State of Colorado

HB14-1343 Peace Officer Post-Traumatic Stress Disorder Task Force Report: Additional Reading

January 15, 2015

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As Passed by the Senate

130th General Assembly
Regular Session
2013-2014

Sub. S. B. No. 252

Senators Patton, Brown

Cosponsors: Senators Hughes, Turner, Schiavoni, Kearney, LaRose, Gardner, Sawyer, Tavares, Bacon, Balderson, Eklund, Faber, Gentile, Hite, Jones, Lehner, Manning, Obhof, Oelslager, Uecker, Widener

—

A BILL

To amend sections 4123.01, 4123.026, and 4123.46 of 1
the Revised Code to make peace officers, 2
firefighters, and emergency medical workers 3
diagnosed with post-traumatic stress disorder 4
arising from employment without an accompanying 5
physical injury eligible for compensation and 6
benefits under Ohio's Workers' Compensation Law. 7

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 4123.01, 4123.026, and 4123.46 of 8
the Revised Code be amended to read as follows: 9

Sec. 4123.01. As used in this chapter: 10

(A)(1) "Employee" means: 11

(a) Every person in the service of the state, or of any 12
county, municipal corporation, township, or school district 13
therein, including regular members of lawfully constituted police 14
and fire departments of municipal corporations and townships, 15
whether paid or volunteer, and wherever serving within the state 16

or on temporary assignment outside thereof, and executive officers of boards of education, under any appointment or contract of hire, express or implied, oral or written, including any elected official of the state, or of any county, municipal corporation, or township, or members of boards of education.

As used in division (A)(1)(a) of this section, the term "employee" includes the following persons when responding to an inherently dangerous situation that calls for an immediate response on the part of the person, regardless of whether the person is within the limits of the jurisdiction of the person's regular employment or voluntary service when responding, on the condition that the person responds to the situation as the person otherwise would if the person were on duty in the person's jurisdiction:

(i) Off-duty peace officers~~. As used in division (A)(1)(a)(i) of this section, "peace officer" has the same meaning as in section 2935.01 of the Revised Code.~~;

(ii) Off-duty firefighters~~, whether paid or volunteer, of a lawfully constituted fire department.~~;

(iii) Off-duty ~~first responders, emergency medical technicians-basic, emergency medical technicians-intermediate, or emergency medical technicians-paramedic, whether paid or volunteer,~~ emergency medical workers of an ambulance service organization or emergency medical service organization ~~pursuant to Chapter 4765. of the Revised Code~~.

(b) Every person in the service of any person, firm, or private corporation, including any public service corporation, that (i) employs one or more persons regularly in the same business or in or about the same establishment under any contract of hire, express or implied, oral or written, including aliens and minors, household workers who earn one hundred sixty dollars or

more in cash in any calendar quarter from a single household and casual workers who earn one hundred sixty dollars or more in cash in any calendar quarter from a single employer, or (ii) is bound by any such contract of hire or by any other written contract, to pay into the state insurance fund the premiums provided by this chapter. 48 49 50 51 52 53

(c) Every person who performs labor or provides services pursuant to a construction contract, as defined in section 4123.79 of the Revised Code, if at least ten of the following criteria apply: 54 55 56 57

(i) The person is required to comply with instructions from the other contracting party regarding the manner or method of performing services; 58 59 60

(ii) The person is required by the other contracting party to have particular training; 61 62

(iii) The person's services are integrated into the regular functioning of the other contracting party; 63 64

(iv) The person is required to perform the work personally; 65

(v) The person is hired, supervised, or paid by the other contracting party; 66 67

(vi) A continuing relationship exists between the person and the other contracting party that contemplates continuing or recurring work even if the work is not full time; 68 69 70

(vii) The person's hours of work are established by the other contracting party; 71 72

(viii) The person is required to devote full time to the business of the other contracting party; 73 74

(ix) The person is required to perform the work on the premises of the other contracting party; 75 76

(x) The person is required to follow the order of work set by 77

the other contracting party; 78

(xi) The person is required to make oral or written reports of progress to the other contracting party; 79 80

(xii) The person is paid for services on a regular basis such as hourly, weekly, or monthly; 81 82

(xiii) The person's expenses are paid for by the other contracting party; 83 84

(xiv) The person's tools and materials are furnished by the other contracting party; 85 86

(xv) The person is provided with the facilities used to perform services; 87 88

(xvi) The person does not realize a profit or suffer a loss as a result of the services provided; 89 90

(xvii) The person is not performing services for a number of employers at the same time; 91 92

(xviii) The person does not make the same services available to the general public; 93 94

(xix) The other contracting party has a right to discharge the person; 95 96

(xx) The person has the right to end the relationship with the other contracting party without incurring liability pursuant to an employment contract or agreement. 97 98 99

Every person in the service of any independent contractor or subcontractor who has failed to pay into the state insurance fund the amount of premium determined and fixed by the administrator of workers' compensation for the person's employment or occupation or if a self-insuring employer has failed to pay compensation and benefits directly to the employer's injured and to the dependents of the employer's killed employees as required by section 4123.35 of the Revised Code, shall be considered as the employee of the 100 101 102 103 104 105 106 107

person who has entered into a contract, whether written or verbal, with such independent contractor unless such employees or their legal representatives or beneficiaries elect, after injury or death, to regard such independent contractor as the employer. 108 109 110 111

(d) Every person to whom all of the following apply: 112

(i) The person is a resident of a state other than this state and is covered by that other state's workers' compensation law; 113 114

(ii) The person performs labor or provides services for that person's employer while temporarily within this state; 115 116

(iii) The laws of that other state do not include the provisions described in division (H)(4) of section 4123.54 of the Revised Code. 117 118 119

(2) "Employee" does not mean: 120

(a) A duly ordained, commissioned, or licensed minister or assistant or associate minister of a church in the exercise of ministry; 121 122 123

(b) Any officer of a family farm corporation; 124

(c) An individual incorporated as a corporation; or 125

(d) An individual who otherwise is an employee of an employer but who signs the waiver and affidavit specified in section 4123.15 of the Revised Code on the condition that the administrator has granted a waiver and exception to the individual's employer under section 4123.15 of the Revised Code. 126 127 128 129 130

Any employer may elect to include as an "employee" within this chapter, any person excluded from the definition of "employee" pursuant to division (A)(2) of this section. If an employer is a partnership, sole proprietorship, individual incorporated as a corporation, or family farm corporation, such employer may elect to include as an "employee" within this chapter, any member of such partnership, the owner of the sole 131 132 133 134 135 136 137

proprietorship, the individual incorporated as a corporation, or the officers of the family farm corporation. In the event of an election, the employer shall serve upon the bureau of workers' compensation written notice naming the persons to be covered, include such employee's remuneration for premium purposes in all future payroll reports, and no person excluded from the definition of "employee" pursuant to division (A)(2) of this section, proprietor, individual incorporated as a corporation, or partner shall be deemed an employee within this division until the employer has served such notice. 138 139 140 141 142 143 144 145 146 147

For informational purposes only, the bureau shall prescribe such language as it considers appropriate, on such of its forms as it considers appropriate, to advise employers of their right to elect to include as an "employee" within this chapter a sole proprietor, any member of a partnership, an individual incorporated as a corporation, the officers of a family farm corporation, or a person excluded from the definition of "employee" under division (A)(2) of this section, that they should check any health and disability insurance policy, or other form of health and disability plan or contract, presently covering them, or the purchase of which they may be considering, to determine whether such policy, plan, or contract excludes benefits for illness or injury that they might have elected to have covered by workers' compensation. 148 149 150 151 152 153 154 155 156 157 158 159 160 161

(B) "Employer" means: 162

(1) The state, including state hospitals, each county, municipal corporation, township, school district, and hospital owned by a political subdivision or subdivisions other than the state; 163 164 165 166

(2) Every person, firm, professional employer organization as defined in section 4125.01 of the Revised Code, and private corporation, including any public service corporation, that (a) 167 168 169

has in service one or more employees or shared employees regularly in the same business or in or about the same establishment under any contract of hire, express or implied, oral or written, or (b) is bound by any such contract of hire or by any other written contract, to pay into the insurance fund the premiums provided by this chapter.

All such employers are subject to this chapter. Any member of a firm or association, who regularly performs manual labor in or about a mine, factory, or other establishment, including a household establishment, shall be considered an employee in determining whether such person, firm, or private corporation, or public service corporation, has in its service, one or more employees and the employer shall report the income derived from such labor to the bureau as part of the payroll of such employer, and such member shall thereupon be entitled to all the benefits of an employee.

(C) "Injury" includes any injury, whether caused by external accidental means or accidental in character and result, received in the course of, and arising out of, the injured employee's employment. "Injury" does not include:

(1) Psychiatric conditions except ~~where~~ as follows:

(a) Where the claimant's psychiatric conditions have arisen from an injury or occupational disease sustained by that claimant ~~or where~~;

(b) Where the claimant's psychiatric conditions have arisen from sexual conduct in which the claimant was forced by threat of physical harm to engage or participate;

(c) Where the claimant is a peace officer, firefighter, or emergency medical worker and is diagnosed with post-traumatic stress disorder that has arisen from the claimant's employment as a peace officer, firefighter, or emergency medical worker.

(2) Injury or disability caused primarily by the natural deterioration of tissue, an organ, or part of the body; 201 202

(3) Injury or disability incurred in voluntary participation in an employer-sponsored recreation or fitness activity if the employee signs a waiver of the employee's right to compensation or benefits under this chapter prior to engaging in the recreation or fitness activity; 203 204 205 206 207

(4) A condition that pre-existed an injury unless that pre-existing condition is substantially aggravated by the injury. Such a substantial aggravation must be documented by objective diagnostic findings, objective clinical findings, or objective test results. Subjective complaints may be evidence of such a substantial aggravation. However, subjective complaints without objective diagnostic findings, objective clinical findings, or objective test results are insufficient to substantiate a substantial aggravation. 208 209 210 211 212 213 214 215 216

(D) "Child" includes a posthumous child and a child legally adopted prior to the injury. 217 218

(E) "Family farm corporation" means a corporation founded for the purpose of farming agricultural land in which the majority of the voting stock is held by and the majority of the stockholders are persons or the spouse of persons related to each other within the fourth degree of kinship, according to the rules of the civil law, and at least one of the related persons is residing on or actively operating the farm, and none of whose stockholders are a corporation. A family farm corporation does not cease to qualify under this division where, by reason of any devise, bequest, or the operation of the laws of descent or distribution, the ownership of shares of voting stock is transferred to another person, as long as that person is within the degree of kinship stipulated in this division. 219 220 221 222 223 224 225 226 227 228 229 230 231

(F) "Occupational disease" means a disease contracted in the course of employment, which by its causes and the characteristics of its manifestation or the condition of the employment results in a hazard which distinguishes the employment in character from employment generally, and the employment creates a risk of contracting the disease in greater degree and in a different manner from the public in general. 232 233 234 235 236 237 238

(G) "Self-insuring employer" means an employer who is granted the privilege of paying compensation and benefits directly under section 4123.35 of the Revised Code, including a board of county commissioners for the sole purpose of constructing a sports facility as defined in section 307.696 of the Revised Code, provided that the electors of the county in which the sports facility is to be built have approved construction of a sports facility by ballot election no later than November 6, 1997. 239 240 241 242 243 244 245 246

(H) "Public employer" means an employer as defined in division (B)(1) of this section. 247 248

(I) "Sexual conduct" means vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of gender; and, without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal cavity of another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse. 249 250 251 252 253 254 255

(J) "Other-states' insurer" means an insurance company that is authorized to provide workers' compensation insurance coverage in any of the states that permit employers to obtain insurance for workers' compensation claims through insurance companies. 256 257 258 259

(K) "Other-states' coverage" means insurance coverage purchased by an employer for workers' compensation claims that arise in a state or states other than this state and that are 260 261 262

filed by the employees of the employer or those employee's dependents, as applicable, in that other state or those other states. 263 264 265

(L) "Peace officer" has the same meaning as in section 2935.01 of the Revised Code. 266 267

(M) "Firefighter" means a firefighter, whether paid or volunteer, of a lawfully constituted fire department. 268 269

(N) "Emergency medical worker" means a first responder, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, certified under Chapter 4765. of the Revised Code, whether paid or volunteer. 270 271 272 273 274

Sec. 4123.026. ~~(A)~~ The administrator of workers' compensation, or a self-insuring public employer for the peace officers, firefighters, and emergency medical workers employed by or volunteering for that self-insuring public employer, shall pay the costs of conducting post-exposure medical diagnostic services, consistent with the standards of medical care existing at the time of the exposure, to investigate whether an injury or occupational disease was sustained by a peace officer, firefighter, or emergency medical worker when coming into contact with the blood or other body fluid of another person in the course of and arising out of the peace officer's, firefighter's, or emergency medical worker's employment, or when responding to an inherently dangerous situation in the manner described in, and in accordance with the conditions specified under, division (A)(1)(a) of section 4123.01 of the Revised Code, through any of the following means: 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289

~~(1)~~(A) Splash or spatter in the eye or mouth, including when received in the course of conducting mouth-to-mouth resuscitation; 290 291

~~(2)~~(B) A puncture in the skin; 292

~~(3)~~(C) A cut in the skin or another opening in the skin such as an open sore, wound, lesion, abrasion, or ulcer. 293 294

~~(B) As used in this section:~~ 295

~~(1) "Peace officer" has the same meaning as in section 2935.01 of the Revised Code.~~ 296 297

~~(2) "Firefighter" means a firefighter, whether paid or volunteer, of a lawfully constituted fire department.~~ 298 299

~~(3) "Emergency medical worker" means a first responder, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, certified under Chapter 4765. of the Revised Code, whether paid or volunteer.~~ 300 301 302 303 304

Sec. 4123.46. (A)(1) Except as provided in division (A)(2) of this section, the bureau of workers' compensation shall disburse the state insurance fund to employees of employers who have paid into the fund the premiums applicable to the classes to which they belong when the employees have been injured in the course of their employment, wherever the injuries have occurred, and provided the injuries have not been purposely self-inflicted, or to the dependents of the employees in case death has ensued. 305 306 307 308 309 310 311 312

(2) As long as injuries have not been purposely self-inflicted, the bureau shall disburse the surplus fund created under section 4123.34 of the Revised Code to off-duty peace officers, firefighters, and emergency medical ~~technicians, and first responders~~ workers, or to their dependents if death ensues, who are injured while responding to inherently dangerous situations that call for an immediate response on the part of the person, regardless of whether the person was within the limits of the person's jurisdiction when responding, on the condition that the person responds to the situation as the person otherwise would 313 314 315 316 317 318 319 320 321 322

if the person were on duty in the person's jurisdiction. 323

As used in division (A)(2) of this section, "peace officer," "firefighter," and "emergency medical ~~technician," "first responder~~ worker," ~~and "jurisdiction"~~ have the same meanings as in section 4123.01 of the Revised Code. 324 325 326 327

(B) All self-insuring employers, in compliance with this chapter, shall pay the compensation to injured employees, or to the dependents of employees who have been killed in the course of their employment, unless the injury or death of the employee was purposely self-inflicted, and shall furnish the medical, surgical, nurse, and hospital care and attention or funeral expenses as would have been paid and furnished by virtue of this chapter under a similar state of facts by the bureau out of the state insurance fund if the employer had paid the premium into the fund. 328 329 330 331 332 333 334 335 336

If any rule or regulation of a self-insuring employer provides for or authorizes the payment of greater compensation or more complete or extended medical care, nursing, surgical, and hospital attention, or funeral expenses to the injured employees, or to the dependents of the employees as may be killed, the employer shall pay to the employees, or to the dependents of employees killed, the amount of compensation and furnish the medical care, nursing, surgical, and hospital attention or funeral expenses provided by the self-insuring employer's rules and regulations. 337 338 339 340 341 342 343 344 345 346

(C) Payment to injured employees, or to their dependents in case death has ensued, is in lieu of any and all rights of action against the employer of the injured or killed employees. 347 348 349

Section 2. That existing sections 4123.01, 4123.026, and 4123.46 of the Revised Code are hereby repealed. 350 351

THE STATE OF SOUTH CAROLINA
In The Supreme Court

Brandon Bentley, Appellant,

v.

Spartanburg County, and S.C. Association of Counties SIF, Respondents,

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Appeal from Richland County
Workers Compensation Commission

Opinion No. 27140
Heard March 8, 2012 – Filed July 11, 2012

AFFIRMED

Jeremy A. Dantin, of Harrison, White, Smith & Coggins, of Spartanburg, for Appellant.

Richard B. Kale Jr., of Willson Jones Carter & Baxley, of Greenville, for Respondents.

Grady L. Beard, B. Gibbs Leaphart Jr., and Nicolas L. Haigler, all of Sowell Gray Stepp & Laffitte, of Columbia, for Amicus Curiae.

CHIEF JUSTICE TOAL: Brandon Bentley (Appellant), a deputy sheriff with the Spartanburg County Sheriff's Department, alleged that he developed Post Traumatic Stress Disorder (PSTD) and depression after he shot and killed a suspect who attempted to assault him. An Appellate Panel of the Workers' Compensation Commission (Appellate Panel) unanimously found that Appellant failed to meet his burden of proof in establishing a compensable mental injury that arose out of an "unusual or extraordinary condition" of employment for a Spartanburg County deputy sheriff. We affirm.

FACTS/ PROCEDURAL BACKGROUND

On October 21, 2009, Appellant was on road patrol when he was dispatched to a residence in Spartanburg following a call involving disturbances between neighbors. As he arrived at the scene, he saw a man in khaki shorts standing just outside the carport of the residence. He stepped out of his car and asked the man to approach him to talk. The man refused to cooperate and exchanged words with Appellant before walking toward Appellant with an umbrella raised in an "offensive posture." Appellant issued several commands for the man to drop the umbrella. In response, Appellant claimed the man threatened to take Appellant's gun and kill him. Appellant then fired one shot "center mass" at the man's chest resulting in his death.

Following this incident, Appellant began to suffer psychological symptoms including anxiety and depression and sought treatment at Post Trauma Resources in Columbia. Based on his psychological symptoms, his psychiatrist and psychologist concluded that Appellant was unable to work.

On March 10, 2010, Appellant filed a Form 50 to claim workers' compensation benefits. After a hearing, the Single Commissioner found that the October 21, 2009 event was not an unusual or extraordinary condition of Appellant's work, and Appellant had not suffered a compensable mental injury by accident arising out of his employment. The Commissioner noted

that deputies received training on the use of deadly force and that Appellant admitted he knew he would sometimes be required to use deadly force in the course and scope of his employment. Appellant then appealed to the Appellate Panel, which affirmed the Commissioner's Order and denied Appellant's claim. Appellant filed an appeal and this case is before this Court pursuant to Rule 204(b), SCACR.

ISSUE

> Whether the shooting and killing of a suspect by a deputy sheriff while on duty is an extraordinary and unusual employment condition such that mental injuries arising from that incident are compensable under the Workers' Compensation Act.

STANDARD OF REVIEW

The South Carolina Administrative Procedure Act (APA) governs appeals from the decisions of an administrative agency. S.C. Code Ann. § 1-23-380 (Supp. 2011); *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 134–35, 276 S.E.2d 304, 306 (1981). Under the APA, an appellate court may not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact, but it may reverse when the decision is affected by an error of law. S.C. Code Ann. § 1-23-380(5). If the findings, inferences, conclusions, or decisions of that agency are "clearly erroneous in view of the reliable, probative and substantial evidence on the whole record," a reviewing court may reverse or modify. *Id.* Substantial evidence is not a mere scintilla of evidence, nor evidence viewed blindly from one side of the case, but is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion the administrative agency reached. *Pratt v. Morris Roofing, Inc.*, 357 S.C. 619, 622, 594 S.E.2d 272, 274 (2004).

ANALYSIS

Appellant argues he sustained a compensable mental injury that arose from an extraordinary and unusual condition of employment. We disagree.

Workers' compensation pays an employee benefits for damages resulting from personal injury or death by accident arising out of and in the course of the employment. S.C. Code Ann. § 42-1-310 (Supp. 2011). In determining whether a work-related injury is compensable, the Workers' Compensation Act (Act), S.C. Code Ann. §§ 42-1-10 to -19-10 (1976 & Supp. 2011), is liberally construed toward the end of providing coverage rather than denying coverage in order to further the beneficial purposes for which it was designed. *Shealy v. Aiken Cnty.*, 341 S.C. 448, 535 S.E.2d 438 (2000) (citation omitted). Any reasonable doubt as to the construction of the Act will be resolved in favor of coverage. *Mauldin v. Dyna-Color/Jack Rabbit*, 308 S.C. 18, 22, 416 S.E.2d 639, 641 (1992).

Some context regarding the evolution of mental damages in workers' compensation will illuminate the framework which necessarily binds this Court in resolving this case. As set forth by Professor Larson in his treatise on workers' compensation, work-related injuries fall into three categories: 1) mental stimulus causing physical injuries (mental-physical injuries), 2) physical stimulus causing mental injuries (physical-mental injuries), and 3) mental stimulus causing mental injuries (mental-mental injuries). Arthur Larson, *Larson's Workers' Compensation Law* § 56.06[3] (2011). Historically, given the suspicion surrounding mental injuries, courts and legislatures refused to award compensation for mental injuries, or if they did, required that covered mental injuries be accompanied by a physical manifestation. *See id.* at § 56.06[1][b]. A majority of states now recognize the compensability of purely mental-mental injuries, injuries without accompanying physical manifestation, although a large number of states, including South Carolina, place heightened restrictions on recovery by requiring that the precipitating stressor be unusual and extraordinary compared with normal working conditions.[1] *Id.* at § 56.06[3]; *Stokes v. First Nat'l Bank*, 306 S.C. 46, 410 S.E.2d 248 (1991); *Davis v. Workmen's Comp. Appeal Bd.*, 751 A.2d 168, 170 (Pa. 2000) (denying workers' compensation to police officer suffering from PSTD because encountering traumatic events was normal for a police officer).

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[1] Larson indicated that at least 29 states now recognize mental-mental injuries. Larson, *supra*, at § 56.06[3].

South Carolina's standard for recovering benefits for mental-mental injury is codified in section 42-1-160 of the South Carolina Code, which provides:

> (B) Stress, mental injuries, and mental illness arising out of and in the course of employment unaccompanied by physical injury and resulting in mental illness or injury are not considered a personal injury unless the employee establishes, by a preponderance of the evidence:
>
> (1) that the employee's employment conditions causing the stress, mental injury, or mental illness were *extraordinary and unusual* in comparison to the normal *conditions* of the particular employment; and
>
> (2) the medical causation between the stress, mental injury, or mental illness, and the stressful employment conditions by medical evidence.

S.C. Code Ann. § 42-1-160 (emphasis added).[2]

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[2] The standard codified by S.C. Code Ann. § 42-1-160 (Supp. 2011) for a mental-mental injury is known as the "heart attack standard." *See Powell*, 299 S.C. at 327, 384 S.E.2d at 726 ("Mental or nervous disorders resulting from either physical or emotional stimuli are equally compensable provided the emotional stimuli or stressors are incident to or arise from unusual or extraordinary conditions of employment."); *Stokes v. First National Bank,* 298 S.C. 13, 377 S.E.2d 922 (Ct. App. 1988). A heart attack suffered by an employee constitutes a compensable accident if it is induced by unexpected strain or overexertion in the performance of his duties of employment, or by *unusual and extraordinary* conditions in employment. *Bridges v. Housing Auth., City of Charleston*, 278 S.C. 342, 295 S.E.2d 872 (1982). However, if a heart attack results as a consequence of ordinary exertion that is required in performance of employment duties in an ordinary and usual manner, and without any untoward event, it is not compensable as an accident. *Shealy*, 341 S.C. at 457, 535 S.E.2d at 443 (citation omitted).

Although we are constrained to decide this case according to the standard mandated by the General Assembly, we offer our opinion that this standard should be updated to account for the scientific and technological progress in medicine and psychology, which have undermined the old public policy argument used to deny mental-mental recovery.

Historically, a lack of understanding about mental-mental injuries fueled the negative reaction toward allowing recovery. The traditional justifications for imposing barriers to recovery were that claims for mental-mental injuries were easier to falsify than claims for physical injuries, and any recovery for mental anguish damages must be limited with bright line rules lest the courts be flooded with litigation. *See* Frances C. Slusarz, *Work Place Stress Claims Resulting from September 11th*, 18 Lab. Law. 137 (Fall 2002); Jon L. Gillum, Note, *Fear of Disease in Another Person: Assessing the Merits of an Emerging Tort Claim*, 79 Tex. L. Rev. 227 (Nov. 2000). However, those in favor of allowing broader recovery point out that advances in medical science have made it easier for medical professionals to diagnose and verify the validity of mental injuries, enabling courts to weed out fraudulent claims. *See Towns v. Anderson*, 579 P.2d 1163 (1978) (finding that "the medical profession has made tremendous advances in diagnosing and evaluating emotional and mental injuries. While psychiatry and psychology may not be exact sciences, they can now provide sufficiently reliable information concerning causation and treatment of psychic injuries, to provide a jury with an intelligent basis for evaluating a particular claim."); *Eckenrode v. Life of Am. Ins. Co.*, 470 F.2d 1, 3 (7th Cir. 1972) (citation omitted) (stating that mental anguish can be diagnosed and verified by health professionals). In addition, proponents note that claims of physical injury, especially in relation to damages for pain and suffering, can be as susceptible to fraud as mental-mental injuries, rendering it illogical to allow recovery for one while denying it for the other. *Molien v. Kaiser Found. Hosps.*, 616 P.2d 813, 821 (Cal. 1980) (noting the rule requiring mental injury be accompanied by physical injuries "encourages extravagant pleading and distorted testimony" by claimants trying to fit their emotional anguish claims into the physical injury framework). We agree with these proponents for reform.

