knowledge and experience working with the fire department culture and traumatic exposure."[85] No national standards body in law enforcement is equivalent to the NFPA, but in this arena the NFPA's standard is one that law enforcement agencies could be encouraged to follow through incentive programs or accreditation bodies.

A number of states have taken steps to improve the legislative protections for peer support programs and to improve definitions of service-related injuries to include post-traumatic stress. Leaders in the field in Massachusetts and Texas reported that state statutes give law enforcement peer support members legal privilege, California and Illinois have recently enacted similar laws. All noted that policy and training is also designed to educate and explain what can and cannot be kept confidential and privileged.

The proposed Confidentiality Opportunities for Peer Support Counseling Act, which passed in the Senate in May 2020, would introduce similar protections for peer support programs that serve federal law enforcement officers, stating "Except as provided in subsection (c), a peer support specialist or a peer support participant

82. "Fire Chiefs Endorse Position Papers on Hot Work Safety, the Economic Impact of Firefighter Injuries, Suicide Prevention, the National Firefighter Registry, Data Analyst/Chief Information Officer, and the Center for Homeland Defense and Security," National Fire Protection Association, last modified September 24, 2019, https://www.nfpa.org/News-and-Research/Publications-and-media/Press-Room/News-releases/2019/Fire-Chiefs-endorse-position-papers.
83. National Fire Protection Association, NFPA 1500: Standard on Fire Department Occupational Safety, Health, and Wellness Program (Quincy, MA: National Fire Protection Association, 2018).
84. National Fire Protection Association, NFPA 1500, 12.1.1, 12.1.1.1 (see note 83).
85. National Fire Protection Association, NFPA 1500, 13.1.1.1, 13.1.1.2 (see note 83).

may not disclose the contents of a peer support communication to an individual who was not a party to the peer support communication."[86]

Ensuring that communications are privileged is not to suggest that the privilege is absolute. Exemptions do exist in states with confidentiality statutes, keeping them in line with standards established in other professions and statutes on mandatory reporting. For example, Hawaii has enacted the following exemptions:

> "This section does not apply to: (1) Any threat of suicide or homicide made by a participant in a peer support counseling session or any information conveyed in a peer support counseling session relating to a threat of suicide or homicide; (2) Any information relating to abuse of spouses, children, or the elderly, or other information that is required to be reported by law; or (3) Any admission of criminal conduct."[87]

The pending Confidentiality Opportunities for Peer Support Counseling Act includes similar language:

> "Subsection (b) shall not apply to a peer support communication if— (1) the peer support communication contains— (A) an explicit threat of suicide; (B) an explicit threat of imminent and serious physical bodily harm or death to a clearly identified or identifiable individual; (C) information— (i) relating to the abuse or neglect of— (I) a child; or (II) an older or vulnerable individual; or (ii) that is required by law to be reported; or (D) an admission of criminal conduct."[88]

Although the goal of building comprehensive wellness programs is to keep officers on the job through a full career, the reality is that sometimes that is not possible. The post-traumatic stress an officer may develop as a result of the trauma faced on the job may make continued employment in the profession untenable. But unlike a physical injury sustained on duty, a mental health reason requiring an officer to leave their job would in many cases not be considered a service-related injury that could be compensated through workers' compensation programs, as definitions of service-related injuries are set in state legislation.

However, some states have taken steps to recognize that stress should be a compensable injury for first responders. For example, in 2019, New Hampshire amended its state statute to state that

> "'Injury' or 'personal injury' shall not include diseases or death resulting from stress without physical manifestation, except that, if an employee meets the definition of an 'emergency response/public safety worker' under RSA 281-A:2, V-c, the terms 'injury' or 'personal injury' shall also include acute stress disorder and post-traumatic stress disorder."[89]

Emergency response or public safety workers who present with acute stress disorder (ASD) or PTSD no longer need exhibit physical symptoms to be covered. As with statutory confidentiality protections, legislation like this is important to normalizing and encouraging help-seeking behavior. Fear of loss of income and health benefits should not stand in the way of officers getting the mental health treatment they need.

86. COPS Counseling Act, S. 3434, 116th Cong. § 2 (2020), https://www.congress.gov/bill/116th-congress/senate-bill/3434/text.
87. Haw. Rev. Stat. §78-52 (2014), https://www.capitol.hawaii.gov/hrscurrent/Vol02_Ch0046-0115/HRS0078/HRS_0078-0052.htm.
88. COPS Counseling Act, S. 3434 (see note 86).
89. N.H. Rev. Stat. Ann. § 281-A:2.XI. (2019), https://www.gencourt.state.nh.us/rsa/html/XXIII/281-A/281-A-2.htm.

