



An Occupational Risk:

*What Every Police Agency Should Do
To Prevent Suicide Among Its Officers*



CRITICAL ISSUES IN POLICING SERIES

An Occupational Risk:

*What Every Police Agency Should Do
To Prevent Suicide Among Its Officers*

October 2019



POLICE EXECUTIVE
RESEARCH FORUM

This publication was supported by the Motorola Solutions Foundation. The points of view expressed herein are the authors' and do not necessarily represent the opinions of the Motorola Solutions Foundation or all Police Executive Research Forum members.

Police Executive Research Forum, Washington, D.C. 20036
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Printed in the United States of America

ISBN: 978-1-934485-54-5

Graphic design by Dave Williams.

Text photos by Matthew Bencivenga/NYPD.

Contents

Acknowledgments..... 1

Executive Summary: We Need to Make the Prevention of Police Suicides a National Priority 3

Addressing the Crisis of Law Enforcement Suicide..... 4

What Research Can Tell Us about Law Enforcement Suicide..... 4

Promising Strategies and Programs 5

Law Enforcement Leaders Play a Crucial Role in Reducing Stigma 6

10 Recommended Actions for Preventing Officer Suicides 7

A National Commitment to Suicide Prevention 8

Message from New York City Police Commissioner James P. O’Neill 9

Part One: Research, Risk Factors for Suicide, and Challenges..... 11

What the Data Tell Us about Suicide 11

 National Statistics on Suicide..... 11

Sidebar: Blue H.E.L.P. Collects Data on Officer Suicides and Assists Families..... 12

Sidebar: Police Suicides: An International Perspective 15

What We Know about Suicide Risk Factors..... 17

 Stigma Against Seeking Mental Health Care 17

Sidebar: Stories of Three Officers Who Have Experienced Suicidal Thoughts— and What We Can Learn from Them 18

 Masking 21

 Cumulative Effects of Trauma 21

 Depression..... 22

 Alcohol Abuse and PTSD 22

Sidebar: The Impact of Organizational, Operational, Occupational, and Family Variables on Officer Suicide 23

Sidebar: Suicide Among Retired Officers 24

Availability of Firearms 25

Warning Signs..... 25

Turning Research into Action..... 26

Sidebar: A Montréal Police Program Reduced Officer Suicide Rate by 79 Percent 27

Part Two: 10 Recommended Actions to Prevent Suicide Among Police Officers..... 29

Recommended Action 1: Data Collection 29

Sidebar: National Occupational Mortality Surveillance (NOMS) Program; National Violent Death Reporting System (NVDRS)..... 30

Recommended Action 2: Psychological Autopsies..... 31

Sidebar: Elements of a Psychological Autopsy 31

Sidebar: How the NYPD and LAPD Use Psychological Autopsies..... 32

Recommended Action 3: Routine Mental Health Checks..... 34

 Implementing effective mental health check programs 35

Sidebar: Fairfax County, VA Survey Led to Mandatory Mental Health Checks..... 36

Recommended Action 4: Leadership from the Top..... 37

Recommended Action 5: Gun Removal Policy 38

Sidebar: How Chicago Addressed a Technicality in Illinois Law that Was Affecting Officers Seeking Mental Health 39

Recommended Action 6: Confidential Support Programs and Training..... 41

 Employee Assistance Programs (EAP) 41

 Maintaining Confidentiality..... 43

 Peer Support Units 44

 The Boston Police Department’s Peer Support Unit 44

NYPD's POPPA Program 44

Sidebar: Boston's LEADER program 45

Sidebar: The Role of Resilience in Combating Suicide 46

Recommended Action 7: Easy-to-Access Tools 47

American Foundation for Suicide Prevention
Interactive Screening Program 47

Cordico Shield mobile wellness app 49

Crisis Text Line 49

Recommended Action 8: Regional Partnerships 50

Southeastern Massachusetts Law Enforcement
Council 50

Prince William County, VA Wellness and
Resiliency Unit 50

Western New York Police Hotline 50

Recommended Action 9: Family Support 51

Recommended Action 10: Communications Plan 52

*Sidebar: Thoughtless news coverage can
increase the likelihood of additional suicides* 53

**Conclusion: Action to Prevent Police
Officer Suicides Is Overdue 54**

About PERF 56

About the Motorola Solutions Foundation 57

Appendix: Participants at the Critical Issues
Meeting, "Suicide Among Members of
Law Enforcement Agencies" 58



Acknowledgments

SUICIDE AMONG MEMBERS OF LAW ENFORCEMENT is not an easy topic to approach. It is sad and painful on many levels. It is challenging to research and, therefore, difficult to understand. Many people find it hard even to talk about the subject.