We do not believe that removing South Carolina's heightened requirement for mental-mental recovery would result in a flood of litigation given the safeguards that the General Assembly has built into section 42-1-160.[3] S.C. Code Ann. § 42-1-160 (Supp. 2011). Even without the requirement that all compensable mental-mental injuries must arise from employment conditions that are unusual and extraordinary, under current law, claimants must pass a causation test and show that the employment condition is the proximate cause of the mental injury. *Id.* § 42-1-160(B)(2). In addition, under section 42-1-160(C), mental-mental stress are not considered compensable if they result from any event which are "incidental to normal employer/employee relations including, but not limited to, personnel actions by the employer such as disciplinary actions, work evaluations, transfers, promotions, demotions, salary reviews, or terminations, except when these actions are taken in an extraordinary and unusual manner." S.C. Code Ann. § 42-1-160. Consequently, when one considers that a claimant must show

[3] California's experience has shown that liberalizing mental-mental recovery too broadly could indeed unintentionally unleash a flood of litigation that raises costs, burdens the courts, and unduly interferes with the hiring and firing of workers. Larson, *supra*, at § 56.06[1][a]. In *Albertson's, Inc. v. Workers' Compensation Appeals Board*, 182 Cal. Rptr. 304 (1982), the California Court of Appeals ruled that the compensability for mental-mental injuries could be judged purely on a plaintiff's subjective perception of stress at work and not objective reality. This overly broad holding dramatically increased the workers' compensation claims that were compensable so that by 1986, the number of claims increased nearly seven-fold along with the expenses to litigate those claims. Larson, *supra*, at § 56.06[1][a]. In an effort to control costs, the California legislature reversed course and enacted a series of reforms that made it tougher to recover for mental-mental damages. *Id.* South Carolina has not and should not allow recovery based on a claimant's subjective perception of stress as California did in 1982. *Id.* However, removing the requirement that the employment condition be unusual and extraordinary in order to recover is not the same as what was done in California, and would not result in a flood of litigation given the safeguards already built into section 42-1-160. S.C. Code Ann. § 42-1-160.

causation and that he is excluded from bringing claims that are "incidental to normal employer/employee relations," the framework for recovery adequately errs on the side of caution even without requiring that all mental-mental claims arise from unusual and extraordinary conditions of employment. Moreover, it has been argued that even if an observed increase in litigation results, it is the primary business of courts to redress wrongs. W. Page Keeton et al., *Posser and Keeton on the Law of Torts* § 54, at 360 (5th ed. 1984) ("It is the business of the courts to make precedent where a wrong calls for redress, even if lawsuits must be multiplied . . . .").

If South Carolina reforms section 42-1-160, it would not be alone. At least five states already do not require that the conditions of employment be unusual and extraordinary to be compensable.[4] Larson, *supra*, at § 56.06D[7]. We believe that in light of the safeguards already in place and the scientific progress made in our understanding and diagnosis of mental-mental injuries, the *Powell* framework as promulgated in 1989 is obsolete.[5] Removing the unduly restrictive barrier in mental-mental cases that requires employment conditions to be unusual and extraordinary would further South

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[4] Those five states are Hawaii, Michigan, New Jersey, New York, and Oregon. Larson, *supra*, at § 56.06D[7].

[5] We note that South Carolina's requirement that in mental-mental cases employment conditions causing the mental injury must be unusual and extraordinary was judicially created before being legislatively adopted. In *Powell v. Vulcan Materials Co.*, 299 S.C. 325, 327, 384 S.E.2d 725, 726 (1989), this Court applied the "heart attack standard" to mental-mental injuries and recognized that mental-mental injuries that arose from extraordinary and unusual conditions of employment are compensable. *See* n. 2, *supra*. In 1989, when the Court decided *Powell*, section 42-1-160 of the South Carolina Code did not specifically address mental-mental injuries nor require that they arise from extraordinary and unusual conditions of employment. *See* S.C. Code Ann. § 42-1-160 (1976 & Supp. 1989). Only in 1996 did the legislature amend section 42-1-160 to statutorily adopt *Powell*'s framework for determining the compensability of mental-mental injuries. *See* S.C. Code Ann. § 42-1-160 (Supp. 1996).

Carolina's public policy of favoring coverage for injuries suffered at work, while not unleashing an uncontainable flood of litigation or unduly burdening business activities.

Nevertheless, we are interpreters not legislators and are bound by the language of section 42-1-160 as written. *Citizens' Bank v. Heyward*, 135 S.C. 190, 204, 133 S.E. 709, 713 (1925) ("The primary source of the declaration of the public policy of the state is the General Assembly[, and] the courts assume this prerogative only in the absence of legislative declaration."). Section 42-1-160 refers to *conditions* of employment and not the frequency of an event occurring during the course of employment. S.C. Code Ann. § 42-1-160(B)(1). Furthermore, it requires those conditions to be "unusual or extraordinary." *Id*. Unusual or extraordinary conditions refer to conditions of the particular job, not to conditions of employment generally. *Shealy*, 341 S.C. at 456, 535 S.E.2d at 442.

The parties do not contest that the October 21, 2009 incident, where Appellant, while on patrol, shot and killed a suspect, is the proximate cause of Appellant's mental injury. S.C. Code Ann. § 42-1-160(B)(2); *Tennant v. Beaufort Cnty. Sch. Dist.*, 381 S.C. 617, 674 S.E.2d 488 (2009) (claimant must show that "unusual or extraordinary conditions were the proximate cause of the mental disorder"). The only issue is whether the employment condition was extraordinary and unusual with respect to Appellant's profession as a deputy sheriff.[6] *Shealy*, 341 S.C. at 456, 535 S.E.2d at 442.

In *Stokes v. First National Bank*, 306 S.C. 46, 48, 410 S.E.2d 248, 249 (1991), as a result of a merger and the resignation of one of plaintiff's managers, claimant's work hours increased from approximately 45 hours per week to 60 hours per week in January 1984; to workdays of approximately 12 to 15 hours in July 1984; and then 16 to 18 hours after November 10, 1984.

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[6] Black's Law Dictionary defines "extraordinary" as "out of the ordinary, exceeding the usual, average, or normal measure or degree; beyond or out of the common order, method, or rule; not usual, regular or of a customary kind; remarkable; uncommon; rare; employed for an exceptional purpose or a on a special occasion." Black's Law Dictionary 586 (6th ed. 1990). "Unusual" is defined as "uncommon; not usual; rare." *Id.* at 1540.

This Court found that Stokes's excessively increased workload constituted an unusual and extraordinary condition of employment which rendered his resulting nervous breakdown a compensable accident. *Id.* at 50, 410 S.E.2d at 250. It may be tempting to extrapolate that if excessive increases in work hours constitute an "extraordinary and unusual" condition of employment, then so too would killing a person in the course of duty. However, *Shealy v. Aiken County* directs us not to compare apples and oranges, but rather to examine cases involving Appellant's particular profession as a deputy sheriff or law enforcement officer. 341 S.C. 448, 456, 535 S.E.2d 438, 442 (2000) (unusual and extraordinary conditions refers to conditions to the particular job in which the injury occurs, not to conditions of employment in general).

In *Shealy*, the claimant worked as a deputy sheriff in Lexington County from 1981 to 1990. *Id.* at 452, 535 S.E.2d at 440. During this time, he developed depression and an alcohol problem, which led to his departure from his job. *Id.* In November 1990, the Aiken County Sheriff, aware of claimant's alcohol problem, nonetheless, hired him to work as a "deep cover" narcotics agent. *Id*. The Aiken County Sheriff's Department hired deep cover agents to go to known drug locations, typically bars and nightclubs, to befriend drug dealers and other criminals in order to gain information, intelligence, and to make drug buys, which were then given to the police as evidence. *Id.* Deep cover work is extremely stressful and differs from regular police undercover work because agents do not wear a wire, are not operating under police surveillance, do not have access to police back up, and do not carry police identification. *Id.* In August 1992, following an incident with a drug dealer while working undercover, claimant believed that he was in danger due to constant death threats. *Id.* at 452–53, 535 S.E.2d at 441. On December 30, 1992, the sheriff's department dismissed him from his job when a new sheriff decided to eliminate the deep cover program. *Id.* According to claimant, the dismissal caused severe stress because he still faced death threats and would lose both his permit to carry a weapon and the protection of law enforcement. *Id.* Claimant was diagnosed with major depression, PTSD, anxiety, alcoholism, and panic disorder with agoraphobia. He sought workers' compensation benefits, and the Single Commissioner awarded claimant benefits for aggravation of his preexisting alcoholism and psychological injury resulting from the extraordinary conditions of his employment. *Id.* at 454, 535 S.E.2d at 441. This Court agreed with the

Commissioner finding that substantial evidence in the record demonstrated that claimant's work conditions were unusual and extraordinary. *Id.* at 458, 535 S.E.2d at 444. We held that the "*combination* of death threats, gun incidents with violent drug dealers, high tension confrontations, fear of being uncovered, and loss of security as a police officer constitutes unusual or extraordinary conditions of employment when they occur over several months." *Id.* at 455, 535 S.E.2d at 442 (emphasis added).

Shealy is distinguishable from the case at hand. While it is expected that deep undercover work is dangerous and stressful, the combination of a serious death threat, claimant's layoff, and claimant's subsequent loss of police protection occurring over a period of several months elevated claimant's employment conditions to extraordinary and unusual. *Id.* No such aggravating combination is present in this case where admittedly Appellant's mental injuries result solely from the shooting of a suspect who threatened him on October 21, 2009.[7]

The use of deadly force is within the normal scope and duties of a Spartanburg County deputy sheriff. Claimant himself, upon direct questioning, confirmed that he knew that he would sometimes be required to use deadly force in his job. In addition, the Spartanburg County Sheriff's Office General Order 520.1 provides:

> Deadly force may be used by officers only when they reasonably believe the action is in defense of human life (the officer's or others) . . . . When any arrestee initiates action to cause physical harm, there should be no hesitancy in using such force as necessary to bring that person under control.

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[7] As to whether the incident was an extraordinary and unusual event, Appellant presented letters from his psychiatrist and psychologist opining that it was, while Respondents presented a letter from an expert vocational consultant and certified vocational evaluator opining it was not. We note these opinions, but are ultimately persuaded by other factors in this case, which we discuss in the body of this opinion.

Deputies are also required to attend the South Carolina Criminal Justice Academy where they are instructed on the use of firearms and deadly force, and each deputy receives annual training in the same area. Moreover, Spartanburg County Sheriff Chuck Wright testified that when he became a deputy sheriff, he was aware of the possibility that he might be required to fire his weapon to shoot and kill, and that all deputies are aware of this possibility through their training.

Appellant would like this Court to reframe the issue, take it out of its particular employment context, and ask "whether killing another human being is 'unusual.'" This approach, however, contradicts *Shealy*'s command to look at conditions of the particular employment in which the injury occurs and not to conditions of employment in general. 341 S.C. at 456, 535 S.E.2d at 442. Appellant also argues that because statistics show that the killing of suspects by a Spartanburg County deputy sheriff occurred about once a year, this meant that shooting and killing was an unusual and extraordinary event.[8] However, in defining what constitutes unusual and extraordinary, the statute and our case law speak of *conditions* of employment and not the frequency of an event occurring. S.C. Code Ann. § 42-1-160; *Shealy*, 341 S.C. at 456, 535 S.E.2d at 442. Moreover, if the frequency of killing is the decisive factor,

[8] This same frequency argument has been adopted by the dissent. Furthermore, the dissent finds it "difficult to fathom, let alone countenance, a rule which would allow Deputy Sheriff Bentley to recover workers' compensation if he had tripped and fallen and injured his leg while drawing his gun on this suspect, yet does not permit him to recover for the real mental trauma he undeniably suffered by shooting and killing the man." We are deeply sympathetic to the views expressed in the learned dissent. While we certainly echo the dissent's concerns in our call for reform, we note that the hypothetical that the dissent employs involves a physical injury that would be compensable because it is not constrained by § 42-1-160, which only places barriers to recovery in cases involving mental-mental injuries. Here, however, we are dealing with a mental-mental injury and are bound by the heightened statutory restriction that the conditions of employment must be unusual and extraordinary.

then it is difficult to put a precise number on how many suspects must be killed before the killing ceases to be extraordinary and unusual. Under our case law, we cannot ignore the particular employment context and hold that killing a suspect is generally and inherently extraordinary and unusual. *Shealy*, 341 S.C. at 456, 535 S.E.2d at 442. Thus, we agree with the Appellate Panel that the issue this Court must decide is whether or not using deadly force, which may result in fatalities, is a standard or necessary condition of a deputy sheriff's job, not how frequently the use of deadly force results in fatalities.

We hold that Appellant's testimony that he "might be in a situation where he might have to shoot someone," similar testimonies by Sheriff Wright that officers were aware of the possibility that they might be required to shoot and kill, Appellant's training in the use of deadly force, and the department's policy addressing when deadly force should be used constitutes substantial evidence supporting the Appellate Panel's conclusion that the October 21, 2009 incident was not extraordinary and unusual, but was a standard and necessary condition of a deputy sheriff's job.

CONCLUSION

For the foregoing reasons, we affirm the Appellate Panel's holding.

AFFIRMED.

PLEICONES and KITTREDGE, JJ., concur. HEARN, J., dissenting in a separate opinion in which BEATTY, J., concurs.

JUSTICE HEARN: I unequivocally join in the majority's call for the General Assembly to revisit Section 42-1-160(B) of the South Carolina Code (Supp. 2010). As the majority thoroughly explains, our present "mental-mental" statute is an anachronism and the time has come for it to be updated based on the current understanding of mental injuries. However, I part company with the majority's conclusion that Deputy Sheriff Brandon Bentley has failed to prove that shooting and killing another human being in the line of duty is not an unusual or extraordinary circumstance for a law enforcement officer, which is the standard we must apply. I believe that it is and would reverse, holding the Appellate Panel committed an error of law in ruling otherwise. I therefore respectfully dissent.

As noted by the majority, beginning with the court of appeals' decision in *Stokes v. First National Bank*, 298 S.C. 13, 377 S.E.2d 922 (Ct. App 1988), the compensability of a mental injury caused solely by emotional distress has been analyzed consistent with the standard of compensability for heart attack injury cases. This Court, in *Powell v. Vulcan Materials Co.*, 299 S.C. 325, 384 S.E.2d 725 (1989), specifically approved the court of appeals' decision to adopt the heart attack standard—unusual or extraordinary conditions of employment—to determine compensability in cases of mental-mental injuries, and quoted this from the *Stokes* opinion: "'[M]ental or nervous disorders resulting from either physical or emotional stimuli are equally compensable provided the emotional stimuli or stressors are incident to or arise from unusual or extraordinary conditions of employment.'" *Id.* at 327, 384 S.E.2d at 726 (quoting *Stokes*, 298 S.C. at 22, 377 S.E.2d at 927). In 1996, the General Assembly, in response to this developing case law, amended section 42-1-160 to limit recovery for purely mental injuries to situations where "it is established that the stressful employment conditions causing the mental injury were extraordinary and unusual in comparison to the normal conditions of the employment." 1996 Act No. 424 § 2.

Applying the statute to this case requires us to discern the meaning of unusual and extraordinary in the context of the responsibilities of a law enforcement officer. The majority correctly defines "extraordinary" as "out of the ordinary, exceeding the usual, average, or normal measure or degree; beyond or out of the common order, method, or rule; not usual, regular or of a customary kind; remarkable; uncommon; rare; employed for an exceptional

purpose or on a special occasion." Black's Law Dictionary 586 (6th ed. 1990). Additionally, it defines "unusual" as "uncommon; not usual; rare." *Id.* at 1540. Therefore, under the plain language of section 42-1-160, Deputy Sheriff Bentley should be able to recover if shooting and killing another human being in the line of duty is not a common occurrence or if it is beyond what is ordinary. The majority finds, on the other hand, primarily because all officers are trained for this very eventuality, that it cannot be unusual or extraordinary. Thus, the majority equates a mere *possibility* of an event occurring with it being usual and ordinary. With that analysis, I cannot agree, because I believe it is contrary to the plain language of the statute and it improperly conflates the standard of compensability for mental-mental injuries with the concept of foreseeability.

This record is replete with evidence that Deputy Sheriff Bentley, like all law enforcement officers, was trained to kill a suspect in the line of duty, if his own life or the life of another was in jeopardy. However, it is also undisputed that despite this preparation, the vast majority of law enforcement officers fortunately never have to take this grave step; indeed, many never even draw their gun to fire in the course of their professional lives. In this regard, the testimony of Deputy Sheriff Bentley's boss, Sheriff Chuck Wright, is particularly compelling. Sheriff Wright testified that in his twenty-two years in law enforcement—seventeen as a patrol officer and five as sheriff—he never shot someone in the line of duty. He also testified that during the prior six years in Spartanburg County, a suspect had been shot and killed by a deputy six times, or once per year, on average. Moreover, when an officer shoots a suspect, an in-house and a SLED investigation are triggered, and significantly, the officer is required to take administrative leave and to see the department's psychologist. In response to the question as to whether his deputies rarely have to use deadly force, Sheriff Wright responded: "It's not an everyday occurrence, thank God." It is difficult to imagine clearer testimony on whether an event is a common occurrence or is out of the ordinary, consistent with the definitions noted above.

While I do not suggest that we define what is unusual and extraordinary only by what is rare, I do believe that the sheer rarity of this situation is a factor to consider in determining whether it is unusual and unexpected. Indeed, this is even borne out by the definitions of extraordinary and unusual

employed by the majority, both of which contemplate an event being a possibility yet still extraordinary and unusual. *See* Black's Law Dictionary 586 (6th ed. 1990) (defining "extraordinary" as "out of the ordinary, exceeding the usual, average, or normal measure or degree; beyond or out of the common order, method, or rule; not usual, regular or of a customary kind; remarkable; uncommon; rare; employed for an exceptional purpose or on a special occasion"); *id.* at 1540 (defining "unusual" as "uncommon; not usual; rare"). Because the Appellate Panel did not take these ordinary definitions into consideration, it committed an error of law. Under the proper standard, the evidence unquestionably reveals that shooting and killing a suspect is both unusual in terms of the frequency of such an event and extraordinary in that it is not a common occurrence in the professional life of a police officer. I therefore believe the heightened burden has been satisfied. To the extent that section 42-1-160(B) would preclude Deputy Sheriff Bentley from recovering, this case perfectly illustrates the problem with the present standard. I find it difficult to fathom, let alone countenance, a rule which would allow Deputy Sheriff Bentley to recover workers' compensation if he had tripped and fallen and injured his leg while drawing his gun on this suspect, yet does not permit him to recover for the very real mental trauma he undeniably suffered by shooting and killing the man.

In *Shealy v. Aiken County*, 341 S.C. 448, 455-6, 535 S.E.2d 438, 442, (2000), which involved the compensability of injuries for mental distress for a "deep cover" narcotics officer, we stated: "In determining whether a work-related injury is compensable, the Workers' Compensation Act is liberally construed toward the end of providing coverage rather than noncoverage in order to further the beneficial purposes for which it was designed." The majority, however, loses sight of this lodestar of workers' compensation law and interprets the phrase "extraordinary and unusual" in a manner which is not only contrary to the plain meaning of the words used, but also defeats coverage. Cast against the proper legal canvas, I would hold that Deputy Sheriff Bentley's mental injuries—injuries which are admitted and indisputably resulted from this necessary yet regrettable event—are compensable because while shooting and killing a suspect in the line of duty may have been something he was trained to do, it was clearly an unusual and extraordinary part of his job as a law enforcement officer.

BEATTY, J., concurs.

7 LEO myths that stress you out and scare your family

In a hard-hitting presentation at the ILEETA annual training conference, Dr. Alexis Artwohl challenged widely held misconceptions about police work

Seven persistent, negative myths about law enforcement are needlessly deepening officer stress, damaging recruitment, and generating unnecessary anxiety and fear in cop families, says a popular researcher and trainer in the field of police psychology.

In a hard-hitting presentation at the ILEETA annual training conference, Dr. Alexis Artwohl challenged widely held misconceptions about the danger, emotional trauma, alcoholism, divorce rate, premature mortality, suicide incidence, and burnout associated with police work.

She set the record straight with well-documented findings that officers overwhelmingly are well-grounded, mentally healthy, and resilient.

“Of course, some people fail to thrive in law enforcement, as with any profession,” she says. “But certain prevailing beliefs about the personal risks of a policing career are extreme exaggerations and need to be corrected.”

Artwohl is a faculty member with the certification course in Force Science Analysis and is co-author of the best-selling book, Deadly Force Encounters. She formerly served law enforcement as a clinical and police psychologist in the Pacific Northwest.

Here’s a fiction-versus-fact summary of the fallacies she addressed at ILEETA.

MYTH #1: Law Enforcement is Among the Top Five Most Dangerous Jobs

"There's no doubt policing can be dangerous, but it's not even in the top 13 of the most dangerous occupations," Artwohl says.

According to the U.S. Bureau of Labor Statistics, loggers are the most likely to be killed on the job. Even farmers are twice as likely as cops to experience a work-related death.

Police rank 14th in danger, between heavy equipment operators and electricians.

When it comes to death from homicide, taxi drivers and chauffeurs are at greatest risk—more than four times likelier than cops to be murdered.

That's not to belittle the risks officers are exposed to or to encourage complacency, Artwohl emphasizes. Rather, she says, it shows that "officers are pretty skilled at keeping themselves safe and alive in threatening circumstances."

MYTH #2: A Shooting Will Likely Cause Significant Emotional Problems and a Career Change

"We've all heard alarming allegations about officer-involved shootings," Artwohl says. "It's claimed that two-thirds of officers in shootings have serious traumatic reactions and that 70 percent leave law enforcement within seven years.

"That's absolutely untrue," Artwohl says. Multiple studies have found that while short-term emotional reactions are common, "the vast majority of officers cope very well with shootings," reporting only "mild, transitory symptoms." In one study of 540 shooting survivors, only two ever filed workers comp claims for psychological problems afterward.

And quitting the job is extremely rare. In a study of nearly 1,000 officers, more than 80 percent reported no post-shooting change in their job satisfaction. Indeed, 8 percent even found their work "more enjoyable" after their OIS. One researcher reports that 30 percent of officers received a promotion post-shooting.

"Individual reactions vary," Artwohl says. "If an officer does experience adverse emotional problems that seem overwhelming and chronic, he or

she should definitely seek professional help, without being stigmatized."

MYTH #3: LEOs Abuse Alcohol More than Other Occupations
After digging into this subject, Artwohl concluded that "there is no research whatsoever that documents an unusually high level of alcoholism among police officers."
The same determination was reached by another police psychologist who examined data from the U.S. Department of Health and Human Services, comparing alcoholism rates by occupation. Indeed, that researcher identified eight other occupations that have a significantly higher rate than cops, Artwohl says.
"Although there's a widespread belief that massive amounts of alcohol are consumed by police, there is very little rigorous research on this topic," she says. "If you hear people say this, challenge them to come up with studies to prove it."

MYTH #4: LEOs Have a Higher Divorce Rate than Other People
"Again, absolutely not true," Artwohl asserts. "An analysis of U.S. census data reveals that police officers, detectives, and their supervisors actually have a lower divorce rate than the national average for other occupations and for what would be expected from their demographic profile. This has held true for more than a century."
A subcategory of transit and railroad police, for example, ranks among the five occupations with the lowest divorce rate, about the same as the clergy.
One social scientist concludes: "There are no data to demonstrate that law enforcement…has a statistically significant negative impact upon marriages."

MYTH #5: Most Cops Die Within Five Years of Retirement
As a sampling, pension records in Arizona and California show otherwise, Artwohl points out. They document that male LEOs, who typically retire at age 55, live an average of 24 more years (to 79), while females live an average of 29 years post-retirement (to 84).
"It's possible other jurisdictions have different death rates," she says,

“but there are no studies that prove a cop on the force today is automatically doomed to an early death as a result of serving in law enforcement.”

MYTH #6: LEOs Have a Higher-than-average Suicide Rate
“It’s always controversial to say this is a myth,” Artwohl admits, “because police officers do have a higher suicide rate when compared to the general population. But that’s an invalid comparison.
“Males as a whole are more likely to kill themselves than are women. Since law enforcement is predominately a male profession, that skews the statistics. If you compare cops to their demographic peers in other professions — matching for gender, age, race, and so on — you get an entirely different picture.”
With that comparison, multiple studies have shown the police suicide rate actually to be lower than the norm. “LEOs are 26 percent less likely to kill themselves than their demographically matched peers in nonpolice occupations,” Artwohl says. “To keep from feeding the myth, researchers need to be careful to always do demographic matching before reaching any conclusions and to be certain their statistics are gathered from a large sample over a long span of time.”

MYTH #7: Burnout is Inevitable in Law Enforcement
“The image of cynical, burned-out cops who hate their job and the public they serve is a disservice to law enforcement,” Artwohl says. “Again, responsible research shows a much more positive picture.”
She cites a study that surveyed officers and other workers on job satisfaction and “general happiness.” Nearly 60 percent of cops said they were “very satisfied” with their job. Overall, LEOs ranked “in the middle” among occupations, on a par with nurses and accountants. About four in ten reported being “very happy.”
Another survey, of suburban departments in the Midwest, found that officers generally reported “low levels of emotional exhaustion” and moderate to high levels of “personal accomplishment.”
“There is simply no evidence to support the idea that police work produces more burnout than other occupations,” Artwohl says.

Reflecting on the seven myths, Artwohl stresses the importance of “dealing with the statistical realities” of law enforcement. “Being overly concerned about exaggerated problems creates more stress for officers, more worry and fear for their families, and hampers efforts to recruit good people to the profession,” she says.

“Also if a police career is viewed as being destructive, it encourages officers to think of themselves as victims of the profession rather than as resilient individuals who can determine their own outcomes.

“The truth is that law enforcement is a noble, challenging calling with many rewards that far outweigh the negatives for most officers.”

Dr. Artwohl can be reached viae mail.