Recommendations

Even with the amount of work on improving mental wellness and suicide prevention in law enforcement currently underway, it is possible to identify a few key recommendations that would help improve the DOJ's ability to assist state and local law enforcement in protecting their officers. The following five recommendations reiterate and build on ones that have been offered to the Congress and to the larger community of state and local policymakers and agency leaders through the *LEMHWA Report to Congress*, the National Consortium issue brief, and the commission report. They are not offered here to be all-encompassing but to set a foundation upon which all the other work to be done can be built.

With this foundation in place, the DOJ is well positioned to continue to provide information on promising practices as well as technical assistance to agencies implementing new efforts through its BJA and COPS Office components, as well as to continue to administer grant funds to support efforts at the state, local, and national levels. What is important is that the funding and policy continue to move together in the direction of comprehensive efforts that recognize the unique wellness needs of a law enforcement officer throughout a career and that the programs are designed to provide both prevention and intervention services.

Recommendation 1. Increase support for peer-led prevention programs that build resiliency, educate gatekeepers, and capitalize on the strong peer networks that officers already rely on for support and advice.

Because law enforcement officers are more likely to be willing to talk to their peers before anyone else, supporting peer support programs with clinical partnerships is a critical step for increasing the use of behavioral health programs and services. This importance is backed by research both in and outside of the law enforcement community that finds that talking about a crisis, disaster, or underlying trauma with a trusted peer is the most common way of coping across communities and employment cultures.

As part of these programs, it is also important to educate agency leaders and supervisors about mental wellness and how they can help reduce the stigma around seeking help. (These programs should also recognize families as crucial partners in health and wellness.) Training of peer supporters is also key for a successful program. The amount and depth of training may vary by program, but at minimum peer support training should cover successful strategies to gain trust and ask questions, the referral process, the limits of confidentiality and how to talk about them, and the ethics of being a good peer supporter. All of this work should be supported by behavioral health clinicians.

These programs should also recognize that a peer support program is the beginning, not the end, of service and that it cannot serve only those exposed to a critical incident. A robust peer support program can reduce the stigma of seeking help, but the next step of getting help must be easy, timely, and effective to be successful. Culturally competent behavioral health specialists are critical so that peers have trusted places to refer those who need additional assistance. Peer supporters are the intermediary between the officer and the mental health professional. There is therefore a need for specialized training and certification for police psychologists and other professionals to work in the law enforcement setting. Some have also suggested the need for evidence-based trauma treatment guidance for clinicians serving law enforcement similar to the Veteran Administration's clinical practice guidelines on evidence-based therapies.

Recommendation 2. Support efforts to maximize the availability and variety of peer support programs that are backed by clinical partners so that agency size and location is not a barrier to service access.

There are more than 17,000 law enforcement agencies in the United States, and just about half of them have fewer than 10 sworn staff. As the *LEMHWA Report to Congress* noted, part of the support for the expansion of programs should also explore alternative models of delivery. For example, statewide and regional programs can be used to offer access to peers for officers in small departments. A few of the 2019 LEMHWA awardees are doing this with their COPS Office funding: The Connecticut State Troopers are expanding their program to all law enforcement in the state, and the Cleveland (Ohio) Division of Police and the Metro Nashville (Tennessee) Police Department are opening their programs to all officers in their adjacent counties.

There is also opportunity to support the expansion of clinician-backed telehealth style programs, not just for crisis intervention but also for day-to-day peer advice. The COPS Office featured one such program in a recent episode of its video series, *What's New in Blue*, where officers can sign anonymously into video chat rooms where they can talk with a trained law enforcement peer at any time. Similarly staffed text lines offer the same opportunity, and a national directory of peer supporters is currently being developed by the FOP that will allow all officers to connect with trained peers outside of their immediate agency.

Recommendation 3. Similarly, support state and national programs for retirees.

Access to suicide prevention and other behavioral health services for retired and separated officers is even more opaque than for those currently in service. When officers leave the profession because of injury or retirement, they are not systematically tracked as former officers by any agency other than their pension boards. Those organizations are not designed to provide behavioral health services. Staying connected to the agency where they served can also be challenging, as retired officers are generally younger than other retirees—often only in their 50s—and may move geographically away from the agency where they served and embark on second careers with benefits geared to a civilian workforce. The limited pool of culturally competent service providers therefore becomes even harder for retired officers to access.

Recommendation 4. Improve privilege laws at both federal and state levels so that help-seeking behavior is protected.