But it is imperative that we do talk about the problem, try to understand it more fully, and find new ideas for preventing suicide among our officers, because officer suicide is a national crisis. More officers die by suicide each year than are killed in the line of duty. Nationwide, the risk of suicide among police officers is 54 percent greater than among American workers in general. This is why PERF decided to take on this issue as part of our *Critical Issues in Policing* series.

As PERF started researching officer suicide, we knew that it would be helpful to have a police agency working with us—a department that understood the issue and was already undertaking new approaches to it. When I asked New York City Police Commissioner James O’Neill about partnering with us, he did not hesitate in saying yes. The NYPD has faced enormous challenges with officer suicide; as of early October, nine officers have taken their lives in 2019, which is roughly three times higher than the average in recent years. The department has devoted tremendous energy and resources to addressing the problem, and the NYPD has had the courage to talk about it openly and honestly.

The NYPD was an invaluable partner throughout this project. For our national conference on suicide prevention on April 2, 2019, the department provided the venue—its auditorium at One Police Plaza—and helped to manage the meeting logistics, including room setup, audio-visual services, photography, registration, and all the other details that go into a PERF meeting. With more than 300 participants, this was one of our largest *Critical Issues* meetings ever, and we relied on the support of Commissioner O’Neill and his team.

The NYPD also was instrumental in helping PERF develop the agenda, ensuring we had the best experts in the room, and facilitating a productive dialogue. Commissioner O’Neill and other members of the NYPD made presentations and contributed to the discussion at our meeting. While there are too many people to acknowledge individually, a few deserve special recognition for their support of this project: First Deputy Commissioner Benjamin Tucker; Chief of Department Terence Monahan; Chief of Strategic Services John Donohue; Chief of Patrol Rodney Harrison; Deputy Commissioner Robert Ganley; Assistant Commissioner Maria Otero; Deputy Inspector Kenneth Quick; Lieutenant Janna Salisbury; and Detective Jeff Thompson, whose knowledge and experience in this area were instrumental in putting together the entire program. Thanks go to every member of the NYPD who helped PERF on this project.

I am also grateful to the four leading researchers on police suicide who participated in the meeting and shared their insights: Dr. John Violanti of the University of Buffalo; Dr. Miriam Heyman of the Ruderman Family Foundation; Dr. John Mann of Columbia University Medical Center; and Dr. Antoon Leenaars, a mental health and forensic psychologist from Windsor, Canada. Their presentations at the beginning of the meeting provided a solid foundation for our understanding of police suicide.

We were also fortunate to have representatives from many of the leading research, advocacy, and support organizations participate in our conference, including the American Association of Suicidology, the American Foundation for Suicide Prevention, Badge of Life, Blue H.E.L.P., Crisis Text Line, National Action Alliance for Suicide Prevention, Police Organization Providing Peer Assistance (POPPA), and the Ruderman Family Foundation.

And, of course, our thanks to the 300-plus individuals who took the time to participate in this



groundbreaking conference. (See page 58 for a list of conference attendees.) We brought together an impressive and diverse group of police chiefs and sheriffs, supervisors, and line personnel; police labor union leaders; researchers and mental health experts; service providers; and federal government agency officials. Because police suicide is a global concern, we had participants from Australia, Canada, New Zealand, and the United Kingdom, who shared their perspectives and promising practices on this issue.

This report is the 38th publication in PERF's *Critical Issues in Policing* series, which is made possible by the generous support of the Motorola Solutions Foundation. Over the past two decades, with Motorola's support, PERF has been able to explore the most important and difficult issues facing the policing profession, and we have been able to provide important, practical guidance to police leaders. Motorola's longstanding support of the *Critical Issues* project is emblematic of the company's commitment to the safety of our communities and the men and women who police them.