About the author

Charles Remsberg co-founded the original Street Survival Seminar and the Street Survival Newsline, authored three of the best-selling law enforcement training textbooks, and helped produce numerous award-winning training videos. His nearly three decades of work earned him the prestigious O.W. Wilson Award for outstanding contributions to law enforcement and the American Police Hall of Fame Honor Award for distinguished achievement in public service.

The impact of danger and critical incidents

By Alexis Artwohl, Ph.D.

Have you ever heard these "factual" statements before?

- Law enforcement is America's most dangerous occupation.
- Cops are traumatized by critical incidents.
- Cops leave law enforcement within seven years after being involved in a shooting.

When I first starting working with police officers as a clinical and police psychologist years ago, I was told that police work was America's most dangerous job, that officers were subjected to so much trauma that they had a high rate of post-traumatic stress disorder and that officer-involved shootings were so traumatic that most officers were gone from law enforcement within five years of being involved in a shooting. These observations *sound* right, don't they? Sure, but bold, sweeping statements like these aren't necessarily based in fact, and may not even be close to any semblance of the truth.

How deadly is the occupation of law enforcement?

There is no question that law enforcement is dangerous. In fact, it's about three times more dangerous than the average of all occupations in the U.S. However, it is not the *most* dangerous by a long shot.

In data compiled by the U.S. Bureau of Labor Statistics, "to fairly compare occupations, the method used is to look at the death rate per 100,000 workers," even when comparing death by homicide, police officers are not at the top of the list (Figure 1). Although they are much more likely to die from homicide than the average American worker, they are four times less likely to die from homicide than a taxi driver. This is not to downplay the dangers of the job. However, police officers do a pretty good job of keeping themselves safe and alive. As Curran points out, "This is not meant to minimize the incidents of horrific, life-threatening danger that police officers face each and every day. However, the data are so clear that to perpetuate this myth is dishonest. Unfortunately, these myths undermine police recruitment efforts and strike fear into families of those already on the job."

PTSD rates in police officers

Are police officers traumatized by critical incidents? Certainly cops see and experience a lot of ugly stuff during their careers. Some of it is so horrible and distressing that it does wind up traumatizing those who are subjected to it. Horrendous events like the attack on the World Trade Center are likely to produce higher than usual rates of post-traumatic stress disorder in the first responders. However, PTSD is not an inevitable outcome of exposure to traumatic incidents, not even something as horrific as the WTC event. In fact, research indicates a PTSD rate in only 6.2 percent of police officers who were first responders at the WTC event, and a rate of only 13 percent in rescue workers, mostly firefighters, at the Oklahoma City bombing.

Who develops PTSD and why is a complex combination of the nature of the event and each individual's genetic predisposition, demographics and the sum total of his previous personal and work life experiences. For excellent research exploring these factors, visit the Police Stress and Health Program's Web site found at www.policestressandhealth.net. One of their research projects was the development of an inventory to measure the amount of traumatic incident distress experienced by police officers and a demographically matched comparison group of non-police. They looked at two variables: what percentage of each group had experienced a

Figure 1

Occupation	Death rate from all causes
All occupations	4.7
Logging	128.7
Fishing	123.4
Water transportation	94.2
Aircraft pilots	83.3
Mining	51.7
Construction	41.1
Taxi drivers	40.3
Truck drivers	27.9
Roofers	27.5
Farming	27.5
Firefighters	18.3
Non-construction laborers	15.6
Heavy equipment operators	15.0
Police and detectives	14.0
Electricians	12.1

Occupation	Death rate from homicide
All occupations	0.5
Taxi drivers and chauffeurs	17.9
Police and detectives	4.5
Private guards and police	4.1
Supervisors/proprietors, sales	2.5
Managers, food and lodging	2.5
Cashiers	1.5
Truck drivers	0.7

Death rate numbers are per 100,000 workers

traumatic incident, and how distressed the individual felt at the time of the incident. While the police officers were more likely to report having witnessed a traumatic incident, they were actually less likely than the comparison group to report having personally experienced a traumatic incident. They also found that the comparison group more frequently endorsed items indicating distress at the time of the incident than the police officers.

Audrey Honig, in a 2004 article, points out that: "Extensive research…has found a 4 percent PTSD rate among officers involved in shootings. Similar police studies report a rate of no more than 14 percent. In comparison, the rate of diagnosable PTSD among combat veterans is approximately 30 percent."

Darrell Ross (2007) followed 121 officers who were involved in 86 cases in which he served as an expert witness defending officers and agencies in litigation, mostly federal civil rights violation cases. He found that only 25 percent reported stress reactions in response to their officer-involved shooting, mostly mild and transitory. In fact, 88 percent said that they would not hesitate to pull the trigger again when faced with the same situation in spite of going through stressful litigation.

In their study of almost 1,000 officers from the Los Angeles County Sheriff's Department involving hundreds of critical incidents, almost all of which were officer-involved shootings, Honig and Sultan found that only a minority had severe stress reactions to these events. Most had mild to moderate transitory symptoms. In terms of how being involved in a shooting impacted their sense of job satisfaction, 83 percent reported no change, only 9 percent reported it made their job less enjoyable and 8 percent reported it actually made their job more enjoyable.

Do cops leave the job after shootings?

Cops will be gone from law enforcement within seven years after being involved in a shooting. I've heard this one for years but I've never been able to track down the original research that documents this supposed nationwide phenomenon among modern police officers. I've asked colleagues if they have ever seen this study, and no one seems to have ever laid eyes on it. Honig, in research that is unpublished but reported in the abovementioned Honig and Sultan study, followed 540 officers from the Los Angeles County Sheriff's Office who were involved in shootings from 1998 to 2002. She found that only two officers ever filed a stress disability claim connected to their OIS, and none left law enforcement as a result of the OIS.

Based on this sampling of research, with hopefully more to come, a picture emerges of officers as individuals who actually cope well with the traumas of their job. They don't suffer high rates of PTSD and being involved in a shooting is rarely the beginning of the end of a career.

In his research following 121 officers involved in litigation, Ross found that two years after being involved in an OIS, 90 percent were still in law enforcement and 30 percent of those had actually been promoted. I did many mandatory debriefings on many police officers involved in shootings in the 1990s. Although I did not do systematic data collection, it was clear that very few of them were leaving law enforcement and most were coping well. I asked my colleagues if the officers they were debriefing were showing high rates of trauma and leaving law enforcement, and they all said no. As Curran points out, "Officers usually do not leave the force within five years… they generally continue to exhibit healthy patterns of behaviors and emotions."

Based on this sampling of research, with hopefully more to come, a picture emerges of officers as individuals who actually cope well with the traumas of their job. They don't suffer high rates of PTSD and being involved in a shooting is rarely the beginning of the end of a career.

Public safety personnel are professionals who are trained to cope with these life-threatening events. Trauma is, to some extent, in the mind and heart of the beholder. People are more likely to feel traumatized by events that make them feel vulnerable, helpless, overwhelmed and out of control. If people feel a sense of mastery, competence and confidence when facing threatening events, then they are less likely to be traumatized.

In addition to a sense of mastery, there are factors that can make officers more resilient, or more vulnerable, and research is being done to identify these variables. As these variables are identified we can start using them to further enhance police officer resiliency. In the meantime, it turns out officers actually are coping pretty well with the trauma of their work. Those who do wind up developing PTSD or other problems deserve our compassion, high quality mental health services specifically oriented toward cops and well-trained peer support groups. ◀◀

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TYPES OF DEBRIEFINGS

By Alexis Artwohl, Ph.D.

In previous articles I have written in-depth about the rationale for conducting debriefings after a critical incident, as well as issues related to confidentiality. This article will discuss some of the key elements of four types of debriefings that can be done in the wake of an officer-involved shooting (OIS) and other critical incidents:

1. Individual debriefing with a licensed mental health professional (MHP)
2. Group psychological debriefing
3. Tactical debriefing
4. Incident clarification

The purpose of such debriefings is education and support, with an emphasis on resiliency, positive coping and potential for personal growth. It is recommended that debriefings provided to involved personnel be considered as on-duty and paid assignments, but the officer should not return to work immediately following the debriefings.

The nature of the incident, the feelings of involved personnel and their family members and the legal, investigative and political aftermath should all be taken into consideration when deciding if, when and how the various types of debriefings are to be conducted. Rigid adherence to any particular model or rules about how debriefings should be conducted is discouraged. While some issues such as confidentiality may have little leeway, there are aspects of debriefings that can, and should be, fluidly adapted to individuals, incidents, local customs and other considerations.

Some of the recommendations below are taken from the OIS Guidelines written by the Psychological Services Section of the International Association of Chiefs of Police (PSS/IACP). A copy of this and other guidelines published by the PSS/IACP can be obtained by going to the IACP Web site at www.theiacp.org.

Individual debriefing with a licensed mental health professional (MHP)

As noted in the OIS Guidelines, it is generally recommended that one confidential individual debriefing with a licensed MHP be mandatory for involved personnel. This is not because there is an expectation of widespread traumatization. Research shows that most people, including most officers, are resilient and will cope well over the long term. However, there is no way of perfectly predicting who will be in the minority that will develop PTSD, so the debriefing is an opportunity to educate everyone about the latest research on resiliency, reactions to trauma, and to provide current information on where and how to seek treatment for self and/or others if PTSD should develop.

It is recommended that this information be provided both verbally and in writing. It should be noted that while attendance can be mandated, once the officer is there, any further participation or discussion on his/her part should be voluntary. Voluntary follow-up sessions for those officers wanting further assistance should be offered.

In addition to being a licensed MHP, the provider should have experience and training in working with law enforcement and trauma, and be up-to-date on the research in the field. It is recommended that this debriefing happen within a week after the incident and take place before any group debriefings.

If the agency is going to require a fitness-for-duty evaluation, it should not be conducted by the same MHP who provided the debriefing. In regards to the fitness-for-duty exam after an OIS, the OIS Guidelines state that:

It should be made clear to all involved personnel, supervisors, and the community at large that an officer's fitness-for-duty should not be brought into question by virtue of their involvement in a shooting incident. Post-shooting psychological interventions are separate and distinct from any fitness-for-duty assessments or administrative or investigative procedures that may follow. This does not preclude a supervisor from requesting a formal fitness-for-duty evaluation based upon objective concerns about an officer's ability to perform his or her duties. However, the mere fact of being involved in a shooting does not necessitate such an evaluation prior to return to duty.

It is recommended that significant others be invited to participate in individual debriefings. The officer and his/her significant other may have preferences about whether the significant other will accompany the officer into his/her debriefing, or whether each one will have separate and confidential sessions. Separate individual sessions plus a joint session are not mutually exclusive.

Group psychological debriefings

Group debriefings bring together the involved personnel to share their perceptions, memories and feelings about the incident. This may include dispatchers and other involved personnel the officers may want to invite. Tactical analysis of the event is typically discouraged in this type of debriefing to keep it focused on personal feelings and reactions.

Attendance in group debriefings should be voluntary. The officers are typically receiving education and support from multiple sources: The mandated individual sessions with an MHP provide an opportunity for the involved personnel to receive education and support in a private setting with privileged confidentiality; peer support teams also can provide individualized support; and officers often receive additional support from attorneys, union reps, police clergy, etc. Group sessions are not for everyone, although most personnel like them and will choose to attend if they are well conducted. If attendance is mandated, participation should still be voluntary.

Group debriefings should be led by a team of at least one licensed MHP plus members of a trained peer support team. Confidentiality may not be privileged depending on local laws, and local laws may or may not apply in federal court cases. (The PSS/IACP has also published guidelines for peer support teams.)

The advantage of group debriefings is that they are an opportunity for the officers to find out what happened from the perspective of the other participants. Since it is highly likely that everyone will have different memories about exactly what occurred, this will help the officers get the big picture and clear up second-guessing of self and others.

Second-guessing of self and others is a common reaction of individuals in critical incidents. In research done by the L.A. County Sheriff's Department, it was a common emotional effect reported by 982 officers involved in critical incidents, 90 percent of which were OIS. It should be noted that this second-guessing is in fact an emotional reaction in which individuals obsess over things that typically no one could have had any control over under the same circumstances. It should not be taken as evidence that anyone has done anything wrong. Clearing up second-guessing, no matter how it's done, can be helpful to both individual recovery and repairing relationships among involved personnel that might have been strained by the incident.

> **"Research shows that most people, including most officers, are resilient and will cope well over the long term. However, there is no way of perfectly predicting who will be in the minority that will develop PTSD...**

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Getting the big picture is also helpful since it is common for people involved in critical incidents to have memory gaps or false memories. Most people are not comfortable with memory gaps and feel the need to find out what really happened.

Another advantage of group debriefings is that it helps mobilize peer social support, which is important when individuals are struggling with a difficult circumstance.

Hopefully agencies also have family peer support teams who offer voluntary group sessions for the involved officers' significant others. As in the individual sessions, the officers can be asked if they would like to combine the officer and family group debriefings into one group, or if they prefer to keep them separate. Combining these debriefings may seem like a radical idea to some, but one agency I worked with did this routinely and it worked very well. The agency started out with an officer peer support team for OIS. Later, a family OIS peer support team was developed. Each team decided to integrate into one team so both could receive the same peer support training opportunities.

After an OIS, the officer members of the team offered individual peer support to the officers, and the family members of the team offered individual peer support to the officers' family members. When the group debriefing was offered, the involved officers and their significant others attended one group together. This proved to be popular and voluntary attendance was virtually 100 percent.

Group tactical analysis

At some point after the individual and group psychological debriefings, involved personnel (which might include dispatchers) may want to participate in a voluntary group tactical analysis in which they come together to discuss the event from a tactical perspective. This can often be a valuable "lessons learned" training opportunity for the officers. It can also further dispel second-guessing, as well as help instill a sense of mastery over the event.

This voluntary debriefing should be led by tactical experts, preferably of the officers' choosing, who are trained to conduct tactical discussions in a positive and constructive manner. This is not to be confused with any administrative shooting review process done by the agency.

Depending on the nature of the incident, the officers may feel more comfortable having a familiar and trusted MHP in attendance and this can be offered as an option for them to choose. These debriefings are unlikely to have any confidentiality.

One thing to consider for this type of debriefing is that it may be best done only after the investigations are over and it has been determined that officers will not be facing any criminal or disciplinary charges.

Incident clarification debriefings

Critical incidents, especially OIS, are high-profile events that typically engender large amounts of curiosity, second-guessing, rumors and a range of emotional reactions on the part of many people who were not involved in the event, including community members, the media and everyone else in the agency.

Incident clarification debriefings are multiple debriefings provided to all these interested individuals and groups in which knowledgeable representatives of the investigative process provide appropriate facts of the event as they become available. Agencies have learned, sometimes the hard way, that withholding information is rarely a constructive strategy, so most seek to proactively provide swift and accurate incident clarification to the media and the community.

What is sometimes overlooked is incident clarification within the agency itself. Critical incidents have the potential to cause emotional reactions for uninvolved personnel because many officers may realize "that could have been me," or they may be close and personal friends of the involved officers.

Since involved officers are generally ordered or at least recommended to not discuss the details of the event (outside of with those officially involved in the aftermath, such as attorneys, MHPs, investigators and such), this dearth of information can help feed the internal rumor mill. Unfortunately, sometimes these rumors are not complimentary to the involved personnel, and as the rumors spread they have the potential to cause harm.

Telling people not to gossip is rarely effective. People are naturally curious, especially about dramatic and anxiety-producing situations. Discussing them (or "gossiping") is a perfectly normal way for people to try and find out what happened and cope with their own feelings about an event. A more effective strategy is to provide accurate information on a regular basis as it becomes available so they can talk about what really happened instead of passing along false rumors. This can be done in a variety of ways, such as updates at roll calls and emails.

The involved officers themselves may also want to consider doing their own incident clarification upon returning to work, assuming the circumstances make it feasible. Sometimes the officers wonder what their peers are thinking and want to get their side of the story out, yet are sick of talking about it and just want to get back to normal without answering anymore questions.

One strategy for returning officers would be to proactively take charge of this return to work process by arranging ahead of time with their supervisor to schedule a briefing with their immediate coworkers during which the officers will explain the incident from their perspective, offer any information they want on how they are doing and offer to answer questions. Once this peer incident clarification is done, then the returning officers have the option of requesting that their coworkers not focus on the incident unless the officers themselves bring it up. This peer incident clarification could be done as group and/or individually.

Summary

Critical incidents have the potential to be disruptive and even destructive for the involved officers and their families, the agency and the community. Getting the facts of the incident clarified, educating the involved personnel about reactions and how to seek further assistance if needed, mobilizing social support and giving everyone an opportunity to process their own feelings and reactions can help mitigate the destructive potential of these events. ■

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Stressed out cops?

By Alexis Artwohl, Ph.D.

Editor's note: *In the Spring 2009 issue of* The Tactical Edge*, Dr. Artwohl discussed the perceived effects of career stress on cops and the case studies and statistics that refuted many well-known myths. This installment of her series of articles addresses the belief that police officers suffer from more personal problems than other citizens in less stressful jobs.*

It is a widely accepted belief that law enforcement personnel suffer from divorce, alcoholism and other problems more than the average person because of all the stress they are exposed to on the job. The alcoholic cop? Most people would agree that there must be many. Divorced cops? Sure, aren't they all? And perhaps the best-known sentiments: most cops are burned out from job stress, and worse, are dead within five years of retirement. However, based on my experiences as a clinical and police psychologist, it is my belief that all of the above "facts" are actually far from the truth. Most police psychologists whom I have asked over the years also find the popular notions to be false. However, regardless of beliefs on either side, the answers to these questions should be researched-based. The following are samplings of research that refute the myth of the stressed-out, dysfunctional cop.

Divorce

Divorce is common in our society, so we would expect divorce to be common in law enforcement. But is it more common among police than their non-police counterparts? McCoy and Aamodt did an analysis of U.S. census data to look at the divorce rate in law enforcement. They chose census data because it compares divorce rates among different occupations, thus giving a more accurate picture of which occupations are more or less likely to get divorced. Their analysis of the 2000 U.S. census data revealed that police officers, detectives and supervisors actually have a lower divorce rate, not only than the national average for other occupations, but than would be predicted by their demographic profile. Transit and railroad police, in particular, had a very low divorce rate: they were in the five occupations with the lowest, just below clergy. The divorce rate for correctional officers was in the average range. The four occupations with the highest divorce rates were dancers and choreographers, bartenders, massage therapists and gaming cage workers.

All occupations suffer from job-related stress, but the image of cynical, burned-out cops who invariably hate their job and the public they serve is one that many believe in. Again, research shows that this is not actually true.

McCoy and Aamodt also looked at census data from the 1900 census, as analyzed by Lichtenberger, who rank-ordered 39 occupations based on divorce rate. His category of "watchmen, policemen, firemen, etc." came up 30th out of 39, well below most other occupations, thus showing a lower divorce rate going back a century.

McCoy and Aamodt concluded: "This study demonstrates that the idea that divorce rates are extremely high for law enforcement is a myth…When compared to the national average, police officers are actually less likely to get divorced than the average American."

Curran also reviewed some of the literature on police divorce rates. Like McCoy and Aamodt, he found that although it is a common perception that police have a high divorce rate, in reality they do not. His conclusion was, "There are no data to demonstrate that law enforcement, per se, has a statistically significant negative impact upon marriages."

Alcoholism

Honig examined 2002 – 2004 data from the Department of Health and Human Services which compared alcoholism rates by occupation. She did not find a pattern of unusually high rates of alcoholism among police officers; in fact, eight other occupations had a significantly higher rate. In spite of the widespread belief in massive amounts of "choir practice" allegedly taking place in law enforcement, there is very little rigorous research on this topic. More data is needed, but there is no valid basis at this time for claiming that scientific research has proven that police have an unusually high rate of alcoholism or drug abuse.

Burned out from job stress

All occupations suffer from job-related stress, but the image of cynical, burned-out cops who invariably hate their job and the public they serve is one that many believe in. Again, research shows that this is not actually true. Smith analyzed job satisfaction in the U.S. using two variables: "job satisfaction," defined as "on the whole, how satisfied are you with the work you do?" and "general happiness," defined as "taken altogether, how would you say things are these days – would you say you are very happy, pretty happy, or not too happy?" He found that when asked about "job satisfaction," police officers were in the middle compared to other occupations and similar

to registered nurses and accountants. Approximately 59 percent of police officers said they were "very satisfied" with their work. Regarding "general happiness," the average for police officers was also in the middle and 44 percent reported being "very happy."

Burgo et al. surveyed 142 officers from three suburban Chicago police departments to measure their levels of burnout. They used three different measures. On the measure of "emotional exhaustion," defined as "feeling overextended or emotionally exhausted by the workload," officers reported low levels of emotional exhaustion. On the measure of "personal accomplishment," defined as "feelings of success or accomplishment in working with people," the officers report moderate to high levels of personal accomplishment. On the measure of "depersonalization," defined as "feelings of detachment from themselves and the citizens to whom they provide services," they reported moderate to high levels of depersonalization. Depersonalization can potentially be negative, but it can also be a healthy defense mechanism for people whose jobs require intense and stressful interaction with others. Although the officers reported relatively high levels of depersonalization, it is clear this was not automatically translated into cynical dislike of their job or the public. Their feelings of personal accomplishment remained moderately high and they reported low levels of emotional exhaustion.

Dead within five years of retirement

Relax! There are plenty of old cops cruising around enjoying their retirement. Honig reports that "according to both the Arizona Public Safety Personnel Retirement System and the Los Angeles County Employees Retirement Association, male law enforcement officers who retire at age 55, the typical age of retirement, live an average of 24 years while females live an average of 29 years after retirement." This means that retired male cops live to age 79 and female cops to age 84. It's possible that other jurisdictions might have earlier death rates, but there is no research out there that proves a cop on the force today is doomed to an early death.

It's still a stressful job so take care of yourself

Life is tough, and being a cop is a demanding job. However, police officers, as a group, do not feel unusually stressed out or demoralized by their job compared to other occupations, and they do a pretty good job of coping with that stress. It is a disservice to law enforcement to present a falsely negative picture of the occupation and those who serve and protect. Officers and their family members can feel proud of the fact that they are resilient group who can enjoy their law enforcement career instead of fearing they will suffer unusually high rates of dysfunction because of it. I agree with Curran's conclusion that "when we remove the unwarranted fear of negative consequences from police work, we enable police officers to develop a healthy expectancy of success, both personally and for their families — an especially important attitude to encourage post-9/11."

This is not an excuse to not take care of yourself and your family members. Most of you know what to do: eat right, exercise regularly, get adequate sleep and rest, etc. We also need ongoing research on what promotes resilience, and the training to provide that information to officers and their families so they can each develop their own individualized stress management strategies. And, like any group, some will develop serious problems that will need compassion and intervention, and we need to be there for them in their time of need. ◂◂

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Why do debriefings?

By Alexis Artwohl, Ph.D.

True or false quiz

1. Critical incidents are psychologically devastating and likely to cause post-traumatic stress disorder.
2. In order to prevent post-traumatic stress disorder (PTSD), everyone involved should be debriefed.

Resiliency

The answer to the first question is *false*. Yes, critical incidents can be upsetting. However, current research is increasingly showing that people in general are quite resilient, meaning that they quickly and naturally bounce back from the slings and arrows of life. This only makes sense, really. For many thousands of years humans have been subjected to frequent traumatic stressors, many far worse than those that exist in modern life. If we weren't naturally resilient we would have perished as a species long ago. Yet here we are, still muddling through and taking our place in the sun in the history of the planet.

Lating and Bono point out, "Current estimates are that most people living in the United States will experience at least one violent or life-threatening event during their lives... Recent data suggest, however, that most people exposed to traumatic events do not experience serious disruptions in normal life functioning, and are in fact resilient." Creamer states, "A fundamental starting point in the immediate aftermath of trauma is to expect normal recovery. The presumption of clinically significant mental health problems in the early post-incident phase is inappropriate."

In his review article on the neuroscience of resiliency, Stix came to the following conclusions:

1. People are naturally resilient and this is the norm rather than the exception.
2. Although temporarily upsetting, trauma and loss do *not* cause permanent damage in 90 percent of individuals.
3. Most will recover quickly with no professional help.
4. About 10 percent are less resilient and will not quickly bounce back. These individuals can benefit from professional help.
5. People's natural resiliency is a complex and still poorly understood combination of genetic predisposition and life experiences.
6. The jury is still out on whether you can train people to be more generally resilient.

> "For many thousands of years humans have been subjected to frequent traumatic stressors, many far worse than those that exist in modern life. If we weren't naturally resilient we would have perished as a species long ago."

7. Coping styles are highly personal and incorporate a wide range of effective strategies that therapists have sometimes deemed not healthy, such as denial, egocentric bias that bordered on narcissism, repression of negative thoughts and emotions, blind

faith in their own resilience and smiling and laughing their way through it. George Bonanno, a leading researcher in the area of resilience, termed this "coping ugly." People may not do what others, including some therapists, think they should do to process the trauma, but it works for them. Interfering with these natural coping abilities and telling people how they should be reacting and coping may in fact do more harm than good.

8. As Stix sums up, "Sometimes the worst does happen, but our innate capacity to bounce back means that most of the time things will turn out all right."

Research done by Honig and Sultan at the Los Angeles County Sheriff's Department showed that resiliency was also the norm among almost 1,000 police officers who had been involved in on-duty critical incidents. Consistent with the research on resiliency, only about 10 percent experienced severe symptoms; the rest reported mild to moderate transitory symptoms.

It's unlikely that debriefings prevent PTSD

The answer to the second question is also *false*. Debriefings, especially group CISD debriefings, are controversial in the field of psychology. Multiple researchers have pointed out that debriefings do *not* lower the incidence rate of PTSD. Some are even concerned that debriefings may cause more harm than good by interfering with people's individualistic natural coping mechanisms and fostering the idea that trauma is supposed to cause serious psychological damage.

Creamer points out, "Despite its widespread use, the effectiveness of debriefing is far from clear… The research evidence is inconclusive… Research in this area is notoriously difficult to conduct and severe methodological problems limit the interpretability of most published studies… The field is polarized, with strongly held views both for and against the process."