Without a doubt, fear of any request for help being used against them in a future court proceeding has a chilling effect on officers' willingness to seek mental health assistance. And one of the biggest barriers to officers seeking help is the fear of retribution or losing their job. Even peer support members will sometimes say they don't want to harm a colleague's career by making a referral.

Consistent legal privilege would help ensure confidentiality and confidence in peer support programs. The Confidentiality Opportunities for Peer Support Counseling Act introduced by Senators Chuck Grassley and Catherine Cortez Masto will, when signed into law, ensure the information disclosed during peer support counseling sessions by federal law enforcement officers is kept confidential. Similar state laws should also be introduced or updated to bring consistency to expectations and practice across the law enforcement and first responder profession.

Recommendation 5. Strengthen confidentiality policies within agencies while building culturally competent programs.

Department policy governing the peer support program is the second way confidentiality is covered. Policy should outline the conditions for confidentiality and privilege and what is reported to whom and when. Model policies are needed to help agencies create internal procedures that align to best practices and state laws. Law enforcement agencies, accreditation bodies, and professional membership organizations can play a key role in the development and dissemination of these model policies.

Conclusion

Mental health and wellness services and programs aiming to prevent officer suicide are not a one-size-fits-all approach. Research in this space repeatedly notes the layers of suicide prevention, starting with mental health and resiliency training at the academy and continuing to building an organizational culture that supports officers in crisis throughout their careers. Just as with many things in life, what works for one officer might not work for another, so officers need access to a continuum of care that includes a diverse range of support services.

Officers benefit most when they can access an interagency, multilayered mental health and wellness response mechanism that includes training, supportive leadership, peer support services, crisis response teams for trauma, and law enforcement–focused clinicians. Developing robust programs, especially in smaller police departments, is challenging, and all programs require financial investment and a holistic approach to officer wellness services. While there are significant hurdles that individual departments may face in implementation if each organization is expected to implement on its own, these programs need to be actualized across the United States to effectively address the distinct and unique trauma that law enforcement personnel face throughout their careers. That process can be incentivized and supported by the Federal Government through continued research, funding, and technical assistance that promotes evidence-based practices and policies and a broader understanding of the pathology of stress and trauma. And support for national, regional, and technologically remote programs can supplement the offerings of individual agencies to broaden the options and ensure officers can talk to someone whether they are early in their career or managing the transition to their post–law enforcement life.

Recent events only emphasize the importance of this work. Policing during COVID-19 has not been a threat just to the physical health of officers given the risk of infection of interacting with large numbers of people in the community. Beyond worrying about getting infected themselves or sharing the infection with their families, they have also had to cope with staffing shortages caused by quarantines impacting their coworkers that have resulted in longer hours; the closure of nonessential support services, making it harder to do their jobs while on shift; and even a lack of access to food, water, and restrooms while working when restaurants and stores are not open for business. The loss of child care and impact of school closures for officers who are parents has also been an unexpected stressor—and one that is exacerbated by the realities of shift work. The loss of traditional coworker support networks with the frequent elimination of roll call and other gatherings at the station reduces a sense of connectedness with colleagues. There are currently efforts underway to measure impact of the pandemic on officer mental health. Discussions with numerous law enforcement leaders suggest that there is a general sense of increasing officer stress as a result of COVID-19 and that while agencies have done a good job on physical preparedness to help reduce the potential for infection, helping officers mentally prepare for the continual stress of the public health emergency was more challenging as some of the best tools are not compatible with social distancing.

Of special note, this report was largely written prior to the death of George Floyd in police custody on May 25, 2020. As protests continue across the country and the national conversation has pivoted from managing a virus to the role of the police and calls for significant reform, the physical and emotional stress law enforcement officers feel will only continue to grow. Without a robust body of tools and resources to help officers cope, the costs to both their health and that of the communities they serve is bound to be significant.

Officers are the most important resource law enforcement agencies have, and healthy officers are necessary to healthy communities. We must do what we can to prevent thoughts of suicide from becoming actions. This report assesses the availability of existing mental health resources for law enforcement agencies; it provides a review of peer responder programs and makes recommendations for establishing evidence-based behavioral health and suicide prevention efforts for both law enforcement and other first responders as requested in Senate Report 116–127 accompanying the Consolidated Appropriations Act, 2020.

U.S. Department of Justice
Office of Community Oriented Policing Services
145 N Street NE
Washington, DC 20530

To obtain details about COPS Office programs, call the COPS Office Response Center at 800-421-6770.

Visit the COPS Office online at **cops.usdoj.gov**.

e062017954
Published 2021