PERF is thankful to Greg Brown, Motorola Solutions Chairman and CEO; Jack Molloy, Senior Vice President for Sales, North America; Jim Mears, Senior Vice President; Gino Bonanotte, Executive Vice President and Chief Financial Officer; Cathy Seidel, Corporate Vice President, Government Relations; Jamie Munro, Vice President; Tracy Kimbo, Director of Government Marketing; Juan Padilla, Senior Account Manager; Monica Mueller, Director of the Motorola Solutions Foundation; and Sirisha Sualy and Wesley Anne Barden of the Foundation's staff.

This project was another team effort by the PERF staff, requiring extensive background research, meeting planning and logistics, and producing this report on our findings. Kevin Morison, PERF's Chief Operations Officer, leads our *Critical Issues* initiative. He was responsible for providing strategic

direction to the project and ensuring that all of the pieces came together. Kevin also assisted with writing the final report. Three PERF staff members had major responsibility for conducting background research and drafting sections of the report: Senior Research Assistant Amanda Barber, Research Assistant Nora Coyne, and Research Associate Sarah Mostyn. Senior Research Associate Dave McClure assisted with report preparation and project support. Sarah, Amanda, and Nora oversaw meeting planning and day-of logistics, assisted by PERF Intern Tatiana Lloyd-Dotta. Meeting registration and participant communications were handled by Membership Coordinator Balinda Cockrell and Assistant Communications Director James McGinty, who also designed and executed audio-visuals and graphics at the meeting.

Communications Director Craig Fischer authored parts of the report, edited the entire document, and oversaw production. Dave Williams designed and laid out the publication. And Executive Assistant Soline Simenauer helped to keep the project team—especially me—on track.

For years, police suicide was a difficult topic to acknowledge or talk about. We hope that this publication will help elevate the dialogue on this issue—to get it out in the open within the policing profession and in the community as a whole. Breaking the silence around police suicide is a critical first step to breaking down the stigma against mental health care that often prevents officers in need from seeking help.

This report is also a call to action. The 10 recommended actions that we provide are concrete steps that agencies can take to get a handle on the problem and to save lives. Police suicide is preventable, if we make the commitment to adopt bold and creative approaches. We owe that much to all of the police personnel who are serving today and to their families as well.

Chuck Wexler
Executive Director
Police Executive Research Forum
Washington, D.C.

Executive Summary:

We Need to Make the Prevention Of Police Suicides a National Priority

WHEN A POLICE OFFICER OR SHERIFF'S DEPUTY is killed in the line of duty, either in an act of violence by a criminal offender or in a motor vehicle crash or other accident, there is a time-honored response. Agencies conduct a thorough investigation to understand every detail of what happened, how it happened, and why. There is typically extensive news media coverage of the tragedy, and police executives and other leaders speak about the incident and the fallen officer. Officers are laid to rest with honors, and their survivors can receive emotional support and financial assistance through a combination of local, state, and federal programs.

At the national level, the FBI, the National Law Enforcement Officers Memorial Fund, and other groups collect detailed data about line-of-duty deaths—how, when, and where they occurred—and these organizations issue periodic reports examining trends in officer fatalities. This information is used to develop policies, new training programs, and procurement of equipment that can help keep officers safe and prevent tragedies in the future.

But when an officer dies by suicide, no such playbook or set of protocols exists.

An investigation is conducted to determine the manner and cause of death. But very few police or sheriffs' departments perform a deeper analysis of *why* the person took his or her life. Agency leaders and officers struggle to address the suicide inside their organizations and often do not know what to

say publicly—if they choose to say anything at all. Except for unusual circumstances, such as when an agency experiences a high number of officer suicides in a short period of time, there seldom is media coverage of officer suicides. Worst of all, family members may not always receive much organized support from law enforcement agencies or service providers.

Unlike with line-of-duty deaths, there is no official central repository for information about how many suicides take place among law enforcement officers and under what circumstances. The volunteer, nonprofit group, Blue H.E.L.P. (and Badge of Life, earlier) has done an outstanding job in compiling statistics on law enforcement suicides obtained through agency reports or open-source information. *But its data are incomplete and almost certainly undercount the actual number of law enforcement suicides.*

This lack of accurate and comprehensive data hampers efforts by police and sheriffs' agencies to develop effective suicide prevention strategies, and to know whether their efforts are making a difference.