…Honig and Sultan found that of almost 1,000 officers who were ordered to attend a mandatory individual debriefing with a police psychologist, 60 percent stated that they would not have attended voluntarily, yet 100 percent found it helpful.

In her review article Dunning states, "One result has been the widely popular development of CISD teams positioned to respond within hours of the occurrence of a traumatic situation, yet what is troubling is that anecdotal and more methodologically rigorous research has seriously questioned the efficacy of debriefing police officers… In fact, many have concluded that CISD caused the very disorder it was said to prevent — PTSD… It is now accepted by clinicians that debriefing accentuated the stress response and exacerbated traumatic stress in participants who were traumatized or if not already, caused an iatrogenic effect… Following the 9/11 World Trade Center event, warnings were posted on the Web site of the American Psychological Association cautioning psychologists against the utilization of CISD protocols given the controversy that was occurring in the clinical and research fields."

Stix wrote, "Several studies over more than 15 years have shown the technique is not effective and might cause harm… After the 2004 Indian Ocean tsunami, the World Health Organization warned against debriefings because they might prompt some victims to feel more unsettled."

It seems unlikely that debriefings would be adequate to prevent PTSD and other long-term psychological consequences in the 10 percent of the population who are less resilient and therefore more vulnerable to any particular traumatic incident. Those individuals are more likely to benefit from professional treatments tailored to their individual needs. Fortunately, there are now effective treatments for PTSD and other problems. As for debriefings causing harm, like any intervention it's likely to depend on the quality and sophistication of the services that are being provided.

So why do debriefings?

In spite of the fact that debriefings may well not prevent PTSD, various authors have pointed out they still have value when skillfully done. Clark and Haley state "CISM is an effective and valuable crisis intervention system that can mitigate the impact of traumatic incidents on police officers and other emergency responders." Bohl discusses the benefits of debriefings tailored specifically for law enforcement. Creamer points out that although debriefings have not been proven to be effective in preventing PTSD, "A final point worthy of note is the consistent finding that participants in debriefings usually report high satisfaction ratings with the experience, even when it does not reduce long-term symptoms." Consistent with this finding, Honig and Sultan found that of almost 1,000 officers who were ordered to attend a mandatory individual debriefing with a police psychologist, 60 percent stated that they would not have attended voluntarily, yet 100 percent found it helpful.

So there are valid reasons other than prevention of PTSD to provide high quality debriefings to police officers. Best, Artwohl and Kirschman provided the following reasons why they can be valuable:

- Debriefings provide an opportunity to be educated about attention, perception, memory and decision-making under stress.
- Group debriefings can provide a more complete and accurate picture of the event which trauma survivors often find helpful.
- Group debriefings mobilize peer support and provide a supportive social milieu for recovery.
- The availability of individual and group debriefings is a demonstration by the agency and peers that they have concern for the officers and want to help.
- For those who may develop PTSD or other mental health issues, debriefings provide education about these potential reactions and where and how to seek help.
- Debriefings educate officers about the impact of critical incidents on family members.
- Debriefings educate and support officers through the investigative process and potentially negative reactions from the media and the community.

The educational component of debriefings is important because regardless of the task or challenge an individual is facing, anything that increases skill, mastery and confidence will help the individual perform better. In this case the performance demand will be negotiating the challenges of a critical incident aftermath. This is especially important in officer-involved shootings whose aftermath will entail

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skillfully confronting a variety of legal and administrative risks, intense media and community scrutiny and the impact on family members. These challenges in and of themselves can drag on for weeks, months or even years, so it is important that officers have as much knowledge as possible so they know what to expect and can garner additional ideas on how to cope.

The social support component is also important since that has been shown to be one of keys for a healthy life in general. Officers will often be sensitive to support (or lack thereof) from peers and their agency. Debriefings are a way to emphasize and formalize that support and thereby lessen the risk that officers will feel abandoned by their employers and co-workers.

Although most individuals are resilient and will bounce back naturally without any formal intervention, one problem is that there is no way to predict with certainty which 10 percent of individuals in any particular event will go on to develop long-term problems that will need treatment. Therefore, it is helpful to educate everyone about possible problems that might arise so those few who are vulnerable can recognize the issues in themselves or others and know where and how to seek treatment.

Resources that assist agencies and officers in the aftermath of a critical incident include guidelines on officer-involved shootings and peer support written by the Police Psychological Services Section of the International Association of Chiefs of Police. See references below for information on how to obtain the guidelines.

Summary

Most people are naturally resilient and will quickly bounce back from life's traumas with no formal interventions. Only about 10 percent will go on to develop PTSD or other problems that will need treatment. Although research shows debriefings are unlikely to prevent PTSD in vulnerable individuals, they can still provide education that may enhance the natural coping skills of the majority who do not develop the disorder.

For those who are not as resilient, the education can help them realize when recovery is lagging and where and how to seek help. The social support component can be helpful for all. Debriefings can formalize the social support of employers and peers and thus enhance the relationship between officers and their employers. ◂◂

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Police suicide

By Alexis Artwohl, Ph.D.

Suicide is serious public health problem.
Here are some facts confirmed by research:

- Approximately 33,000 people in the U.S. commit suicide each year.
- Americans (including police officers) are significantly more likely to commit suicide than be killed in a homicide.
- Suicide is a devastating consequence of untreated mental health problems and/or feeling overwhelmed by life stressors.
- Suicide is traumatic for friends, families and co-workers of the deceased. They will need help and support to cope with the confusing and tragic aftermath.
- Many suicides can be prevented.
- Suicide prevention and education programs should be widely offered to everyone, including police officers.

Rate of suicide in law enforcement

In his 1996 book "Police Suicide: Epidemic in Blue," John Violanti reported that law enforcement personnel are more likely to commit suicide than the average person. His findings supported the popular notion that the stressors of police work lead to increased suicide.

While Violanti is to be commended for drawing attention to the problem of police suicide, subsequent research studies have shed doubt on the finding that law enforcement has a higher-than-average suicide rate.

In 2001, Hem and Ekeberg did a systematic worldwide literature review to examine the hypothesis that police are a high-risk group for suicide. The results of their review revealed that "none of the recent nationwide studies show elevated suicide rates among police. Other studies show inconsistent results. Conclusively, it is not documented that there is an elevated suicide rate in police."

In 2001, Aamodt and Stalnaker published the results of their detailed statistical analysis of the suicide rate among American police officers across the nation. They found that the police suicide rate was *not* higher than that of the average person, and it was in fact 26 percent *lower* than expected, based on the demographic profile of the average cop.

In 2002, Marzuk et.al. examined the suicide rate at the NYPD by reviewing the death certificates of active NYPD officers who died from 1977 through 1996. As in Aamodt's national survey, they found that the suicide rate for NYPD officers was actually somewhat lower than the rate for their non-police demographic peers in New York City, concluding that "the rate of suicide among New York City police officers is equal to, or even lower than, the suicide rate of the city's resident population."

In 2003, Loo did a meta-analysis of 101 studies of police suicide from around the world and found that "the mean of America's police to comparison population ratio in the present study was .86, indicating that police suicide rates are lower than in the comparison population. Therefore, the overall picture from the present meta-analysis is that suicide rates for police in the Americas are not significantly different from the comparison male population." He also found that there was no difference in mean suicide rates between the Americas and Europe.

Research errors

Research conducted during the last decade has revealed that it is unlikely that police officers in America have a higher suicide rate, so why does the myth of the high police suicide rate still persist? Perhaps this is so because it *is* true that police officers have a higher suicide rate when compared to the overall rate for the general population.

However, comparing police officers to the general population is a mistake. As Aamodt (2008) and many of the above researchers point out, errors in scientific methods can lead to false conclusions. One major error is comparing apples to oranges, as with comparing a select portion of the population to the population at large. Instead, it is essential to compare any group of people to another group that is similar to them in their demographic profile, which includes criteria like age, race and gender. In the case of police officers, most of them are male. Analysis of national death rates from the Centers for Disease Control reveals that males consistently have a much higher suicide rate than females.

Suicide rates also vary by age and gender. Demographically, police officers across the United States are mostly white males between the ages of 21 and 55. Aamodt and Stalnaker carefully analyzed the demographic profile (gender, age and race) of American police officers and predicted their suicide rate based on the suicide rate for their demographically matched non-police peers. When this proper comparison was done, it turned out that the police suicide rate was lower than would be expected, leading them to the conclusion that police

actually have a lower suicide rate than their non-police peers. Other researchers also did demographic matching and came to the same conclusion. As the demographic profile of America and those employed in law enforcement changes over time, researchers must be careful to always do demographic matching before reaching any conclusions.

The above researchers also point out other research errors that can lead to false conclusions. One is sample size. Accurate statistical analysis cannot be done with a very small group of people. For instance, one researcher found that the suicide rate for female officers appeared to be higher, but pointed out that no conclusion could be made due to the small sample size.

Another error is looking at too short a time frame. Events are not perfectly evenly distributed in time, so looking at the number of events for just a year or two can lead to false conclusions as well. A single unusual occurrence can skew the results for any given short time period. A more accurate picture can be obtained by looking at trends over a longer time period. How much time will be needed to yield accurate results depends on what is being studied. So while it is true that some departments may suffer from a high suicide rate over a relatively short period of time, this does not mean that being employed as a police officer in general represents an unusual suicide risk. There are other factors that can also be considered, such as shift work and intense public contact, which can make a job stressful but are hardly unique to law enforcement.

It is also true that more officers die from suicide than are killed by perpetrators. However, this is meaningless as far as it concerns the suicide rate for cops, because the same thing is true for the general population, meaning that the average person is far more likely to commit suicide than be killed in a homicide. However, this is still an alarming statistic that should spur us to put continued effort into the prevention of suicide.

More research needs to be done to find out if there are subgroups within law enforcement that may be more at risk for suicide. This is a question that is still unanswered.

Some people may believe the actual police suicide rate is much higher than the reported rate because the suicides are covered up and reported as deaths from accidents or other causes. There are obviously reasons why people would want to cover up suicide as the cause of death. These would include the stigma of suicide and the financial losses from disqualifying the survivors from insurance and other death benefits. However, these motivations apply to the general population as well as police officers. While this may happen in some cases, there is no scientific evidence to support the idea that it happens with any greater frequency in the police population than in the general population, or even how frequently it actually does happen.

Suicide prevention resources

Although police do not appear to have a higher than average suicide rate, it is still a critical problem that needs addressing. The causes of suicide are complex and Aamodt and Stalnaker found that the reasons officers commit suicide are similar to those of the general population (with the possible exception of legal problems).

Although suicide prevention strategies are beyond the scope of this article, there are resources available. The IACP Police Psychological Services Section, the Bureau of Justice Administration and EEI Communications donated their services to produce an interactive CD-ROM titled "Preventing Law Enforcement Officer Suicide: A Compilation of Resources and Best Practices." This publication can be ordered on the IACP Web site (www.theiacp.org). This is an excellent publication summarizing the latest up-to-date information on suicide prevention.

Other resources (listed in our references section) that review suicide prevention strategies include the book "Police Suicide: Tactics for Prevention" by Hackett and Violanti and the article *By Their Own Hand: Suicide Among Law Enforcement Personnel* by Honig and White.

Summary

In this and my two previous articles *(The Tactical Edge* Spring 2009 and Summer 2009), I examined what research literature tells us about the psychological adjustment of police officers. It turns out that the widely accepted ideas that police officers have unusually high rates of suicide, divorce, alcoholism, PTSD, early death and job burnout are not supported by current data. In fact, these are myths and police officers are as well adjusted as any other group. However, police officers do have problems like anyone else in the general population, and these problems should not be ignored.

Why some individuals have more mental health or life problems than others is a complex combination of genetic predisposition and the sum total of their life experiences. This does not make them weak or deficient, and they all deserve help and compassion. ◂◂

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Mitigation of Stress Associated With Critical Incidents

By John Nicoletti, Ph.D., and Sara Garrido, Psy.D.

Introduction

Research is clear that because of an increased exposure to life threatening situations, law enforcement officers are also at an increased risk of experiencing trauma-related symptoms [1]. Shell shock, war neurosis, battle fatigue, combat stress, and posttraumatic stress disorder are just some of the monikers that psychological trauma has garnered over the years. The impact of trauma on individuals, particularly those charged with protecting the public, continued to be observed historically through the experience of soldiers during the First and Second World Wars. Exposure to traumatic events and stimuli caused some soldiers to develop intense feelings of fear, anger, grief, horror, emotional numbness, and disbelief. Today, police officers and other public safety personnel are at risk for similar reactions[2].

Exposure to trauma can be either direct, when the officer is the target (e.g. officer-involved shooting) or vicarious, when they are the responder (e.g. exposure to dead bodies). It is important to note that even traditionally strong, stress tolerant and resilient officers are susceptible to experiencing the occasional negative effects of critical incident stress. Additionally, stress encountered by law enforcement personnel is not restricted to sworn agency members. Civilian employees in police agencies are often impacted by vicarious stress as they are tasked with often distressing duties including answering and dispatching emergency calls for service; photographing and collecting evidence from crime scenes; transcribing suspect and victim interviews; and the reading, the classifying, and the redacting of police case report information.

Categories of Critical Incident Stress

There are several different categories of critical incident stress. However, there is often overlap between these categories, meaning an individual can experience the effects of multiple types of trauma during a single incident.

1. Too much, too ugly, too soon: The defining aspect of this type of trauma is its rapid onset with little preparatory time for psychological inoculation. For example, the Century 16 movie theater shooting in Aurora, Colorado required an immediate response and there was no opportunity to advise responders on what they would see, hear, and experience upon entry to the theater.
2. Too much, too ugly, too long: Prolonged exposure to trauma (i.e. child sexual abuse investigations, crime scenes investigations, homicide investigations) depletes the mind and body's energy reserves, making it increasingly difficult to cope with and process events. This leads to dissociation (emotional numbing) and denial ("I'm fine, it used to bother me but it doesn't anymore.") as the primary coping strategies.
3. Too much, too ugly, too similar: When a victim or a responder is exposed to a trauma that is similar to other life events, it can lead to a cumulative exposure response by triggering both a response to the current trauma, as well as a re-experiencing of prior events [2]. Officers involved in a single critical incident may handle the event with limited distress. However, if a similar critical incident occurs, even several years later, they may find that thoughts of the prior incident come to mind, and their response may disturb them. Officers often become frustrated with themselves when they experience the cumulative impact of

multiple critical incidents ("it didn't bother me last time so I don't understand why it's getting to me now.").

4. Too much, too ugly, too different: This occurs when a victim or responder is exposed to an event that is unpredictable. For example, the assassination of two officers in New York City was devastating in part due to the rare nature of such a violent attack on police officers.

Typical Response Pattern Following a Critical Incident

After potentially traumatic events, it is expected that many people will experience at least some level of distress. The typical response pattern following a critical incident includes several stages:

1. Shock: Psychological shock is considered a common response to a traumatic incident and is comprised of a host of discernable reactions, including denial, disbelief, numbness, giddiness, bravado, anger, depression, and/or isolation. Psychological shock reactions can occur in response to any significant event and aren't limited to trauma. For example, football players who have just won the Super Bowl frequently respond to questions during post-game interviews by saying, "I can't believe it" (disbelief) or "It hasn't sunk in yet" (no impact). These same statements of disbelief and shock are common following a traumatic event as well. Following an officer-involved shooting for example, officers often admit to experiencing emotional detachment, giddiness, or shakiness immediately afterwards.
2. Impact: After the passage of some time (anywhere from several minutes to several days or even weeks) an individual enters the impact stage. Impact normally

involves the realization that, “I could have been killed” or “This was a horrible tragedy.” These thoughts and the feelings that accompany them can be overwhelming and difficult to cope with.

3. Recovery: With proper support and time to process, impact slowly makes way for recovery. Individuals can experience varying degrees of recovery. While some individuals experience no or little recovery after experiencing a traumatic event, others experience full recovery. Full recovery involves disconnecting the memory of the incident from any disabling emotional responses, and placing the incident into psychological history. Part of the recovery process includes accepting the “emotional roller-coaster,” where some days will feel like forward progress is being made while on other days a feeling of irritability and distress may prevail.

Symptoms of Stress Response

For some, the process towards recovery is difficult. This can occur for a number of reasons. For example, an individual that has a higher level of stress in their life prior to the critical incident may have limited energy reserves available to process the new stress; those that have experienced multiple critical incidents may begin to feel the cumulative effects of the job; etc. There following are symptoms often associated with a more significant stress response:

1. Thought or sensory modality intrusions (i.e. thoughts about the incident become disruptive; certain smells, sounds, sights, etc. keep replaying in the mind). Intrusions are often described as “racing thoughts” or “looping” in the brain, which references a repeating cycle of memories that can’t be turned off. This occurs as the brain attempts to organize and process the experience and move the

memory from short-term memory into long- term memory.

2. Flashbacks (i.e. perception of physically re-experiencing the incident). This can be triggered by almost anything (sights, sounds, etc. associated with the event) and lead to a feeling of panic, being trapped, or an intense feeling of powerlessness.
3. Shattered comfort zones and assumptions about the world (i.e. terrorists aren't suppose to be able to crash planes into buildings; mass shootings aren't supposed to occur in schools or movie theatres)
4. Deteriorated physical well-being (difficulty sleeping, lack of energy, increased irritability, etc.)

Mitigation of Critical Incident Stress

1. Realistic scenario-based training aimed at preparing officers for the incidents they are likely to encounter, educating them on the range of "normal" trauma responses, and providing healthy coping strategies for processing through a traumatic event. Include in the training a seminar for family members of law enforcement personnel. Attending to the psychological health of an employee's home and family life has progressively been recognized as beneficial to the agency as well as to the employee.
2. View psychological trauma symptoms the same as physical symptoms. If an accident with a chainsaw leads to significant bleeding, it wouldn't make sense to respond by saying, "This shouldn't be bothering me." Therefore, if one experiences a trauma reaction, it is equally pointless to say, "This shouldn't be bothering me." If the physical chainsaw injury were not treated, the sufferer

would eventually bleed out. It is important to recognize that a psychological trauma, if left untreated, can also lead to a mental bleed out.

3. Develop and maintain an active and adequately trained Peer Support program. Ensure that the team is activated immediately following critical incidents that are determined by members to be most distressing (officer-involved shootings, child deaths, etc.).
4. Based on IACP guidelines, provide a debriefing to those impacted by the critical incident within the first week of a precipitating event.[4] This intervention technique is typically semi-structured, often involving only a single initial session lasting from one to several hours and is designed to provide psychological education to personnel about normal, usually temporary or short-term reactions to critical incident stress. Debriefing should be led by a mental health professional with a proven level of knowledge and expertise as it pertains to the unique experiences of law enforcement personnel.

Summary

Psychological mitigation strategies, including programs to manage critical incident stress should be recognized and relied upon regularly by agencies interested in best serving their personnel. The goal being to better prepare police employees to deal with the stressors of their jobs and to recognize that maintaining psychological healthy is just as important as maintaining physical health.

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IACP SYMPOSIUM
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IACP National Symposium on Law Enforcement Officer Suicide and Mental Health:

BREAKING THE SILENCE
on Law Enforcement Suicides

IACP National Symposium on Law Enforcement Officer Suicide and Mental Health:

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IACP PRESIDENT'S LETTER

IACP: Breaking the Silence on Law Enforcement Suicides

Law enforcement agencies are like families. A special camaraderie forms in a department where men and women work side-by-side in service to their communities. Not unlike more traditional family units, police departments are shaken to the core with the death of one of their own, whether it is an officer or a professional employee. The response, organizationally and individually, is even more complex when that death comes at the employee's own hand. In a profession where strength, bravery, and resilience are revered, mental health issues and the threats of officer suicide are often "dirty little secrets"—topics very few want to address or acknowledge.

But our collective silence only compounds the problem. By ignoring the issue, we implicitly promote the unqualified expectation that police must, without question, be brave, steadfast, and resilient. Our refusal to speak openly about the issue perpetuates the stigma many officers hold about mental health issues—the stigma that depression, anxiety, and thoughts of suicide are signs of weakness and failure, not cries for help.

The truth is our police officers, and professional employees, are not immune to the stresses of the job. Arguably, they are more susceptible given the nature of police work. But continuing to ignore police suicide—to act like it does not happen or that it will not happen in our department—is doing our officers, and professional employees, a grave disservice.

In reality, officer mental health is an issue of officer safety, and we should treat it as such. From body armor and seatbelt use policies, to self-defense and verbal judo training, we can all list a variety of measures available to ensure our officers' physical safety. But what are we doing to actively protect and promote their mental and emotional health? Sadly, in many cases, it is not enough. If one of your officers is in crisis, would he or she know where to turn? Are the needed resources in place to help that officer? Would he or she feel comfortable seeking help, or fear career ramifications? Are you, as chief, or your officers, as peers, prepared to intervene? What if one of your officers took his or her own life? How would you react and respond? How would the department react and respond? These are all hard questions.

The International Association of Chiefs of Police has long recognized that there is an urgent need in the field for leadership on the issues of law enforcement officer, and professional employee, suicide and mental health. In 2008, the IACP's Police Psychological Services Section, the Bureau of Justice Assistance, and EEI Communications, partnered to produce *Preventing Law Enforcement Officer Suicide*, a CD compilation of resources and best practices. Copies of this CD are available today.

Former IACP President Michael Carroll declared 2010 the Year of Officer Safety. Immediate Past President Walter McNeil renewed that pledge in 2011, further stating that suicide prevention would be a major initiative of his presidency.

Officer suicide was covered extensively at the 119th Annual IACP Conference in San Diego in 2012, with several related workshops and a plenary session. Attendance at all these events exceeded expectations, offering a clear indication of the level of interest and need. The IACP's Center for Officer Safety and Wellness (www.theiacp.org/CenterforOfficerSafetyandWellness) highlights existing suicide prevention resources and future resources in development.

Our next steps are to provide the field with meaningful leadership and guidance. With assistance from the U.S. Department of Justice's Office of Community Oriented Policing Services, on July 11, 2013, the IACP hosted Breaking the Silence: A National Symposium on Law Enforcement Officer Suicide and Mental Health. Our objectives for this symposium were to do the following:

- **Raise awareness** regarding suicide and mental health issues in law enforcement and move toward a culture of support and understanding.
- **Identify and evaluate** existing resources, best practices, and training related to suicide prevention, intervention, and response programs.
- **Create a strategic plan** to guide police chiefs in taking proactive measures to mitigate the risk of suicide and openly address officer mental health as a core element of officer safety.

The IACP is committed to these objectives; most important, to deploying a national strategic plan for implementation of state-of-the-art mental wellness and suicide prevention programs in police departments across America. We want police leaders to really look hard at this strategic plan, to assess the recommendations, and to act: to implement the "agency action items" outlined here that will integrate mental health and well-being into the officer safety and wellness discussion, and that will help to save lives.[1]

Craig T. Steckler
Chief of Police (retired)
Fremont (California) Police Department
July 2013

COPS OFFICE DIRECTOR'S LETTER

In 2011, in response to Attorney General Eric Holder's concern for officer safety and wellness, the national Officer Safety and Wellness (OSW) Group was convened. Since then, the OSW Group has met to discuss training, policies, best practices, and research to reduce officer fatalities and injuries as well as support officer physical fitness and psychological wellness.

Some of the most critical topic areas in the psychological health of officers identified by the OSW Group are: 1) providing mental health services and support programs to officers experiencing Post-Traumatic Stress Disorder (PTSD), depression, or suicide ideation; 2) de-stigmatizing officers seeking mental health services; and 3) providing officers with easy and confidential access to mental health and mentoring programs. The OSW Group recommended further exploration of proven best practices and more in-depth research to enhance the field's understanding in preventing and intervening in officer suicides.

In response, the Office of Community Oriented Policing Services (COPS Office) was pleased to partner with the International Association of Chiefs of Police (IACP) in sponsoring the *National Symposium on Law Enforcement Officer Suicide and Mental Health: Breaking the Silence of Law Enforcement Suicides* held in the summer of 2013. Subject matter experts dedicated to the psychological welfare of officers participated in the symposium composed of a diverse cadre of law enforcement executives, officers, police psychologists, researchers, professors, and representatives from federal, professional, and non-profit agencies. The results culminated in prevention, intervention, and post-intervention recommendations set forth in this report.

I hope you will garner meaningful information and strategies from this publication that your agency may implement to address the psychological welfare of your officers. This report embodies the knowledge and consensus of the key stakeholders present at the symposium. It is the COPS Office and IACP's desire to bring the topic of officer suicides to the forefront in order to better understand the imperative role agencies' play in supporting their officers' psychological health.

We also encourage you to share this publication, as well as your successes, with other law enforcement practitioners.

Sincerely,

Ronald L. Davis, Director
Office of Community Oriented Policing Services
U.S. Department of Justice

EXECUTIVE SUMMARY

According to statistics from the Federal Bureau of Investigation (FBI), Law Enforcement Killed and Assaulted (LEOKA)[2] data and survey results from the 2012 National Study on Police Suicides,[3] law enforcement officer deaths by suicide were twice as high as compared to traffic accidents and felonious assaults during 2012. This sobering data indicates that some law enforcement officers suffer from mental health issues and suicidal ideation and behavior, and too many officers are dying from it. Moreover, it suggests that mental health and well-being is integral to the continuum of officer safety and wellness, and critical to preventing officer suicide. Yet, what resources can executives and leaders invest in to support officer mental wellness? While executives provide resources to ensure officer safety and physical fitness standards are met, such as through firearms training and physical fitness programs, what should executives be doing to ensure officers' mental health wellness?

Law enforcement officers are exposed to daily events that threaten their lives and expose them to heinous atrocities. They witness cruel acts to the innocent more frequently than those in other professions. Because of this, officers deserve the best mental health and wellness support that can be provided. Mental health providers, specifically trained and experienced in providing services to law enforcement, should be available in order to provide specialty service throughout an officer's career, from the academy through retirement.

The reality is that the law enforcement profession has long perpetuated a stigma attached to mental health that prevents both officers from seeking the necessary treatment and leaders from providing it. Now is the time to remove that stigma and to openly address the reality of officer mental health issues and suicide prevention. Now is the time when law enforcement leaders must identify and deploy the most effective strategies to protect and enhance the mental health and fitness of officers.

To address this critical issue, the International Association of Chiefs of Police, in partnership with the Office of Community Oriented Policing Services (COPS Office), U.S. Department of Justice hosted *Breaking the Silence: A National Symposium on Law Enforcement Officer Suicide and Mental Health* in July 2013. Participants at the symposium worked together to develop a national strategy to address officer mental wellness and suicide prevention,

built on the following four cornerstones: 1) Culture Change; 2) Early Warning and Prevention Protocols; 3) Training; and 4) Event Response Protocols. The participants identified "Agency Action Items" in each of these four cornerstone categories that offer concrete strategies to create healthier, stronger, and more productive police departments, including:

- Recruit leaders who care about the mental wellness of their officers and who unequivocally endorse physical and mental wellness parity as critical to a resilient and healthy police force.
- Recruit and hire resilient officers who have demonstrated a commitment to public service and proven stress management skills.
- Establish and institutionalize effective early warning and intervention protocols to identify and treat at-risk officers, for example, by launching awareness campaigns on what to look for and who to call when officers may be in a mental health crisis or suffering from clinical anxiety or chronic depression.
- Audit existing psychological services and determine whether they are effective in identifying early warning signs of mental wellness issues, including mental illness and suicidal behavior, and in treating at-risk officers.
- Invest in training agency-wide on mental health awareness and stress management.
- Begin mental wellness training at the academy and continue the training throughout officers' careers, with a particular emphasis on first-line supervisors.
- Include family training to reinforce and invest in those critical family connections.
- Establish clear post-event protocols to implement and follow when officers die by suicide.

The strategies outlined in this report are designed as a roadmap for police departments seeking to include officer mental wellness as a core element of officer safety and well-being and to mitigate the threat of officer death by suicide. These strategies are designed to **prevent** the destructive effects of emotional trauma, mental illness, and officer deaths by suicide on a police community; to successfully **intervene** when officers confront mental health crises, mental illness, or suicidal behavior; and, to provide effective **event response** protocols when an officer dies by suicide in an agency. It is time for a coordinated, national initiative on this all too-critical issue. It is time to integrate mental health and well-being into the mainstream officer safety and wellness continuum.

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Second, thank you to the Alexandria (Virginia) Police Department, who graciously hosted the symposium. It was important to have the symposium hosted by a law enforcement agency and held at a police department to highlight the significance of this critical issue in law enforcement.

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Finally, thank you to the participants who attended the symposium and worked so diligently to fashion the recommendations into a cogent action piece for IACP and the profession. Each participant was chosen for his or her work and commitment to this critical topic. Each participant contributed a unique and important perspective. We hope that we have synthesized and conveyed their contributions faithfully and accurately in this report.

In recognition of their efforts, we have acknowledged each symposium participant at the end of this report in Appendix II. We also have acknowledged IACP project staff in Appendix III.

I. INTRODUCTION

Officer safety is the top concern for police executives. Every chief wants their officers to return home each day as healthy and safe as when they came on duty. Police culture acknowledges the importance of physical safety and wellness. Precautions to ensure an officer's physical safety abound and are often reinforced through official policy statements and training requirements. From wearing bullet proof vests and seat belts to self-defense and firearms training, physical safety is something all departments emphasize and all officers support. Similarly, every police department has initial physical fitness requirements in order for an officer to be accepted into the department.

Unfortunately, mental health and well-being, while equally critical, fail to receive the same level of attention and resources within the officer safety continuum. Mental health issues and the threat of officer suicide are often topics no one wants to acknowledge. In a profession that prides itself on bravery and heroism mental health concerns can be seen as weaknesses and antithetical to the strong courageous police persona. Nevertheless, police officers are not immune to stress, depression, anxiety, post-traumatic stress disorder (PTSD), or other mental health concerns or illness. Arguably, they are more susceptible given the horrific events, trauma, and chronic stress endemic in their profession.

Perpetuating this culture of silence and denial around officers' mental health needs is unacceptable. It endangers every officer in the country. When agencies and individual officers do seek guidance and assistance, they often find that limited resources are available. Those that are available come from disparate sources, with few devoted specifically to law enforcement. As a result, neither officers nor chiefs know where to turn in a time of crisis.

The International Association of Chiefs of Police and the Office of Community Oriented Policing Services (COPS Office) gathered an advisory group, which identified the following policy issues and strategies for discussion at the symposium:

- Refine the leadership role for law enforcement on this issue and empower leaders to change a culture that is dismissive of mental health issues, in part, by identifying first responder experiences that may lead to stress, PTSD or other mental illness, or thoughts of suicide and expand awareness of officers' mental wellness and the capacity of supervisors and other officers to intervene where necessary.
- Encourage police and mental health professional collaboration to ensure that new approaches to officers' mental health services are reflective of current best practices in both the mental health and law enforcement fields.
- Identify state-of-the-art mental wellness programs and suicide prevention strategies available for replication, and provide executives with the corresponding tools they need to create robust mental health and wellness initiatives at the local level.

The National Symposium on Law Enforcement Officer Suicide and Mental Health was held on July 11, 2013 at the Alexandria (Virginia) Police Department. A diverse group of professionals were invited to the symposium based on their contributions and commitment to the issue. This group included sworn officers from different ranks, police psychologists, physicians, academics, advocates, researchers, and policy analysts.

Symposium participants addressed the above-described policy issues and strategies, developed a **national strategic plan** to openly address the reality of officer mental wellness and suicide, and worked to integrate mental health and well-being into the mainstream officer safety discussion. Participants built this plan upon the four categories of Culture Change; Early Warning and Intervention Protocols; Training; and Event Response Protocols. Readers are encouraged to review the "Agency Action Items" in each of these four cornerstone categories described in Section II **Symposium Results** and to consider which recommendations are appropriate for individual departments; and, to implement the strategies accordingly along a continuum of prevention, intervention, and post-vention objectives. In Section III, the **IACP Action Agenda** is outlined and each police executive is encouraged to determine how an agency might further assist in these national efforts. Finally, Section IV **Conclusion**, highlights some of the best practices for agencies seeking to:

- **Prevent** officer suicides by addressing unidentified and untreated emotional trauma and mental illness, while proactively enhancing officers' emotional well-being
- Effectively **intervene** where officers suffer from emotional trauma, mental illness, or suicidal behavior
- Support **post-vention** policies to help give direction to the department, as well as the family of the officer, after an officer dies by suicide

It is the position of the IACP that implementing the innovative approaches outlined in this report—from officer recruitment through retirement—will help to protect agencies from the devastating effects of mental illness and suicide on officers, their families, and their communities. As a result, agency leadership will increase the likelihood of having a stronger, healthier, and imminently more productive police force.

IACP's Response to Enhancing Officer Mental Wellness & Preventing Officer Suicide

To date, not enough work has focused on suicide and mental wellness issues within the law enforcement profession. Some relevant work has focused on suicide and mental wellness in the general workplace setting, including the *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. This report from the U.S. Surgeon General and the National Action Alliance for Suicide Prevention*[4] presents a national strategy to prevent deaths by suicide, and includes a comprehensive blueprint of general goals and objectives applicable to suicide prevention in the workplace. Still, it is not law enforcement specific and does not account for many of the challenges facing those in the law enforcement profession.

The IACP has long recognized that leadership is needed on these issues and has accomplished a great deal already:

- In 2008, the IACP's Police Psychological Services Section, the Bureau of Justice Assistance, (BJA), and EEI Communications, partnered to produce Preventing Law Enforcement Officer Suicide, a CD compilation of resources and best practices.
- In 2010–2011, IACP President Michael Carroll declared 2010 the Year of Officer Safety.
- In 2011–2012, IACP President Walt McNeil renewed that pledge in 2011, announcing that suicide prevention would be a major initiative of his presidency. Then-President McNeil charged IACP future Presidents to continue to prioritize the initiatives; continued efforts have further solidified the Association's long-term commitment to taking a deeper look at officer suicide and mental wellness.
- In 2012–2013, IACP President Craig Steckler continued this priority. In 2012, IACP published a Police Chief magazine article on law enforcement suicide,[5] and included workshops and a plenary session on officer suicide at the 119th Annual IACP Conference in San Diego. President Steckler also published a President's Message, "IACP: Breaking the Silence on Law Enforcement Suicides," in *Police Chief* 80 (July 2013): 6, adapted and reprinted in part above.

The IACP's Center for Officer Safety and Wellness has developed innovative resources on officer mental wellness and suicide prevention. The Center's mission is to emphasize the values of safety, health, and wellness as they impact officer performance by promoting a culture of safety and wellness. The Center fosters the development of these values in policing through educational materials, strategies, policies, training, tools, and resources. It is the IACP's position that no injury to or death of a law enforcement professional is acceptable.

For more information on the Center, visit www.iacp.org/CenterforOfficerSafetyandWellness.

II. SYMPOSIUM RESULTS

Culture Change

Unfortunately, in many law enforcement departments the culture toward mental wellness or addressing emotional problems of any kind is one of disdain and avoidance. The presumption within this culture is often that the mere presence of an emotional problem indicates a weakness on the officer's part. That perception leads to the even more dangerous perception that being open about these issues can make the officer vulnerable, even to the point of losing his or her job. Significant progress in curbing officer suicide and enhancing officer mental wellness is only achievable if the culture does an about-turn toward openness and support for all aspects of officer health and wellness, particularly mental health.

Changing a culture resistant to even *acknowledging* mental health issues is a great challenge. This culture may be so institutionalized that we may not even be cognizant of its existence. Yet, the reality is that our culture often prevents both officers from asking for help and leadership from providing it. The stigma and fear of reprisal associated with asking for help, particularly in law enforcement, leaves officers in need, with nowhere to turn, and only aggravates feelings of hopelessness.

"Officer suicide and mental wellness needs to be addressed just as directly as officer vests."

—Tony West, Acting Assistant Attorney General, U.S. Department of Justice*

It is incumbent on leaders to protect their officers. It is imperative that all police executives and leaders commit not only to changing the culture, but to institutionalizing effective mental wellness support, so that agencies can address mental health issues successfully and foster resilient and productive police officers. Starting the change may be difficult; it takes time and effort, and progress may be slow. Officers deserve this change, and the outcome is worth the investment.

Parity of physical and mental wellness

To effectively address mental wellness and suicide prevention, all levels of leadership must recognize the parity of mental and physical safety and wellness. Law enforcement agencies are committed to officers' physical safety and wellness. From body armor to firearms training, and on-site gyms and fitness programs, there are numerous measures in place to ensure an officer's physical safety. But what is the profession doing to protect and support the mental health of officers? Tragically, many agencies lack the resources and the critical guidance to improve and protect their officers' mental health and wellness.

* Tony West, "Breaking the Silence: A National Symposium on Law Enforcement Officer Suicide and Mental Health" (symposium, Alexandria, VA, July 11, 2013).

Barriers to achieving mental health parity

The stigma of having mental health problems in law enforcement and obtaining professional help for mental illness is a powerful force in police culture and cannot be underestimated. Individuals outside of law enforcement regularly identify and seek mental health treatment for emotional trauma and mental illness for themselves and for others. Why not police?

- The **fear of consequences for seeking help** for emotional problems or mental illness is a reality in our culture. If employees believe that asking for help may hurt their image, slow or stop career advancement, or even end their career, they won't do it.
- Police officers are trained to guarantee the physical safety of their fellow officers, but **officers are not generally trained** to identify or effectively respond to emotional trauma, mental illness, or suicidal behavior in other officers. Officers may be unclear or misinformed about **confidentiality laws and policies**, which impedes both officers seeking help and leaders providing the help to those who need it. Similarly, officers may be confused about the laws and policies governing when an officer's firearm may be removed due to mental wellness issues, which also impedes officers from seeking needed help.
- **Departments with limited resources** may lack the time and capacity to provide the necessary and confidential mental wellness care and training, and suicide prevention programs.

"We need to break the cycle, break the silence, and change the culture."

—Deputy Chief Eddie Reyes, Alexandria (Virginia) Police Department *

Finally, officers may be allowed to bypass supervisors to get counseling. So while the officer may obtain needed help, the department simultaneously may be unaware of officers with mental wellness issues. This dynamic between **an agency's need-to-know** and **confidentiality** concerns may impose serious obstacles to any agency seeking to improve its officers' mental health.

Agency Action Items – Culture Change

Make suicide prevention a top priority for executives

Chiefs should be proactive and speak directly to their officers about mental wellness and officer suicide. Hearing from the chief personally and candidly carries a tremendous amount of weight. In particular, police chiefs or others who have triumphed over their own mental health issues should champion this subject and share their own success stories.

Review mental wellness and suicide prevention policies and practices

One of executives' most important tasks in this effort is to be held accountable for the review, improvement, and auditing of mental wellness and suicide prevention policies and practices. Police chiefs should appoint and personally oversee a specific employee to begin such an agency review, including identification of resources needed and implementation deadlines. **This assessment tool or "checklist" could include items found in Table 1** (see page 6).

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* Eddie Reyes, "Breaking the Silence: A National Symposium on Law Enforcement Officer Suicide and Mental Health" (symposium, Alexandria, VA, July 11, 2013).

Table 1. Suggested Checklist for Comprehensive Mental Wellness and Suicide Prevention Programs

Policy/Practice Review	To Do
Does your agency treat officer mental and physical safety and wellness equally?	A mental resiliency check is like a cholesterol check. Make sure your officers are mentally fit.
Do you and your officers know the early warning signs of depression, other mental illness, and suicidal behavior?	Implement effective education and training initiatives, and aggressively (and routinely) publicize how officers can get the mental health assistance they need.
Do you have an effective Employee Assistance Program (EAP), peer support group, a consortium approach, or other mental health providers dedicated to law enforcement? Do you have a relationship with a local hospital with trusted doctors to treat officers?	Review the mental health resources identified in this report. Know what mental health assistance is available to your department, and find out how you can improve the quality of mental health services delivered to your officers.
What are your mental health intervention protocols for at-risk officers and after critical incidents?	Make sure these protocols are effective and consistent.
Do your training programs from academy recruits to retirees include routine training on mental wellness and stress management? Do you incorporate these curricula at critical incident training?	Invest in this training throughout an officer's career. It is as important as firearms training or wearing bullet proof vests.
If your officers have a union, is the union on board with your mental wellness program?	The union might be the go-to contact for a line officer. Work with your unions to foster support for mental wellness programs.
Do you have clear guidance on confidentiality laws and rules?	Confidentiality laws are complex and have serious ramifications. Educate your agency.
Does employee self-reporting result in discipline or negative consequences, either intentional or unintentional? Do officers fear that self-reporting will result in discipline or even job loss? Do you have clear guidance on the laws and policies that govern when an officer's firearm must be removed due to mental health issues?	Fear of self-reporting may be one of the greatest barriers to achieving a healthy department. Change your culture so that officers are encouraged to self-report. When an officer sees another officer getting help without being de-gunned or de-badged, it is very reassuring.
What are your policies addressing suicides in your department?	Be sure you have an established notification and funeral policy in place for officers who die by suicide, to include outreach, education, support for family members and fellow officers, and media coordination.

Symposium participants recommended that the IACP use this "checklist" to develop a comprehensive national assessment tool to assist executives to critically evaluate, routinely audit, and identify potential enhancements to their mental wellness and suicide prevention policies and practices.

Institutionalize these policies and practices

After reviewing an agency's mental wellness and suicide prevention policies and practices, determine where to make changes or enhancements, or to redeploy resources, in order to ensure a healthier police force. The following should be undertaken:

- Ensure policies and practices to adequately address mental wellness and suicide prevention, intervention strategies after a traumatic event for involved officers, and post-suicide protocol and policies for families, the agency, and the community.
- Formalize policies and practices in writing, and ensure that they are published agency-wide and routinely reiterated via public awareness campaigns.
- Train officers on these policies and practices throughout officer careers and in all types of training—for example, academy training, routine resiliency training ["rest and relaxation (R&R) training"], critical incident training, and retirement transition training. Include them in both formal training (e.g., academy presentations) and informal exercises (e.g., roll call discussions).
- Conduct regular audits of your policies and practices to ensure they're effective and consistently enforced.
- Institutionalize these policies and practices to ensure their survival in future administrations.
- Initiate mental wellness programs and suicide prevention campaigns.
- Flood offices with information, such as training, posters, brochures, and wallet cards, and similarly leverage and update services to identify and publicize available resources for officers in need, including those who suffer from mental illness or are affected by officer suicide.
- Train officers to recognize indicators and warning signs of chronic stress and mental illness within themselves and in their peers.
- Educate officers on self-care, stress-management, and general well-being as a holistic approach to ensure officer mental fitness.
- Provide successful intervention methods, such as the appropriate actions to take when a supervisor recognizes an at-risk officer.
- Encourage officers to police themselves for mental health issues and to look out for the mental well-being of one another. Officers should check in annually with peer support counselors, department psychologists, or outside therapists.
- The chief and the entire command staff must be out in front on these campaigns. This is the most important point of all.

These departmental awareness campaigns can ensure that effective mental wellness and suicide prevention policies and practices endure from one administration to the next. However, a mental wellness and suicide prevention campaign may be a difficult "sell" in an agency. The following identifies four of the reasons why such a campaign might face opposition, and corresponding strategies for overcoming that challenge:

1. **A particular department may not have experienced officer deaths by suicide.** However, for every one suicide that is carried out successfully, there are as many as 25 attempts, according to Dr. Paul Quinnett at the symposium.[6] Agencies may be unaware of officers' suicide attempts or even their suicidal behavior or ideation. This potential lack of agency awareness, coupled with a lack of comprehensive research, may make it a challenge to sell mental wellness or suicide prevention campaigns in an agency.

   A 2009 Centers for Disease Control and Prevention study indicated that suicide in the general population is the 10th leading cause of death, "claiming more than twice as many lives each year as does homicide."[7] Specific to law enforcement, the Federal Bureau of Investigation, Law Enforcement Officers Killed and Assaulted data (2012) shows 47 officers were killed feloniously and 39 killed in motor vehicle accidents.[8] However, it is estimated that **twice as many law enforcement officers every year die from suicide than are killed in either traffic accidents or assaults.**[9]

   The average law enforcement officer who dies by suicide is male, 38.7 years old, has 12.2 years of experience, and is usually below the sergeant rank, according to a May 2012 *Police Chief* article.[10] Yet, any officer with serious mental health issues or suicidal behavior or ideation is vulnerable and leaders need to be able to identify these officers quickly and early for effective intervention.

   - **Better Research:** Symposium participants recognized an urgent need for better statistics and more comprehensive research on officer death by suicide, as well as mental illness in police agencies, and for that reason recommended that IACP conduct an extensive national survey on this issue.
   - **Success Story:** According to the 2012 National Strategy, the U.S. Air Force Suicide Prevention Program "has implemented a community-based suicide prevention program featuring 11 initiatives....Evaluation findings indicate that the program reduced the risk of suicide among Air Force personnel by one-third....Participation in the program was also linked to decreases in homicide, family violence...and accidental death."[11]

     If an agency has not suffered a suicide tragedy, they should not wait for one to occur. Do not allow mental illness or other significant risk factors to remain unidentified and go untreated. Be proactive. Officers should be given the mental health support and resources they deserve.

2. **If officers are not self-reporting, commanders may be unaware of mental illness or suicide risks, and an awareness campaign may be perceived as unnecessary.** The stigmas associated with self-reporting mental health issues, and perceived and possibly real fear of consequent job loss, prevent agencies from being aware of problems and from providing the necessary resources. Ineffective or nonexistent mental health professionals to identify and treat at-risk officers, as well as stringent confidentiality rules, also may prevent executives from being aware of officers with mental health issues, mental illness, or suicidal behavior or ideation. As such, executives may not fully grasp the need to prioritize mental wellness or suicide prevention campaigns in their agency.

   Nonetheless, other indicators may be present in a department. Have any officers ever abused alcohol or prescription drugs? Been involved in domestic violence incidents? Used excessive force? These officers, and officers subject to internal affairs investigations, serious disciplinary actions, unwanted job changes, or relationship trauma, may need mental health counseling or other types of treatment. These events, of course, do not forecast mental illness or suicide risks, but they can be risk factors for or warning signs of underlying mental health issues. Resolve to address these potential mental health issues now, and to target serious mental illness such as depression or suicidal behavior. Begin by instituting an agency-wide campaign on mental wellness.

3. **Any new program costs money and agencies may lack sufficient resources.** While new programs undeniably cost time and money, it may be more cost effective to treat a veteran cop with mental health issues than to hire a brand new officer. If an agency institutionalizes effective detection, prevention, and intervention strategies, the cost of sick time, lost productivity, legal fees, and other expenses may be diminished. Chiefs may want to reach out to risk management professionals to calculate these real costs and to better understand the payoffs involved.

   As noted above, IACP already has developed suicide prevention campaign material. Participants recommended that IACP develop a similar model in a mental wellness campaign kit. These ready-made and inexpensive resources may be a solution to tight budgets.

4. **"Protect the protectors."** Finally, as Dr. John Violanti noted at the symposium, "Officers have an ethical obligation to care for our people. We have a moral imperative to care."

Agencies might consider implementing some of the "best practices" identified by former COPS Office Director Bernard Melekian:

- Anonymous counseling outside the police department
- Consortiums or regional support centers, with money set aside for a prescribed number of officer visits per year
- Emphasis on formally trained peer counselors and police officer support groups
- The display and routine update of posters reflecting photos of respected officers with the caption: "We're here to help you"
- Training of lieutenants and sergeants on how to talk about emotional wellness
- Installation of a formal suicide funeral policy

Recruit and hire the right people

Finally, hire the right people to implement and follow through on effective mental wellness and suicide prevention policies, practices, and programs. Recruit chiefs who will make these issues a priority, will hire resilient police officers, and will adequately screen new recruits. Some of the key personality traits of officers who demonstrate long-term emotional wellness and resiliency were identified as:

- Service orientated and committed to social service
- Empathic balanced with a "cool head"
- Socially competent
- Team player
- Demonstrates integrity
- Good impulse and stress control
- Minimal risk behavior

Participants considered mental health screenings critical to any hiring protocols and to identifying early warning signs of mental illness. Dr. Stephen Curran at the symposium indicated that "[o]ver half the police departments in the United States do not conduct pre-employment psychological screenings consistent with IACP Police Psychological Services Section Guidelines." Consider implementing these recruit screenings if a department has not done so already.

IACP in 2009 produced a model law enforcement suicide prevention program offered on a CD titled *Preventing Law Enforcement Officer Suicide: A Compilation of Resources and Best Practices.* Participants recommended, however, that IACP develop a joint model mental wellness and suicide prevention campaign to include social marketing materials to assist agencies in building their own programs.

Early Warning and Prevention Protocols

Mental health problems are more easily resolved when addressed at their earliest stages. Conversely, mental health problems left unaddressed over significant periods of time may cause irreparable harm up to and including death. Only well-designed, strategic early warning and intervention programs can facilitate this early response to a serious problem. In law enforcement, based on culture and lack of resources, these early warning and intervention programs are often inconsistent, personality-based, or lacking entirely. Officers in departments without early warning programs may display a clear set of warning signs that receive no notice and no response until it is too late.[12]

Institutionalizing efforts to identify early warning signs and implement intervention protocols is crucial to protecting officer mental wellness. Symposium participants focused on strategies for understanding and responding quickly to warning signs to stabilize and protect officers from harm, and empowering officers to improve their resiliency and overall mental health.

What are the stressors affecting and indicators of officers at-risk for suicide or mental illness?

Symposium participants agreed that law enforcement must provide better education and training on officers at-risk for suicide and mental illness. While by no means an exhaustive list, the participants identified some of the stressors and indicators that officers encounter as the following:

Stressors

- Accumulation of chronic stresses and daily hassles
- Exposure to horrific events or acute stresses
- Relationship events, including divorce or loss of major relationship; death of a spouse, child, or best friend, especially if by suicide; infidelity or domestic violence
- Shift work, as officers on midnight shifts may be higher suicide risks because of abnormal sleep patterns, which can impair their ability to make decisions
- High expectations of the profession, followed by perceived futility or social isolation
- Significant financial strain, such as inability to pay mortgages or car payments
- Diagnosis of serious or terminal illness
- Internal affairs investigation
- Significant change in routine, such as a change of duty, or pending or existing retirement

Indicators

- Talking about wanting to die, seeking revenge, feelings of hopelessness, being trapped, being a burden to others, or in unbearable pain
- Increased risk-taking behavior or recklessness
- Looking for a way to kill oneself
- Emotionless, numb, angry, agitated, anxious, enraged, or showing extreme mood swings

- Giving away valued possessions
- Socially isolated or withdrawn
- Weight gain or loss
- Sleep deprivation or sleeping too much
- Cutting themselves
- Increased consumption of alcohol or drugs [13]

What distinguishes at-risk officers with depression, anxiety, and other mental illness?

Officers suffering from emotional trauma, mental illness, or suicidal behavior or ideas may share commonalities. However, distinguishing between officers in a situational emotional crisis or experiencing chronic depression or suicidal thoughts and then determining the appropriate treatment is the great challenge. For example, some officers, who in certain cases may be less resilient than other officers, may not be independently capable of triumphing over an emotional trauma, and may need peer support counseling or professional psychological help. Still others may have clinical anxiety and need professional treatment and supervised medication. Others may be suicidal.

Some of the participants at the symposium conceded that even they were unclear about how to distinguish among at-risk officers exhibiting anxiety and depression. The lack of clarity on these issues was identified as a significant problem in identifying at-risk officers and intervening effectively. Symposium participants recommended that IACP include in its model mental wellness campaign and training curricula specific guidance on the definitions and meanings of these terms and the particular warning signs.

"IACP has helped save the lives of police officers through efforts to prevent police officer suicide."

—Joshua Ederheimer, former COPS Office Acting Director and Principal Deputy Director *

AGENCY ACTION ITEMS—EARLY WARNING & INTERVENTION PROTOCOLS

Examples of early warning and intervention protocols are identified throughout this report, such as comprehensive officer training to assist departments in effectively detecting and responding to emotional trauma. There are numerous other strategies, however, some of which are outlined below:

Identify, evaluate, and routinely audit mental health providers that screen and provide services to officers at risk

To identify early warning signs of mental health issues, mental illness, and suicidal behavior and implement successful intervention programs, departments must **identify, evaluate, and routinely audit their mental health providers**. These providers are the linchpin to the delivery of effective mental health care to officers in need. Symposium participants identified the types of providers typically used by law enforcement, and some of their respective benefits and drawbacks. Participants also made recommendations respective to each type of service to enhance the delivery of these services.

* Joshua Ederheimer, "Breaking the Silence: A National Symposium on Law Enforcement Officer Suicide and Mental Health" (symposium, Alexandria, VA, July 11, 2013).

Whoever the providers are, be sure to not only identify and evaluate their services, but also, to routinely audit their quality and to track how often their services are used. This data is essential to obtaining necessary funding and to deploying effective resources where needed.

Peer Support Personnel

Specially-trained peer support personnel were recognized as critical mental health resources, as officers in crisis may be far more willing to talk to colleagues than to mental health professionals. Peer support services should be reviewed to ensure that the participants are formally trained: 1) to recognize warning signs of officers with mental illness or at-risk for suicide; and 2) to effectively refer appropriate cases to the professionals. Make sure the officers selected for the peer support groups are the best officers for the job, and enforce accountability and oversight of its members. Consider including retirees who bring extensive experience on the job and can speak to the many challenges of the profession. Finally, ensure that written confidentiality guidelines are clear. And of course, if an agency does not have a peer support group, starting one should be considered.

Employee Assistance Programs (EAP)

EAPs provide no-cost, confidential assistance to an agency's employees (and sometimes their families) on health and wellness issues that impact work performance, such as stress management, substance abuse counseling, and mental health concerns. Participants reported that a department's EAP may be underutilized as a source for mental health assistance, in part because officers may not wholly trust the programs. For example, there is a perception that there is a "pipeline" from EAP to the chief, which reduces its effectiveness. Some participants recognized other problems, including that EAP may be the only mental health provider available, in which case an agency may need to consider strengthening its EAP as well as supplementing the program with other services, internally and externally (e.g., peer support and consortiums).

> *"Peer groups act as a portal to get an officer the help they need."*
>
> —Chief Ed Flynn, Milwaukee (Wisconsin) Police Department*

In any event, department chiefs should ensure they are knowledgeable of the EAP process. For example, chiefs should make every effort to contact the EAP associated with their department and discuss the processes for both supervisory referrals and self-referrals.

Mental health professionals

There was a general sense among symposium participants that most mental health practitioners do not typically understand the complexities of the police officer's job. Participants stressed that to reduce the cultural trust gap between mental health professionals and law enforcement officers (LEO), mental health professionals must be exposed to LEO culture and acclimated to the daily rigors of police work. This exposure is critical for a qualified

* Ed Flynn, "Breaking the Silence: A National Symposium on Law Enforcement Officer Suicide and Mental Health" (symposium, Alexandria, VA, July 11, 2013).

evaluator who may be screening potential recruits or interacting with at-risk officers during or following a critical incident.

Consortiums, Cooperative Wellness Groups, and Regional Support Teams

The participants identified this as a useful approach to providing mental health services for small to medium-sized departments. By developing **consortiums, cooperative wellness groups or regional support teams, multiple agencies can hire mental health services which they could not otherwise afford as a single agency.** Smaller departments can pool their resources together to pay into a program so all their officers can get help when they need it.

Technology

Leverage technology as a different type of tool for getting officers help, such as Skype therapy, text support, face time, national hotlines, and online training. Participants also discussed development of a software application that is a self-assessment tool officers can use to determine if they need to seek help and what kind. Available technology needs to be socially marketed, confidential, and can include almost everything short of medication. The downsides of this resource include continuity of treatment, billing issues, and tracking and accountability. Most important, the value of human contact cannot be underestimated. Participants recommended that IACP develop a "technology" guide to mental health services which includes an application or self-assessment tool.

> *"I'll call officers in need of help but they won't answer [my phone call]. But if I text them they'll respond."*
>
> —Stephanie Samuels, MA, MSW, LCSW*

Other

Other prevention and intervention sources include agency chaplains, officers' own chaplains or religious leaders, or medical professionals. Family members are another invaluable resource in identifying and mitigating the effects of mental illness, and in preventing suicidal behavior and death by suicide.

Reinforce family connections

Families are a key resource to any successful early warning and intervention program. Programs and information are important for family members in order for them to understand how they can support their significant other as a LEO, including:

- **Training Families:** It is important that family members understand the stressors and indicators in order to support their loved one in seeking department mental health assistance or professional help at crucial times. One participant indicated that her agency meets with academy recruits and their families for a full day after graduation to prepare families for what to expect in a career in law enforcement; to make them aware of warning signs of depression, anxiety, and other mental illness; and, to educate them on available resources.

  Participants agreed it is crucial to reinforce this family training throughout officers' careers because family members may have changed due to separation, divorce, death,

* Stephanie Samuels, "Breaking the Silence: A National Symposium on Law Enforcement Officer Suicide and Mental Health" (symposium, Alexandria, VA, July 11, 2013).

or simply will not remember what they learned 10 or 15 years earlier should a critical event occur. More important, the resources change over time.

One mental health professional indicated that 70 percent of callers to the agency's internal "help hotline" were concerned spouses, not officers, and that the hotline can provide these family members with valuable prevention and intervention information.

- **Family nights**: Do not underestimate the power of involving family. Hold monthly meetings with officers where family members are invited to discuss issues. If a department cannot manage monthly meetings, it can strive to build in more internal relationships by hosting holiday parties, summer picnics, and other events.
- **Family networks:** Spouse and family networks can organize speakers and training for officers' families. Children should be involved as well, as they too may recognize changes in their parents and may become the "first responders" to officers with mental illness or suicidal behavior.

Encourage or consider routine mental wellness "check-ins" or exams

Participants universally agreed on the parity of officers' mental and physical health and wellness. There was considerable debate over whether routine mental wellness exams should be compulsory to detect early warning signs for mental illness, or suicidal behavior or ideation. Many participants indicated that, while compulsory annual psychological exams may offer an opportunity for police to talk to therapists, the therapists in general are not allowed to report their findings to the agency, and as such executives and leaders may be left unaware of mental illness in their departments. Participants voiced concerns about the legal issues implicated by compulsory annual mental exams. Balancing legal and liability issues with the emotional needs of officers and the ethical responsibility of chiefs is a complex discussion.

Other participants encouraged agencies to ensure that medical evaluators undertake suicide risk assessments when they see officers for required annual physicals. One participant indicated that her agency's psychological services division meets each officer for a voluntary, confidential visit every 18 months for 2 hours. This program is designed **to change the stigma of people going to mental health services** by establishing voluntary but routine, confidential check-ins. For effective oversight, the officers are later surveyed to see if they were satisfied with the therapist "resiliency check" and the service received.

Symposium participants agreed that resolution of these topics was beyond the scope of the symposium regarding agency adoption of compulsory versus voluntary mental exams; confidentiality laws addressing any disclosure of mental health issues; and state and local laws and agency policies governing an officer's status due to mental health illness.

Pay attention to indicators and be prepared to intervene

The following should be considered:

- **Peer responsibility:** Ensure that all officers from recruit to retiree are properly trained to identify indicators of significant emotional problems, mental illness, and suicidal behavior and ideation.
- **Consider a checklist:** Develop a checklist similar to a type of "early warning system" to include in supervisor's annual evaluations when assessing officers' performance. The checklist's goal is to identify whether sufficient warning signs exist to recommend a referral to psychological services. The reality, of course, is that any such checklist may be successfully manipulated, i.e., at-risk officers may know the "trigger" questions, not answer truthfully, and consequently evade detection. Nonetheless, such a checklist may be useful as one type of measurement to establish baseline mental wellness. Implementation of such a tool would necessitate serious discussion over whether this would be part of an employee's official performance record.

  An alternative might be that the checklist is given to the officer as a self-assessment tool to evaluate whether they need to seek help. This type of checklist could be used in training as well and may be less threatening than a supervisory assessment tool.
- **Contacts**: If an officer is in a mental health crisis, have a prepared list of contacts that can help. If an agency has already identified and analyzed their mental health providers as recommended above, they will have this list of contacts readily available in both print and online. Publicize this list for new recruits, officers in training, officers in need, and throughout the officers' careers, both for the individual officer in need and for the officer who recognizes a peer in need.

  Each officer should designate at least **one person to be contacted in an emergency**, including when that officer finds himself in a mental health crisis. Some agencies have officers select a designated contact and have that contact's name embedded in the officer's identification in case of an emergency. Table 2 offers recommendations on how agency personnel can approach an officer's supervisor when it perceived that he or she may be experiencing a mental health crisis.

Table 2. Suggested Response Protocol for Agency Personnel

When	Do this
When an officer notifies Human Resources (HR) of a change in beneficiaries...	...direct HR to notify the supervisor for a check on emergency contacts. Take this opportunity to make sure there is not something bigger going on, check in on any mental wellness issues, and be aware of any major life events, such as a divorce or loss.
When an officer is subject to an Internal Affairs (IA) investigation...	...direct IA to contact the officer's supervisor, and direct the supervisor to talk to the officer and, if necessary, encourage him to make an appointment with your mental health provider. This direct intervention at the beginning of an IA investigation facilitates: (1) identification of at-risk officers, and (2) providing timely mental health resources where needed to assist officers in successfully navigating the emotional impacts of the investigation.

- **Have an established, vetted protocol to address mental wellness policies after critical incidents.** Incorporate that protocol in agency-wide and career-long training, and routinely audit agency policies and practices to ensure that the protocol is implemented effectively and consistently.

  Participants disagreed on the effectiveness of mental wellness programs conducted after critical incidents. They noted that often it is not the critical incident

that can be the most traumatizing, but rather the chronic stress of the job, or a particular event that may be the impetus for an individual officer's mental health crisis or suicide attempt.

Some participants indicated that a compulsory mental health exam to discuss the impact of a trauma reduces the "stigma" associated with the help. However, the participants cautioned the effects of trauma are cumulative and that critical incident interventions must be accompanied by subsequent routine resiliency checks. They emphasized if agencies don't provide officers with the proper resources early on, they may later risk chronic depression and other serious mental health issues.

Other participants disagreed and indicated that mandating officers to see a therapist after coming off a horrific incident may impede their ability to heal. One participant indicated that voluntary, confidential counseling is far more effective in treating such instances.

Regardless of which approach an agency adopts, several recommendations for intervention after critical incidents apply:

- Provide interventions with peers and therapists together, to further break down the stigma of getting mental health assistance.
- Allow a waiting period after the incident before conducting any counseling so officers have a chance to cool down. This provides them with ample time to receive medical assistance post-incident (if necessary) and get past the immediate psychological trauma, which may impact incident recollections and cause distortions and gaps that could affect investigations.
- Provide officers a phone and private space with which to call a family member immediately after a critical incident. While spousal privileges may protect such communications, other legal and liability issues may apply depending upon state and local law.
- Follow up later with post-incident therapy because stress is cumulative.
- Symposium participants suggested that IACP develop a model "mental health" intervention protocol on critical incidents, to include state-of-the-art programs that reflect current best practices in both the mental health and law enforcement fields.

Assess potential at-risk groups for early warning signs of mental health issues and tailored intervention programs

Retirees, disabled officers, and veterans were identified as potential at-risk groups for mental wellness issues. Officers preparing for retirement may face uncertainty about this change in the way they identify themselves and how they spend their time. In some agencies, a retirement seminar or retirement wellness orientation is required. Separation from service may impact the mental welfare of a soon-to-be retiree, starting about two years prior to retirement. Send periodic updates and even cards to retirees, and reiterate that they are always welcome in the department. Leaders might consider including retirees in peer support groups.

Officers who become disabled during their career may also face emotional and mental health challenges. An officer could become disabled and have to consider medical retirement at a very young age. Most officers have not considered this possibility and that sort of change to their livelihood and identity could be a significant trigger for emotional and mental health crisis. One participant indicated that his agency determined that many officers retire because they felt "abandoned" after an injury.

Some officers who are returning veterans may face transitional challenges. Veterans may seek police employment because of the similar environment that law enforcement provides, yet the profession is subject to similar stressors as the military. If veterans suffer from PTSD or other deployment-related issues, they may require specialized intervention resources. IACP's "Vets2Cops" project (www.theiacp.org/Employing-Returning-Combat-Veterans-as-Law-Enforcement-Officers) includes guidebooks for executives, officers, and families specific to this issue.

There is a crucial leadership role in intervention programs and protocols. Symposium participants highlighted that, depending upon the size and nature of the department, executives, command staff, and/or supervisors play an integral role in any intervention program. For example, some participants suggested that executive, command, or supervisory staff "gets back on the street once in a while," and to the extent feasible, get to know their officers' professional and personal lives.

It is a challenge to find the right mental health professionals for an agency's department. One participant reported that there is no list of mental health professionals certified to work with law enforcement. As such, participants recommended that IACP develop standardized training for mental health professionals and possibly certification programs to ensure that officers receive the best mental health care possible from these providers.

Training

Police officers begin their training in the academy, or even earlier in colleges and universities specializing in policing studies, and continue that training throughout their careers via in-service, roll call, and external professional development opportunities. And it's safe to say that most police officers are extremely well-trained in the areas of police policy, protocols, and requisite skills. However, officers may be surprisingly ill-trained or not trained at all in recognizing signs of or effectively responding to emotional distress, PTSD or other mental illness, or suicidal behavior, particularly when it involves one of their peers. Of equal concern, families of law enforcement officers often do not receive information or training on how to detect early warnings of emotional distress, or how to help the officer seek mental health assistance.

- Symposium participants emphasized that agencies must conduct mental wellness and suicide prevention training throughout an officer's career, including the following types of training:
  - Academy
  - In-service
  - Routine resiliency and critical incident
  - Formal (e.g., Power Points) and "informal" (e.g., roll call)
  - Line officer and supervisory/executive, with a particular emphasis on first-line supervisors, as they are the direct link to the officers and in many cases more likely to detect warning signs and need to learn what to say and do if they detect problems
  - Retirement
  - Family training
- Leaders must be front and center at this training to achieve buy-in from officers.
- While symposium participants recommended that IACP, in conjunction with other authorities, develop a national standardized model training on mental wellness and suicide prevention, participants also emphasized that training must be flexible and include the capability to tailor it to each agency's policies and practices.

- There are already resources available on model suicide prevention training, for example, the above-mentioned IACP CD. These prepackaged training presentations, videos, and brochures used by law enforcement agencies provide ready-made and cost-effective materials for an agency. Training should include early warning signs and indicators of mental illness and suicidal behavior; stress-management skills; and the definitions of clinical depression, anxiety, PTSD, and other mental illness. Provide training tailored for supervisors on how they can effectively intervene with at-risk officers (e.g., what words supervisors can use to tell an employee they are concerned about his or her mental wellness).
- The trainer must be a law enforcement officer or someone trained in the law enforcement culture. As with mental health professionals treating officers, if the trainer is not an officer, then the trainer must be acclimated with the daily rigors of police work. This can occur through things such as ride-alongs on all shifts and participating in academy training.
- Symposium participants recommended that mental wellness and suicide prevention training should occur at least once a year for two to four hours. Online training can supplement but not replace live training. With frequent, mandatory training, it normalizes and institutionalizes these concepts.
- Train everyone in the agency to be responsible for everyone in the agency, from the chief to the administrative assistant and dispatcher.
- Find a spokesperson to be the face of the campaign and appoint a person at the training academy level as point of contact for the coordination of all this information.
- Monitor and routinely evaluate the training for effectiveness and consistency.
- States vary in how they institutionalize new training. For example, some states require police training to be set by legislature and agencies have to get buy-in from state legislators. In other states, police academies are decentralized and are able to establish new training as needed. The symposium participants indicated that due to the differences in establishing new training, it is difficult to achieve consistency in training curriculum.

Event Response Protocols

Departments faced with their first officer suicide may have no idea how to handle the aftermath, from basic funeral protocols to post-suicide actions that can help support the department and the officer's family. Without this knowledge and carefully developed protocols, departmental staff, from leaders to line staff to civilian employees, struggle and often fail to handle the suicide in the most productive manner. Two issues are most critical here: 1) have funeral protocols in place that allow officers and family members to honor the service and success of the fallen officer, regardless of the means of his or her death; and 2) have post-suicide protocols in place to offer counseling and information to the entire department to promote healing and open the door to other officers seeking help for an issue to avoid a future officer death by suicide.

Funeral protocols

Symposium participants overwhelmingly agreed that police departments should honor how officers lived and not how they died. The symposium discussions focused on the general theme that the funeral and post-event protocols should celebrate the officers' life

regardless of cause of death. There was some debate, however, about the precise protocols that should govern funerals of officers who die by suicide. For the most part, however, participants recommended that these officers should receive the same funeral protocols as all active-duty officer deaths that have passed away from a heart attack or natural causes. Participants also recommended that department leadership must do the following: 1) be physically present at the funeral; 2) establish the agency's funeral protocols; and 3) ensure that the entire department is well-informed of and routinely updated on these protocols.

Other post-event protocols

Similarly, participants agreed that department leadership must be accountable for well-established and well-publicized post-event protocols that address the bereaving family and the agency, as well as the dissemination of timely, accurate, and controlled information about the suicide. In general, participants agreed that the police leadership should personally handle certain post-event matters, such as first notifying and visiting with the family, and announcing the facts about the death to agency officers. Both of these issues, and others, however, can raise complex dynamics, as addressed below.

Officer's Family

In any officer death by suicide, there may be difficult dynamics between protecting the agency and comforting the officer's bereaving family. Litigation or possible litigation can complicate any officer death by suicide. Some agencies have faced pressure, both internal and external, on the specific descriptive language to be used when documenting a death by suicide that will be sensitive to the officer's family as well as how it may impact the family's ability to receive death benefits.

Regardless of these dynamics and the legal classification of death following a suicide, agency leaders should personally visit with the family who has suffered the loss. If the suicide occurred at work, the agency leaders should also notify the family first before informing the department. The agency leaders should appoint an officer and an alternate to keep in continued, close contact with the family. Some participants recommended that a close friend of the officer and the officer's family should be appointed; others suggested that person might be too bereaved to fill this role. In any event, an alternate should be appointed as a backup.

Officer's Agency

After family notification, agency leaders should personally and in a timely manner address the entire department about the facts of the officer's death by suicide. Leaders should also take this time to advocate strongly for the value of officers utilizing mental health resources; to offer specific and available mental health education opportunities and resources; and to provide post-event counseling to affected officers, including those officers who may have responded to the suicide scene. There was continued debate among

symposium participants about whether counseling should be compulsory or voluntary, but there was universal support that counseling is available by providing the following:

- Contact information for psychological services
- Time for officers to visit mental health resources and to heal
- Post-suicide counseling services to affected officers, as officers who are already at-risk for mental illness and suicidal behavior or ideation may find this time a particular stressor

Information Dissemination

Symposium participants offered several strategic guidelines addressing dissemination of information about an officer death by suicide. Most important, an agency should have established and well-publicized protocols governing notification of the family, officers, and the media, including the following:

- The family must be notified first. As discussed, all active officers should be on record indicating who is to be notified in case of death to ensure timely notification consistent with the officers' wishes.
- When notifying the family designee of an officer's death by suicide, the agency should find out the family's wishes with respect to notification of the agency and the media.
- Request that officers refrain from discussing the death until the family has first been notified. Officers are more willing to comply if the chief personally tells officers what happened.
- When addressing the public, the agency must speak clearly and consistently about the officer's death by suicide:
    - The agency must have precise protocols for dealing with the media in these situations. If an agency develops a trusting relationship with members of the media, these matters can be reported far more efficiently and respectfully.
    - Protocols must include guidelines on officers' use of social media. If agencies reduce the anxiety and anger that may result from the officer's death, they will avoid misuse of social media as an outlet.
    - Ensure that the role of the agency's public information officer is transparent and well-defined.

Some participants expressed high praise for the U.S. military procedures governing funeral and event response protocols for service men and women who die by suicide, and recommended that IACP review those procedures and publish a model IACP protocol for law enforcement officer deaths by suicide.

III. IACP ACTION AGENDA

As indicated throughout this report, symposium participants addressed many instances where additional national guidance and research is needed. The following reflects the participants' recommendations for an "IACP Action Agenda."

1. IACP should lead the effort to enhance data collection on officer suicide and mental wellness.
2. Draft an IACP statement and/or resolution on emotional wellness and suicide prevention that chiefs can distribute to their department to emphasize the critical importance of this issue to every officer and agency in the country.
3. Address mental health awareness at National Police Week every May as a way to show unity on the issue.
4. Publish a recurring piece in the IACP *Police Chief Magazine* addressing mental wellness issues, including stories and testimonials of officers facing and overcoming thoughts of suicide.
5. Publish an IACP *Police Chief* article designed to assist law enforcement executives in assessing, improving, and auditing their agency's mental wellness and suicide prevention policies and practices, including but not limited to their available mental health services. Include a "self-assessment" checklist for officers to determine their own mental health. Encourage agencies to distribute this checklist to all department personnel.
6. Develop an IACP awareness campaign that includes print and online resources, to help agencies and officers identify early warning signs of, and establish intervention protocols for, emotional trauma, PTSD, other mental illnesses, and suicidal behavior.
7. Provide an IACP forum such as a message board for anonymous postings by officers facing emotional challenges.
8. Involve IACP's Center for Officer Safety and Wellness in drafting and delivering model curricula for academy and in-service training on mental wellness and suicide prevention, as well as technical assistance to agencies initiating mental wellness and suicide prevention programs.
9. Include in model IACP training curricula a separate training for mental health professionals on treating law enforcement officers. Develop a certification program for mental health professionals specializing in services to law enforcement personnel.
10. Draft an IACP model protocol in the event of officer death by suicide, to include specific policies and practices that take into account the devastating effects and complex dynamics of officer suicides on their families and their agencies. Include in this model best practices from the U.S. military protocols for military officer suicides.

NOTE: Many of these recommendations will receive funding support from the public or private sector. IACP regularly seeks such support for major policy initiatives and will do so for this issue as necessary.

IV. CONCLUSION

There are numerous strategies outlined in this report addressing officer mental wellness and suicide prevention, and they are most effective if implemented by every federal, state, local, and tribal law enforcement agency along a continuum of **prevention**, **intervention**, and **post-vention** objectives:

- **Prevent** the disastrous effects of mental illness and officer death by suicide on officers, their families, and police agencies
- Effectively **intervene** in those cases where officers are in a mental health crisis, suffer from mental illness, or demonstrate suicidal behavior
- Establish effective **post-vention** policies to help support the families and the department when an officer dies by suicide

Some of the best practices in each of these three areas are highlighted below:

Prevention

- **Start at the top** and recruit leaders who care about the mental wellness of their officers, and who unequivocally endorse physical and mental wellness parity as critical to a resilient and healthy police force.
- **Recruit and hire** resilient officers who have demonstrated a commitment to public service and proven stress management skills.
- **Institutionalize** mental wellness and suicide prevention policies and practices. Formalize in writing, provide training on, and conduct recurring audits of relevant policies and practices, such as whether the agency encourages annual mental check-ins with peer support counselors, department psychologists, mental health professionals, or other providers.
- **Audit the existing psychological providers** and determine whether they are effective in identifying early warning signs of mental crisis or illness, and suicidal behavior and ideation.
- **Initiate an agency campaign** to raise awareness of mental health and wellness, particularly in identifying the warning signs and how to intervene. Use pre-vetted, ready-made model training and awareness campaigns to cut down on costs and resources, but tailor the campaign to the agency's needs and routinely update materials so they don't become stale.
- **Invest in training** agency-wide and throughout officers' careers on mental wellness and stress management. Include both routine resiliency training and critical incident training, with a particular emphasis on training first-line supervisors.
- **Provide family training and events** to reinforce and invest in family connections. Ensure that family members are able to identify signs of emotional trauma and make appropriate referrals when necessary.

Intervention

- Similar to prevention protocols, establish **intervention protocols** tailored to assist officers at-risk for mental health crisis and illness, as well as suicidal behavior or ideation. Again, ensure that these protocols are institutionalized via established written policies, training programs, and agency awareness campaigns.
- Audit **psychological service providers** to ensure that they **effectively intervene** when officers are having emotional problems, suffering from mental illness, or demonstrating suicidal behavior or ideation. For example, ensure that a peer support group is formally trained to identify signs of depression, anxiety, and other disorders, and to whom to refer at-risk officers. Train supervisors on the "words to say" when they encounter an officer in emotional trauma.
- **Pay closer attention to at-risk groups** and develop specially tailored intervention programs, including programs for retirees, veterans, and disabled officers.

Event response

- Develop formalized and routinely published protocols specifying actions to take when an officer dies by suicide. Include in these protocols:
  - Funeral policies
  - Family, agency, and community notification
  - Media relations
  - Post-incident counseling and agency wide mental health awareness actions

If an agency is committed to aggressively deploying the strategies outlined here, departments will foster healthier, stronger, and vastly more productive police departments, and possibly, prevent the devastating effects of mental illness on officers and their families, and the ultimate tragedy of officer death by suicide.

APPENDIX I: RESOURCES

Training Resources

"Preventing Law Enforcement Officer Suicide: A Compilation of Resources and Best Practices." In 2009, the IACP, the Bureau of Justice Assistance (BJA), and EEI Communications partnered to produce a valuable set of innovative resources to help law enforcement agencies prevent and respond to officer suicide. This product is a collection of materials from leading agencies around the country. This interactive CD-ROM contains sample suicide prevention print materials, presentations, training videos, reference publications, and much more. The purpose of this CD-ROM is to provide the law enforcement community with samples and resource materials to initiate a suicide prevention program. All materials were compiled and vetted by the IACP Police Psychological Services Section. EEI Communications and BJA volunteered to design and reproduce the CD-ROM at no cost, allowing the IACP to bring this much-needed product to the field quickly. Order your copy online through NCJRS at www.ncjrs.gov/App/shoppingcart/ShopCart.aspx?item=NCJ%20224436&repro=0

CD-ROM Content Summary:

1. **Developing a Law Enforcement Suicide Prevention Program** – five steps for initiating a campaign using public health principles.
2. **Sample Suicide Prevention Materials** – examples of brochures, posters, wallet cards, and program summaries.
3. **Sample Training Materials** – examples of training presentations, videos, and brochures used by law enforcement agencies.
4. **Sample Presentations** – examples of PowerPoint presentations on a wide range of suicide-related topics, both for the general public and law enforcement-specific.
5. **Sample Funeral Protocols** – examples of funeral protocols, death notifications, and other similar procedures.
6. **Additional Reading** – a wide range of supplemental reports, research, articles, and links to related online resources.
7. **About this CD** – acknowledgements and valuable contact information for key content contributors.

For more information, please contact Kim Kohlhepp at 703-836-6767 ext. 237 or kohlheppk@theiacp.org. For additional police psychological resources, visit the IACP Police Psychological Services Section website at www.theiacp.org/psych_services_section.

"In Harms Way: A Law Enforcement Suicide Prevention Toolkit." This law enforcement suicide prevention toolkit was developed by the Florida Regional Community Policing Institute and distributed to all Florida law enforcement agencies in October 2007. It was designed by law enforcement as well as subject-matter experts to assist departments in providing suicide prevention training, reducing the stigma associated with seeking help, and encouraging

officers to support one another. It includes PowerPoint presentations, model policies and procedures, best practices, research, and recommendations. By clicking on the link below, the user is guided to digital copies of printed materials that are provided in the Toolkit for download and printing. These materials can be customized with each agency seal, logo, name, phone numbers, and contact information. Agencies are permitted to reproduce copies free of charge for distribution within law enforcement agencies provided that agencies do not change the text or delete the credit.

http://cop.spcollege.edu/INHARMSWAYResourceOnline/StartHere.pdf

"QPR for Law Enforcement." The QPR Institute (Question, Persuade, and Refer) offers a customized, best practice suicide prevention training program designed specifically for law enforcement officers, families, and organizations. The basic QPR intervention is listed in the National Registry of Evidence-based Practices and Policies at nrepp.samhsa.gov/ViewIntervention.aspx?id=299.

For a description of the online version of the training go to courses.qprinstitute.com/index.php?option=com_zoo&task=item&item_id=12&Itemid=739.

Classroom training is also available, as is train-the-trainer courses. QPR is the most widely taught suicide prevention gatekeeper training program in the world, with more than 1,300,000 persons trained in more than a dozen countries. Learn more at www.qprinstitute.com.

Additional Training and Other Resources

1. "2012 National Strategy for Suicide Prevention: Goals and Objectives for Action." A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. http://www.armyg1.army.mil/hr/suicide/docs/10%20Sep%202012_NSSP_Final.pdf

   This guide was developed through the joint efforts of the Office of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention. It outlines 4 strategic directions with 13 goals and 60 objectives to help prevent suicides in the nation over the next decade.

2. Florida Suicide Prevention Strategy
   http://www.iadlest.org/Portals/0/Files/Documents/DOJ/Suicide/iacp_site/Educational%20Materials/Data%20&%20Reports/Florida%20Suicide%20Prevention%20Strategy.pdf

   This strategy outlines an integrated partnership between state government and citizen interest groups to lower Florida's suicide rate by one third.

3. U.S. Air Force Suicide Prevention Program
   http://www.af.mil/SuicidePrevention.aspx

   This is a website dedicated to the well-being of members of the U.S. Air Force and their families. It provides news and commentaries on suicide prevention strategies as well as links to the Military Crisis call and chat centers.

4. Great Lakes Summit on Gun Violence: Suicide Prevention Subgroup - Implications for Law Enforcement.
   http://www.iadlest.org/Portals/0/Files/Documents/DOJ/Suicide/iacp_site/Reference%20Material/Resource%20Materials/IACP%20Conference.doc
   The summit's main focus was to discuss prevention and intervention strategies for reducing the use of guns in suicides.

5. Developing a Law Enforcement Suicide Prevention Campaign Using Public Health Principles http://www.theiacp.org/%5CPortals%5C0%5Cpdfs%5CPreventingLESuicideCD%5Cintroduction.doc
   This document provides an abbreviated overview of how an agency can develop a suicide prevention program.

6. Emotional Survival for Law Enforcement. By Kevin M. Gilmartin.
   http://emotionalsurvival.com/
   This book provides information on how an officer's attitude and behaviors can deteriorate both personally and professionally over the years because of what they see every day. The book also provides them strategies on how this can be prevented. It is the goal of this book to help law enforcement personnel remain committed and engaged in their profession.

7. "Managing the Unexpected: Resilient Performance in an Age of Uncertainty." By Karl E. Weick and Kathleen M. Sutcliffe.
   http://www.josseybass.com/WileyCDA/WileyTitle/productCd-0787996491.html
   This book examines different high reliability organization models and how they address unexpected situations from the dramatic, such as a terrorist attack, to the mundane, such as small organizational lapses.

8. "A Guide for Early Responders Supporting Survivors Bereaved by Suicide." By Winnipeg Suicide Prevention Network (2012).
   http://www.suicideprevention.ca/wp-content/uploads/2012/07/Early-Responders.pdf
   This guide provides information for emergency responders on how survivors of a suicide loss may feel and how to support them.

9. "Connect Suicide Prevention and Intervention Training for Law Enforcement and Connect Suicide Postvention Training for Law Enforcement." By Connect.
   http://www.theconnectprogram.org/training-audiences/suicide-prevention-training-law-enforcement
   The Prevention and Intervention Training is designed to increase the competence of law enforcement officers in responding to suicide incidents. It includes best practices specific to law enforcement officers, interactive scenarios, agency policies and procedures, and discussion on how to integrate key community services for an effective and comprehensive response. The Postvention Training is designed to support proactive planning to provide a comprehensive integrated community response with other key service providers after a suicide death. Participants also learn how to reduce the risk of suicide contagion. Each training is six hours and can be tailored for specific audiences. The intended audience includes officers working in local or state law enforcement, schools, probation and parole agencies, and the juvenile justice system. This training is appropriate for all levels, including administrative staff, dispatch, and chiefs.

10. "How Can Emergency Responders Manage Their Own Response to a Traumatic Event?" By M.D. Lerner and R.D. Shelton in *Acute Traumatic Stress Management (2001).*
    http://www.sprc.org/library/EmergencyRespondersOwnResponse.pdf
    This two-page information sheet gives practical suggestions for how emergency responders can manage the way they respond to any traumatic event, including a suicide attempt or death, during and following their involvement in the situation.

11. Badge of Life Police Mental Health Program. By The Badge of Life.
http://www.badgeoflife.com/
This is a suicide prevention program for law enforcement officers. It includes the Emotional Self-Care training, which focuses on being mentally healthy and an annual mental health checkup with a licensed therapist. The website also lists some materials on officer suicide.

12. COPLINE. Hotline number: 800-267-5463.
http://copline.org/
This is a national hotline exclusively for law enforcement officers and their families. It is staffed by retired officers and a therapist with law enforcement experience to help active officers with the psychosocial stressors they face at work. The website also has some resources on officer suicide.

13. Law Enforcement Wallet Card. By Suicide Awareness Voices of Education (SAVE) (2008).
http://www.save.org/index.cfm?fuseaction=shop.productDetails&product_id=57D6AFB1-0933-0111-DC0761950356DACA
This wallet-sized card contains some of the warning signs for suicide and some basic steps that officers can take if they think a fellow officer is considering suicide.

14. National Police Suicide Foundation
http://www.psf.org/
This organization provides several different kinds of training programs on suicide awareness and prevention as well as support services that meet the psychological, emotional, and spiritual needs of law enforcement officers and their families.

15. Police Suicide Law Enforcement Mental Health Alliance
http://www.lemha.org
This network of groups and individuals promotes education and advocacy for new research and mental health strategies for police officers. The website provides access to a large number of written materials on police suicide and mental health.

16. Safe Call Now: Crisis line number: 206-459-3020.
http://safecallnow.org
Safe Call Now is a 24-hour crisis line for public safety employees and their families across the Unites States to talk with law enforcement officers, former officers, public safety professionals and/or mental health care providers who are familiar with public safety work. They provide education, healthy alternatives, and resources.

17. The Pain Behind the Badge
http://thepainbehindthebadge.com
At this website, information is available on the documentary film "The Pain Behind the Badge" and its associated seminar "Winning the Battle." Both focus on officer suicide and positive ways to deal with the stresses of being a law enforcement officer or other type of first responder.

18. "Suicide and Law Enforcement." By the Federal Bureau of Investigation and edited by D.C. Sheehan and J.I. Warren.
https://www.ncjrs.gov/pdffiles1/193528-193589.pdf
This book summarizes the results of a gathering of law enforcement officers, psychologists, attorneys, chaplains and employee assistance professionals who came together to discuss the impact suicide has on the law enforcement profession.

APPENDIX II: PARTICIPANTS

Beverly Anderson, Ph.D.
Director
Metropolitan (DC) Police Department

Ron Clark, RN, MS
Chairman of the Board
Badge of Life Psychological Survival for Police Officers

Scott A. Barthelmass
Corporal
Overland Park (KS) Police Department

Sarah Creighton
Captain
San Diego (CA) Police Department Wellness Unit

Pam Cammarata
Associate Deputy Director
Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice

Stephen Curran, Ph.D., ABPP
Atlantic OccuPsych

Joe Carter
Sergeant
Falls Church (VA) Police Department

Ed Daniel
Lieutenant
Montgomery County (MD) Police Department

Scott Davis
Crisis Intervention Team Coordinator
Montgomery County (MD) Police Department

Ed Flynn
Chief of Police
Milwaukee (WI) Police Department

Katherine Deal, MPH
Deputy Secretary
National Action Alliance for Suicide Prevention Suicide Prevention Resource Center
Education Development Center, Inc.

Theresa Fucigna, LCSW
Police Officer/Social Worker
Department of Employee Assistance
Nassau County (NY) Police Department

Robert Douglass, M.P.A
Founder
National Police Suicide Foundation

Virginia Hays, Ph.D.
Psychologist, Team Leader
Stress Management Team
Montgomery County (MD) Police Department

Joshua Ederheimer
Acting Director / Principal Deputy Director
Office of Community Oriented Policing Services
U.S. Department of Justice

Olivia Johnson, Ph.D.
Illinois State Representative
National Police Suicide Foundation

Mora L. Fiedler, MA
Senior Social Science Analyst
Office of Community Oriented Policing Services
U.S. Department of Justice

Todd Kirchgraber
Training Director
Center for Public Safety Innovation

Dean Kueter
Acting Chief of Staff / Assistant Director of External Affairs
Office of Community Oriented Policing Services
U.S. Department of Justice

John Morrisey
Chief of Police
Kenosha (WI) Police Department

Gary MacNamara
Chief of Police
Fairfield (CT) Police Department

Michelle Nuneville
Deputy Chief of Police
Arlington County (VA) Police Department

Heather McElroy, Ph.D.
Psychological Risk Management Consultant
Stone, McElroy & Associates

Chris Prochut
Commander (retired)
Bolingbrook (IL) Police Department

Bernard Melekian, M.P.A
Former Director (retired)
Office of Community Oriented Policing Services
U.S. Department of Justice
Pasadena (CA) Police Department

Anastasia Pytal, Ph.D.
Employee Assistance Program
Metropolitan (DC) Police Department

Elaine Moore
Commander, Psychological Services
Prince George's County (MD) Police Department

Paul Quinnett, Ph.D.
Founder and CEO
QPR Institute
University of Washington School of Medicine

Sandra Ramey, Ph.D.
Assistant Professor
College of Public Heath
University of Iowa

Beau Thurnauer
Deputy Chief of Police
East Hartford (CT) Police Department

Eddie Reyes
Deputy Chief
Alexandria (VA) Police Department

John Violanti, Ph.D.
Research Professor
University of Buffalo, State University of New York
School of Public Health & Health Professions
Department of Social & Preventative Medicine

Joseph Rollo, LCSW
Director of Psychological Services
Prince George's County (MD) Police Department

Darlene Warrick McLaughlin, M.D.
Associate Program Director
Department of Psychiatry and Behavioral Science
Texas A&M Health Science Center
College of Medicine

Stephanie Samuels, MA, MSW, LCSW
Founder
COPLINE

John Wells
Program Specialist
Office of Community Oriented Policing Services
U.S. Department of Justice

Donna Schulz
Law Enforcement Coordination Manager (retired)
Middle District of Florida
United States Attorney's Office

APPENDIX III: PROJECT STAFF

IACP EXECUTIVE STAFF

Bart R. Johnson
Executive Director
International Association of Chiefs of Police

James W. McMahon
Deputy Executive Director / Chief of Staff
International Association of Chiefs of Police

John Firman
Director – Research Center
International Association of Chiefs of Police

Walter A. McNeil
IACP Immediate Past President
Chief of Police
Quincy (FL) Police Department

Yost Zakhary
IACP 1st Vice President
Chief of Police
Woodway (TX) Public Safety Department

IACP PROJECT STAFF

Rachel Apfelbaum
Research Center Intern

Ross Arends
Supervisory Special Agent
Bureau of Alcohol, Tobacco, Firearms and Explosives
IACP Fellow

Jenny Gargano
Research Center Coordinator

Lucia Arias
Finance & IT Intern

Ian Hamilton
Project Manager

Dianne Beer-Maxwell
Program Manager

Kim Kohlhepp
Manager, Center for Testing Services and Career Development

Christie Bogle
AFOSI Liaison to the IACP

Michael Lagana
Research Center Intern

Aeriale Cooksey-Kramer
State & Provincial Police Intern

Bethany Petersen
Conference Program Intern

John D'Amico
SACOP Intern

Tracy Phillips
Senior Project Specialist

Ryan Daugirda
Project Coordinator

Michael Rizzo
Project Manager

Rock Thomas
NCIS Representative to the IACP

John Tyler
State & Provincial Police Intern

Chrystal Tibbs
Visiting Fellow Research Division

Erin Vermilye
SACOP Manager

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Centers for Disease Control and Prevention. 2010. *Suicide: Facts at a Glance.* Centers for Disease Control and Prevention. http://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf.

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Clark, Ron, RN, MS, and Andy O'Hara. 2012. "2012 Police Suicides: The NSOPS Study," Police Suicide Study. Last modified January 4, 2013. http://www.policesuicidestudy.com/id16.html.

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International Association of Chiefs of Police, Bureau of Justice Assistance and EEI Communications. 2009. "Preventing Law Enforcement Officer Suicide: A Compilation of Resources and Best Practices." *International Association of Chiefs of Police.* http://www.theiacp.org/Preventing-law-Enforcement-officer.

Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012. "2012 National Strategy for Suicide Prevention: Goals and Objectives for Action." *U.S. Department of Health and Human Services.* http://www.armyg1.army.mil/hr/suicide/docs/10%20Sep%202012_NSSP_Final.pdf.

Steckler, Craig. 2013. "IACP: Breaking the Silence on Law Enforcement Suicides." *The Police Chief,* July. http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display&issue_id=72013&category_ID=2.

ABOUT IACP

The International Association of Chiefs of Police (IACP) is a dynamic organization that serves as the professional voice of law enforcement. Building on our past success, the IACP addresses cutting edge issues confronting law enforcement though advocacy, programs and research, as well as training and other professional services. IACP is a comprehensive professional organization that supports the law enforcement leaders of today and develops the leaders of tomorrow.

ABOUT THE COPS OFFICE

The Office of Community Oriented Policing Services (COPS Office) is the component of the U.S. Department of Justice responsible for advancing the practice of community policing by the nation's state, local, territory, and tribal law enforcement agencies through information and grant resources.

Community policing is a philosophy that promotes organizational strategies that support the systematic use of partnerships and problem-solving techniques, to proactively address the immediate conditions that give rise to public safety issues such as crime, social disorder, and fear of crime.

Rather than simply responding to crimes once they have been committed, community policing concentrates on preventing crime and eliminating the atmosphere of fear it creates. Earning the trust of the community and making those individuals stakeholders in their own safety enables law enforcement to better understand and address both the needs of the community and the factors that contribute to crime.

The COPS Office awards grants to state, local, territory, and tribal law enforcement agencies to hire and train community policing professionals, acquire and deploy cutting-edge crime fighting technologies, and develop and test innovative policing strategies. COPS Office funding also provides training and technical assistance to community members and local government leaders and all levels of law enforcement. The COPS Office has produced and compiled a broad range of information resources that can help law enforcement better address specific crime and operational issues, and help community leaders better understand how to work cooperatively with their law enforcement agency to reduce crime.

- Since 1994, the COPS Office has invested more than $14 billion to add community policing officers to the nation's streets, enhance crime fighting technology, support crime prevention initiatives, and provide training and technical assistance to help advance community policing.
- By the end of FY2013, the COPS Office has funded approximately 125,000 additional officers to more than 13,000 of the nation's 18,000 law enforcement agencies across the country in small and large jurisdictions alike.
- Nearly 700,000 law enforcement personnel, community members, and government leaders have been trained through COPS Office-funded training organizations.
- As of 2013, the COPS Office has distributed more than 2 million topic-specific publications, training curricula, white papers, and resource CDs.

COPS Office resources, covering a wide breadth of community policing topics—from school and campus safety to gang violence—are available, at no cost, through its online Resource Center at www.cops.usdoj.gov. This easy-to-navigate website is also the grant application portal, providing access to online application forms.

NOTES

1 Adapted and reprinted in part from Craig T. Steckler, "IACP: Breaking the Silence on Law Enforcement Suicides," President's Message, *The Police Chief 80* (July 2013): 6, http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display&issue_id=72013&category_ID=2.

2 Federal Bureau of Investigation: Law Enforcement Officers Killed and Assaulted, *2012 Law Enforcement Officers Feloniously Killed and Assaulted,* (2012), http://www.fbi.gov/about-us/cjis/ucr/leoka/2012.

3 Ron Clark, RN, MS, and Andy O'Hara, "2012 Police Suicides: the NSOPS Study," http://www.policesuicidestudy.com/id16.html.

4 Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* (Washington, DC: U.S. Department of Health and Human Services, September 2012), http://www.armyg1.army.mil/hr/suicide/docs/10%20Sep%202012_NSSP_Final.pdf.

5 Daniel W. Clark, Elizabeth K. White, and John M. Violanti, "Law Enforcement Suicide: Current Knowledge and Future Directions," *The Police Chief* 79 (May 2006): *48–51*, http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display_arch&article_id=2669&issue_id=52012.

6 *Suicide: Facts at a Glance*, Centers for Disease Control and Prevention, 2012, http://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf.

7 Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* (Washington, DC: U.S. Department of Health and Human Services, September 2012): 10, http://www.armyg1.army.mil/hr/suicide/docs/10%20Sep%202012_NSSP_Final.pdf.

8 Federal Bureau of Investigation: Law Enforcement Officers Killed and Assaulted, *2012 Law Enforcement Officers Feloniously Killed and Assaulted,* (2012), http://www.fbi.gov/about-us/cjis/ucr/leoka/2012.

9 Ron Clark, RN, MS, and Andy O'Hara, "2012 Police Suicides: the NSOPS Study," (2013), http://www.policesuicidestudy.com/id16.html.

10 Daniel W. Clark, Elizabeth K. White, and John M. Violanti, "Law Enforcement Suicide: Current Knowledge and Future Directions," *The Police Chief* 79 (May 2006): 48–51, http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display_arch&article_id=2669&issue_id=52012.

11 Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* (Washington, DC: U.S. Department of Health and Human Services, September 2012: 21), http://www.armyg1.army.mil/hr/suicide/docs/10%20Sep%202012_NSSP_Final.pdf.

12 *Preventing Law Enforcement Officer Suicide: A Compilation of Resources and Best Practices* (International Association of Chiefs of Police, Bureau of Justice Assistance and EEI Communications, 2009), http://www.theiacp.org/ViewResult?SearchID=988.

13 Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* (Washington, DC: U.S. Department of Health and Human Services, September 2012: 19), http://www.armyg1.army.mil/hr/suicide/docs/10%20Sep%202012_NSSP_Final.pdf.

The COPS Office partnered with the International Association of Chiefs of Police (IACP) to sponsor the *National Symposium on Law Enforcement Officer Suicide and Mental Health: Breaking the Silence of Law Enforcement Suicides* in the summer of 2013. The strategies outlined in this report are designed as a roadmap for police departments seeking to include officer mental wellness as a core element of officer safety and well-being and to mitigate the threat of officer death by suicide. These strategies are designed to **prevent** the destructive effects of emotional trauma, mental illness, and officer deaths by suicide on a police community; to successfully **intervene** when officers confront mental health crises, mental illness, or suicidal behavior; and, to provide effective **event response** protocols when an officer dies by suicide in an agency.

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

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

Visit the COPS Office Online at **www.cops.usdoj.gov**.

ISBN: 978-1-932582-90-1
e21411629

LAW ENFORCEMENT WELLNESS

Officer Danny Veith*

Colorado Fraternal Order of Police**

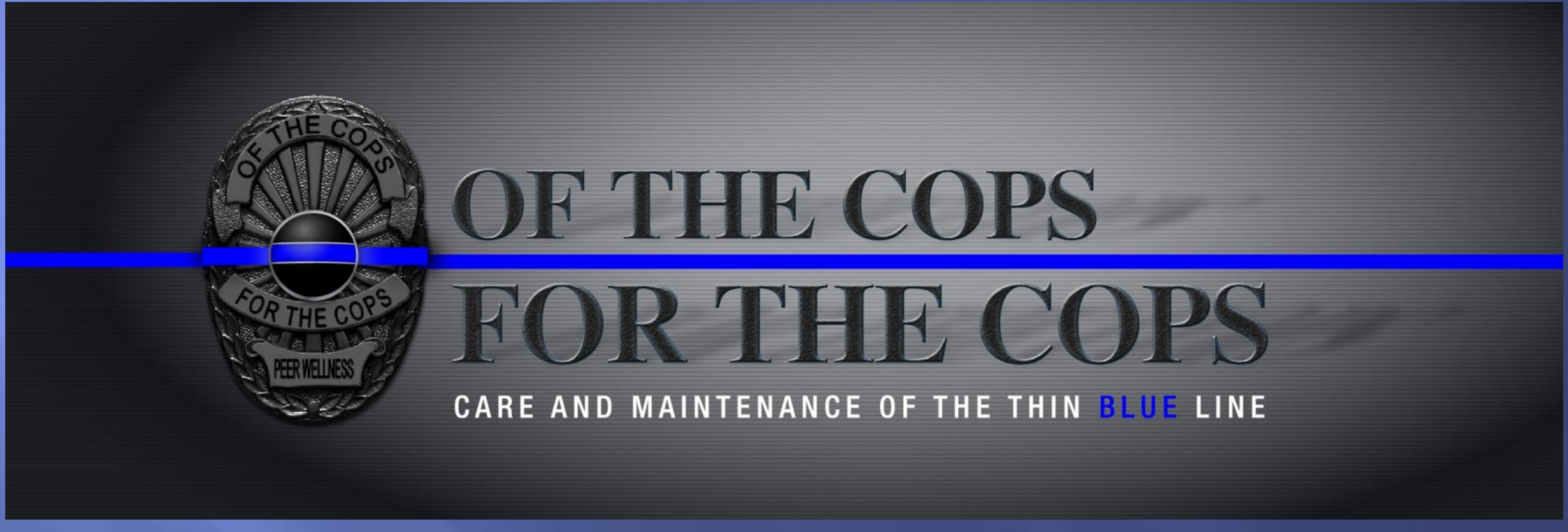
PTSD Task Force Sub-Committee Report

July 31, 2014 Colorado State Capitol

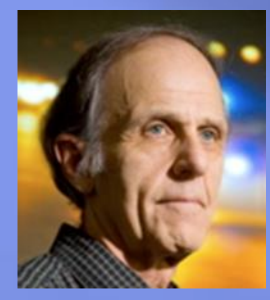
* Per my Deputy Chief, I cannot participate on Task Force on duty (my personal time only);
** Per my Deputy Chief, I cannot represent the Denver Police Department

"Resiliency in Law Enforcement"

www.OfTheCops.com



Threats to an officer's health & wellness normally a two-hour block of my instruction… A quick overview in 30 minutes.



John M. Violanti, PhD (Research Professor, Department of Epidemiology and Environmental Health) University at Buffalo, NY

Commission on Accreditation for Law Enforcement Agencies (2005 report)

Journal American Medical Association (December, 2011)

***POWER* – Police Officer Wellness & Employee Resources…** an employee assistance and wellness program at Denver PD from 2008 to 2012

What Kills the Body, Kills the Brain

The Brain is Plastic. To remain resilient - and thus resistant to PTSD - our brain needs:

1. Exercise (Aerobic)
2. Nutrition (Diet that promotes heart health)
3. Sleep (7 to 8 hours of quality sleep)

Metabolic Syndrome is a risk factor for heart disease, stroke, diabetes, and negatively affects the brain.

Glenn R. Schiraldi, PhD *The Complete Guide to Resilience*

Dying From The Job: The Mortality Risk For Police Officers

- John Violanti, PhD (published 1997)
- Meta-analysis of available studies between 1950 – 1990
- **66-years-old** – average age at death for police officers
- In 1990, average life expectancy for both genders, all races – 75.4
- In 2010, average life expectancy for both genders, all races – 78.7

Florida Mortality Study - 2011

Florida Law Enforcement & Corrections Officers
(compared to)
Florida General Population

Average Age at Death –
Florida LE & Corrections Officers – **62.4 Years**
Florida General Population - **74.2 Years**

http://www.floridastatefop.org/pdf_files/floridamortalitystudy.pdf

"…most published and anecdotal experience suggests police officers live on average two to five years post retirement, depending on the source."

The Commission on Accreditation for Law Enforcement Agencies, Health and Fitness in Law Enforcement: A Voluntary Model Program Response to a Critical Issue

Job Stress & Wellness

U.S. Department of Labor has identified 747 occupations…

- What is the stress tolerance of each occupation?
- Frequency?
- Consequence of errors / mistakes?
- Time restraints / deadlines?
- Imminent danger?
- Scrutiny in the public eye?
- Work competition & relationships?
- Lists for the most stressful jobs are SUBJECTIVE

1. Working Parents
2. Deployed Military Personnel
3. **Police Officer**
4. Teacher
5. Medical Personnel
6. Emergency Personnel
7. Airline Pilot
8. Newspaper Reporter
9. Corporate Executive
10. Miner

(How Things Work October 12, 2010)

1. Enlisted Military Personnel
2. **Police Officer**
3. Miner
4. Taxi Driver
5. Firefighter
6. Commercial Airline Pilot
7. Newspaper Reporter
8. Photojournalist
9. Loss Prevention Officer
10. Mental Health Case Manager
11. Medical Professional
12. Chaplain
13. Assisted Living Manager
14. Military General
15. Purchase Agent

(List25 Most Stressful Jobs of 2013)

1. Enlisted Military Personnel
2. Military General
3. Firefighter
4. Airline Pilot
5. Event Coordinator
6. Public Relations Executive
7. Senior Corporate Executive
8. Newspaper Reporter
9. **Police Officer**
10. Taxi Driver

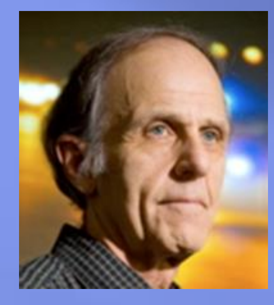
(Chad Brooks, Business News Daily, January 13, 2014)

1. Psychiatric Aides
2. Police, Fire, EMS Dispatchers
3. Psychiatric Technicians
4. Dancers
5. OB GYN
6. Surgeons
7. Air Traffic Controllers
8. Pilots
9. Phlebotomy Techs
10. Nurse Anesthetists
11. Broadcast News Analysts
12. Education Administrators
13. Mental Health Counsellors
14. **First-line Supervisors of Police & Detectives**

(Laurence Shatkin, PhD by Vivian Giang, Business Insider December 26, 2013)

Stress Levels vs Impact

- Headaches
- High Blood Pressure
- Heart Problems
- Diabetes
- Abdominal Fat
- Metabolic Syndrome
- Sleep Disorders
- Skin Conditions
- Asthma
- Arthritis
- Depression
- Anxiety
- Maladaptive Coping (Alcohol, Tobacco, & Drugs)



Stress & Disease

"Psychological stress plays a role in the etiology (cause) of disease."

"Psychological stress may also be a catalyst for malignancy at selected sites. Stress is believed to be mediated immunologically and may lead to the onset of cancer."

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- Atrial Fibrillation
- Cholesterol Management
- Diabetes
- Heart Failure

Heart Disease Health Center

Tools & Resources

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- The Warning Signs of Stroke
- The Truth About Napping
- Low T Health Risks

Listen

Stress Raises Belly Fat, Heart Risks

Study Shows Monkeys Under Long-Term Stress Put on Belly Fat, Get Heart Disease

Save This Article For Later | Share this: | Font size: A A A

By Daniel J. DeNoon
WebMD Health News

Reviewed by Louise Chang, MD

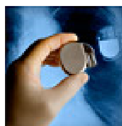
WebMD News Archive

Aug. 6, 2009 - Monkeys fed an American diet get fat -- but those under chronic stress put on much more belly fat.

That extra belly fat is why the stressed monkeys are much more likely to suffer blocked arteries and metabolic syndrome, a constellation of risk factors for heart disease, suggest Carol A. Shively, PhD, and colleagues at Wake Forest University.

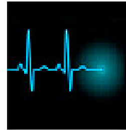
Today on WebMD

ARTICLE
Low T & Heart Disease: What's the Link?



SLIDESHOW
Ways to Treat Atrial Fibrillation

SLIDESHOW
Nutrients Every Woman Needs

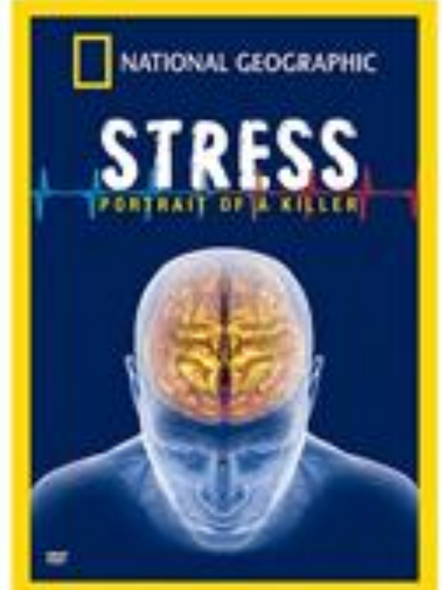


TOOL
How to Live Better With AFib

ADVERTISEMENT

Ranked one of the top two hospitals for cancer care for 25 years.

PBS - where your purchase supports public broadcasting.



Stress: Portrait of a Killer DVD

Own this DVD about Robert Sapolsky's quest to understand the possibly deadly effects of chronic stress on humans and other primates.

BUY NOW

2008

2009

2008

2010

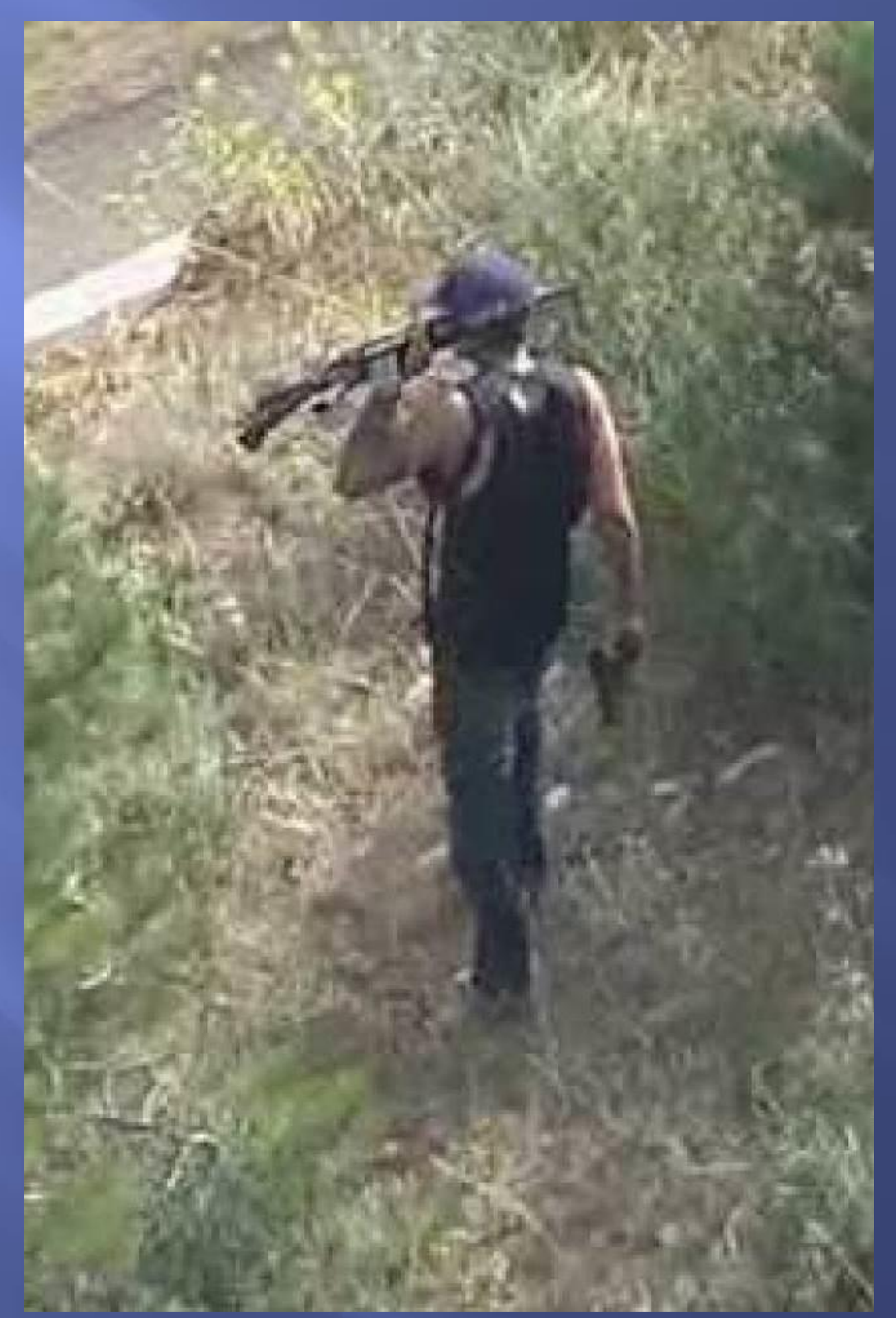
2010

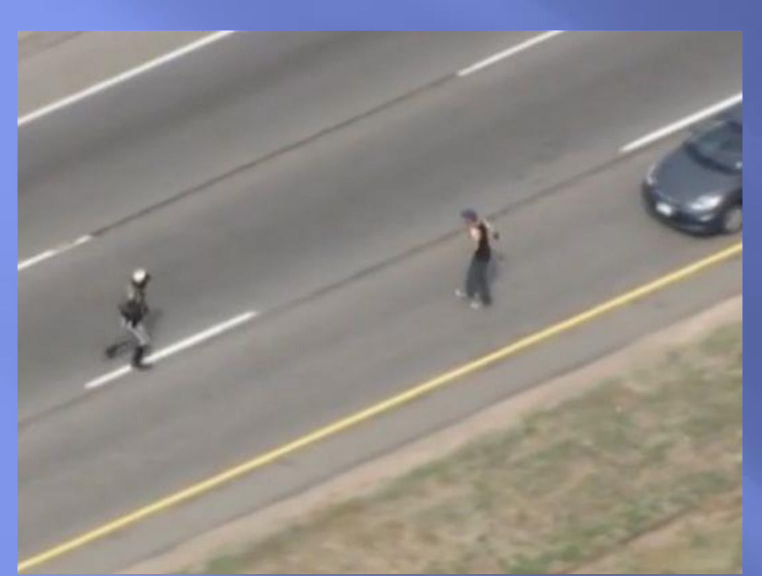
Stress in Law Enforcement

"There is need for police departments to consider alternatives to police organizational structure which can produce much of the stress experienced by police officers. Officers report that approximately 90% of stress in their work is a result of a highly structured, unresponsive, uncaring administration. Changes should include allowing officers the opportunity to participate in decisions affecting their work, and a greater organizational awareness of problems at the street level."

Why?

Control





Administration

Zero to Limited Control over…

- Policy, Procedure, Protocol,…
- IAB / Investigation Process & Outcome
- Risk Management Decisions
- Department's Response to Media
- Department's Response to Citizen Groups, Special Interest Groups, Critics,…
- "Civilian" Oversight, Control, Influence

Stress Levels

Dr. Violanti found police officers with 10-19 years of service reported the highest stress scores.

Stress Levels

"Younger officers, under the age of 35, have a lower risk of medical problems than the average American, but officers 35+ years of age have a higher risk."

Primary Concern for DPD Officers Year 2011 (11 to 20 years on the Job)

Relationship issues	80	
Career Stress	53	
Officer or Family Illness	36	
IA Investigation	22	
Stress from Child / Dependent	20	
Problem with Supervisor	18	
Other Critical Incident (non OIS)	17	
Alcohol (all in the 16 – 20 year category)	15	
Financial Stress	14	
Legal Issues	7	
Officer Involved Shooting	6	
Problem with Subordinate	5	
Criminal Investigation	2	
Outside Agency Investigation	1	
Witness Officer in Officer Involved Shooting	1	307 Contacts

Officers Age 35+ at Higher Risk for Medical Problems Because…

- Cigarette smoking;
- Obesity, that is 25%+ body fat for males and 30%+ females;
- Poor nutrition, which is a significant contributor to the incidence of diabetes and colon cancer among law enforcement officers;
- Substance abuse;
- Sedentary living or poor cardiovascular fitness; and
- Stress – stress management is consistently defined as an in-service training priority by agencies

635 DPD Officers Hired between 2000 - 2008

Mandatory Attendance, in 2011,
In my 8-hour Wellness Class

557 (88%) participated in the APFT

272 (43%) successfully passed the APFT

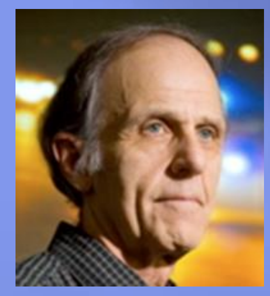
Officers with 10 – 19 Years

Dr. Violanti found police officers with 10-19 years of service reported the highest stress scores.

And

These officers used maladaptive behaviors to deal with the stress…

JAMESON
Established
Triple Distilled
IRISH WHISKEY
PRODUCT OF
IRELAND



Violanti found 25% of police officers experience alcohol dependency

And

40% of police officers smoked

(meta-analysis 1950 to 1990)

Dr. Violanti Learned

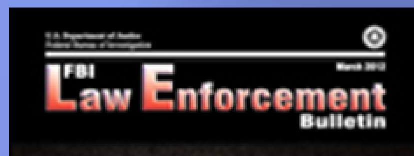
- Officers at significantly high mortality risk for esophageal cancer (stress + alcohol + smoking)

- Significantly elevated risk of cirrhosis of the liver

Cirrhosis of the liver was elevated across all years of service categories and had a 3.3 fold mortality risk for officers with 30+ years of service.

Health Risks of Chronic, Heavy Drinking

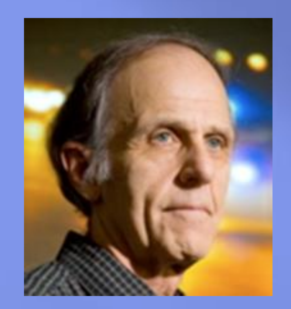
1. Anemia
2. Cancer
3. Cardiovascular Disease (CVD)
4. Cirrhosis
5. Dementia
6. Depression
7. Seizures
8. Gout
9. Hypertension
10. Nerve Damage
11. Pancreatitis



FBI Bulletin 2005

"Nearly 30% of police officers overindulge in alcohol compared with 10% of the general population."

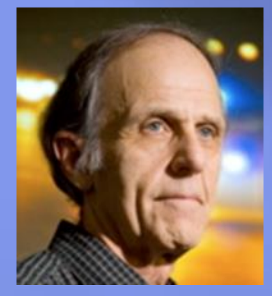
FBI Law Enforcement Bulletin – May 2005
(Ret) Lt Daniel – Maryland State Police
With John Hopkins University



Ultimate Maladaptive Behavior

"The significantly high suicide risk among police officers in our study denotes the possibility that chronic job stress may lead to emotional numbing in officers and make death easier to accept as a coping solution."

" Another reason for the high suicide rate may be the availability and knowledge of firearms. Approximately 95% of all police suicide involve the use of a firearm."



"The police have a higher rate of firearm suicide than other groups who work with firearms."

Military – 59% of military suicides compared to 95% of police officer suicides used a firearm.

Home owners with guns – 58% of all suicides committed with a firearm

(1950 – 1990 meta-analysis, pre OEF/OIF)

Alcohol & Police Suicide

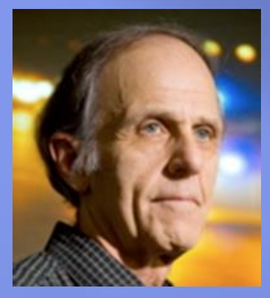
"Alcohol use has also been found to be a factor in suicide, and police use of alcohol may be precipitated by stress. A Chicago police department study documented alcohol abuse in 60% of police officer suicides."

Severe depression, which often leads to officer suicides, is sometimes linked to PTSD but can also be brought on by other life-altering trauma or events. In 2010, "there were 145 police suicides in the United States, a slight increase over 2009, during which there were 143. The suicide rate for police officers remains 17/100,000, compared to the general population's rate of 11/100,000."[31] Depression is debilitating and does not always result in suicide; it can manifest itself from ongoing stress and fatigue, which can also lead to alcoholism, drug abuse, and domestic violence.

http://www.cops.usdoj.gov/pdf/OSWG/e091120401-OSWGReport.pdf

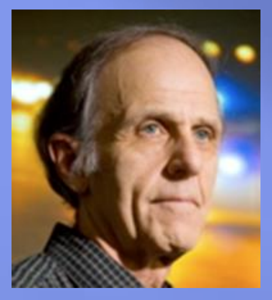
Shift Work

- Working “Swing” and “Graveyard” Shifts
- Child Care Responsibilities
- Court Appearances
- Mandatory Training (different hours)
- “Extra Duty” or “Off Duty” work



Sleep

Disruption of Circadian cycle adds to risk of heart disease.

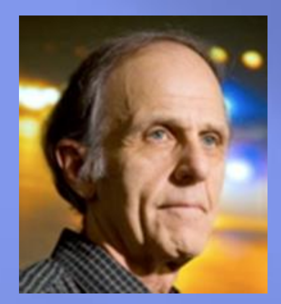


Nutrition

General nutrition of officers is poor (lack fruits and vegetables) and they consume meals high in fat (fast food) at unscheduled times - sometimes between high stress calls.

Regular Exercise

Shift work adversely influences regularly scheduled exercise regimens.



Poor Sleep & Diet, + Poor Exercise Habits

In addition to elevated risk of heart disease:

76% of officers had elevated cholesterol
26% elevated triglycerides
60% elevated body fat

"Other studies have shown that only police officers who exercised regularly had a lower 10-year risk of heart disease and were absent less from work."

Metabolic Syndrome

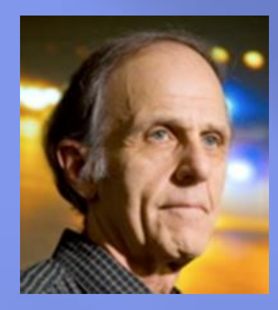
A combination of any 3 of these abnormalities:

- Obesity (40-inch + waistline in men, 34.5 + in women)
- Elevated triglycerides (above 150)
- Reduced HDL (less than 40 in men, less than 50 in women)
- Glucose intolerance
- Hypertension (blood pressure higher than 130/85)

Risks of Metabolic Syndrome

A combination of any 3 of these abnormalities is said to constitute metabolic syndrome, a condition that carries an increased risk of such health perils as

- stroke,
- cardiovascular disease,
- and Type 2 diabetes.



Graveyard Shift

"Officers who predominately work midnights are at greater risk of developing severe health problems than civilians and other cops, especially if they average more than 90 minutes of overtime per week and have trouble sleeping."

"Shifts, Extended Work Hours, and Fatigue: An Assessment of Health and Personal Risks for Police Officers" https://www.ncjrs.gov/pdffiles1/nij/grants/237964.pdf March 2012

At Greater Risk

"In measurement of triglycerides and glucose intolerance, midnight officers fared slightly better than their afternoon counterparts,

BUT IN NO CATEGORY were late-shift officers found to be in better shape than officers working days.

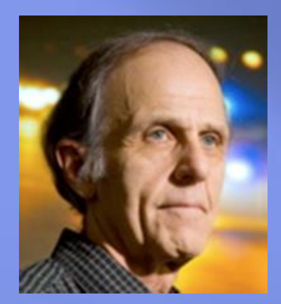
Overall, 30% of midnight officers had metabolic syndrome, versus 11% on days and about 15% on nights (swing shift)."

At Greater Risk

"Studies of the general population have found about that about 22% exhibit metabolic syndrome, and that includes sick people, old people, and others who might be expected to have a negative impact on the number.

Cops at least have been screened for good overall physical and mental health when they joined the force.

Besides that, officers who worked midnights tended to be younger than those working days by an average of 6 years."



Insufficient Sleep

Insufficient sleep causes hormonal changes that, in effect, make the body crave quick energy bursts.

"This triggers an appetite for the kind of foods that result in weight gain, bad cholesterol, and strain on the organs that help you metabolize sugars. In turn, being overweight makes you more susceptible to sleep apnea and other problems that interfere with restorative sleep."

USA TODAY

NEWS SPORTS LIFE MONEY TECH TRAVEL OPINION 74° CROSSWORDS YOUR TAKE INVESTIGATI

This story is part of HEALTH AND WELLNESS

Hysterectomy device pulled, may raise risk of spreading cancer

Study supports screening for 'bubble boy' disease

How sleep loss leads to significant weight gain

Nanci Hellmich, USA TODAY 9:08 a.m. EDT July 20, 2014

Insufficient sleep affects appetite and satiety hormones as well as fat cells, according to the nation's top sleep experts.

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(Photo: Brett T. Roseman for USA TODAY)

If you want to lose weight, be sure to get enough sleep.

Most people know they should cut calories and exercise more to trim down, but there's now significant scientific evidence that another critical component to weight control is avoiding sleep

5 Foods to never eat:
Cut down a bit of killer fat every day by never eating these 5 foods.
NEVER EAT

"Endocrine function and body balance are disturbed by circadian (daily rhythm) disruption. Working nights, especially on a job that's highly stressful, can cause significant wear and tear on the body."

"In summary, the results of this study show that as sleep quality gets worse, depressive symptoms do as well."

Shift Work Recognized as a Carcinogen

- Int’l Agency for Research on Cancer (IARC);
- Nat’l Inst for Occupational Safety & Health;
- Institute for Work Health;

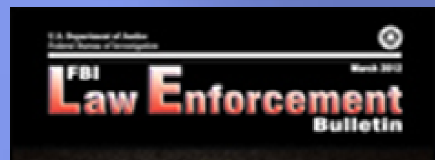
Heart Disease

"Surveys suggest heart disease accounts for 20% to 50% of early retirements."

(back problems account for 15% to 35%)

"The risk of having a heart attack doubles with each decade of law enforcement service."

"Since the year 2000, the average age of a Police Officer, dying from a heart attack or sudden cardiac arrest is 47 years of age."

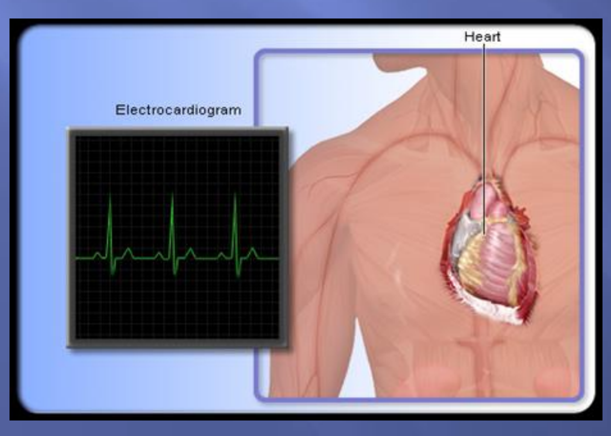


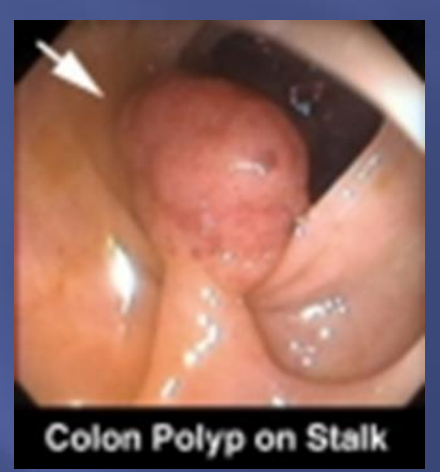
FBI Bulletin 2005

"Officers suffer more often from heart disease, hypertension, and diabetes than the general public.

"They have an above average risk for heart attacks, obesity, arthritis, ulcers, and cancer while also prone to bouts of depression and suicide."

"As an occupational group, law enforcement officers have greater morbidity and mortality rates than the general public, principally due to cardiovascular disease, colon cancer, and suicide."





Sleep Disorders, Health,
And Safety in Police Officers

December 2011

JAMA 2011;306(23):2567-2578. doi: 10.1001/jama.2011.1851

- 5,000 officers (half from major city police department; half from a state police agency);
- 40% reported symptoms consistent with at least one sleep disorder (twice national rate);
- The prevalent sleep disorder was Obstructive Sleep Apnea (OSA)

- Obesity contributes to OSA;
- 30% of officers in study had a BMI of 30+ (obesity);
- Major city police had higher rate of obesity than the state police;

- 28% of all officers reported excessive sleepiness;
- 26% reported falling asleep while driving at least once a month;
- “the loss of even 2 hours of nightly sleep for 1 week is associated with decrements in performance comparable with those seen after 24 hours of continuous wakefulness.”

- Officers with sleep disorder significantly more likely to display uncontrolled anger toward a suspect or citizen;
- Sleep disorders factor in higher rates of absenteeism;
- Officers with OSA at significantly higher risk of heart disease and diabetes;
- Plays role in depression and "burnout."

Healthy in Mind, Body, & Spirit

- Mind (stress management at home & work, peer support, psych services, CISM Debriefings, EMDR, Cognitive Behavioral Therapy, etc)
- Body (regular exercise, regular sleep, good nutrition, preventative screenings, etc)
- Spirit (purpose in life, personal mission statement, emotional intelligence, resiliency, faith / religion, Socrates, Plato, Epictetus, Marcus Aurelius, etc)