Even with these data limitations, we know that the number of officers who die by suicide each year in the United States (167 verified suicides in 2018¹) exceeds the number who are killed feloniously or accidentally (55 feloniously and 51 accidentally in 2018, according to the FBI²). We also know that the

1. Blue H.E.L.P. website: <https://bluehelp.org/>

2. 2018 Law Enforcement Officers Killed and Assaulted. Federal Bureau of Investigation. <https://ucr.fbi.gov/leoka/2018/home>

risk of suicide among police officers is 54 percent greater than among American workers in general.³

Addressing the Crisis of Law Enforcement Suicide

On April 2, 2019, PERF and the New York City Police Department took an important step to elevate the national conversation on police suicide and to identify concrete actions that agencies can take to address this public health and public safety crisis. Our two organizations hosted a one-day conference at NYPD headquarters that brought together more than 300 law enforcement professionals, police labor leaders, researchers, mental health care and other service providers, policymakers, and others—including three brave officers who themselves have dealt with depression, PTSD, and suicidal thoughts in the past and who were willing to tell us their stories.

We had a frank, oftentimes difficult discussion on what we know—and what we do not know—about law enforcement suicide and what can be done about the problem. This report summarizes the discussions at our symposium, the research that supported it, and our recommendations for action.

What Research Can Tell Us About Law Enforcement Suicide

Although the statistics on law enforcement suicide are limited, there is a growing body of research on the issue. At our meeting in New York, some of the leading researchers discussed their findings and the implications for law enforcement agencies.

- **Risk factors:** Dr. John Violanti of the University at Buffalo provided a big-picture overview of his research on **the key risk factors for suicides in policing, including exposure to trauma, alcohol use, availability of firearms, and the strains of shift work.** He also discussed the importance of educating police executives and managers, as well

as family members, about these risk factors and how to address them.

- **PTSD and barriers to seeking health care:** Dr. Miriam Heyman of the Ruderman Family Foundation presented highlights from a 2018 report she co-authored, which focused on the psychological consequences that officers face from exposure to trauma, as well as the cultural and pragmatic barriers that officers face in seeking mental health care.⁴ She reported that **post-traumatic stress disorder (PTSD) among police officers is five times more prevalent than in the general population,** driven in part by the cumulative impact that repeated exposure to trauma can have on individuals.
- **Depression:** Dr. John Mann of Columbia University Medical Center, who has studied suicide in the military, discussed the role of untreated depression in suicide. He estimates that **approximately one out of every 15 police officers is currently experiencing depression or will at some point in their lives.** He outlined risk factors and protective factors that can reduce suicides among law enforcement officers.
- **Access to firearms:** Dr. Mann also discussed the issue of police officers' access to firearms. **The vast majority of officers and soldiers who take their lives do so at home, using their service weapons.** That prompted the Israeli Defense Forces several years ago to establish a system in which soldiers leave their firearms at work. That and other elements of a suicide prevention program contributed to a nearly 50-percent reduction in suicides among IDF members.
- **Officers who mask their suicidal feelings:** Dr. Antoon Leenaars, past president of the American Association of Suicidology, described the patterns of thinking among depressed or suicidal persons, and explained how the use of “psychological autopsies” can uncover the key elements that are present in many suicides. **He said that 60 percent**

3. Analysis of Centers for Disease Control and Prevention data by Dr. John Violanti, University at Buffalo. Presented at the April 2, 2019 PERF-NYPD symposium.

4. Heyman, Miriam; Dill, Jeff; Douglas, Robert (April 2018). “The Ruderman White Paper on Mental Health and Suicide of First Responders.” https://rudermanfoundation.org/white_papers/police-officers-and-firefighters-are-more-likely-to-die-by-suicide-than-in-line-of-duty/

of people who are suicidal “wear masks,” meaning that they camouflage their emotions to the point that those around them (and even the individuals themselves) do not realize how serious the situation has become. This creates tremendous challenges for family members, co-workers, supervisors, and even mental health professionals in being able to recognize who may be at risk of suicide.

Promising Strategies and Programs

At the PERF conference, we heard from police agencies that are developing and implementing promising approaches to preventing suicide among law enforcement officers:

- **Psychological autopsies:** The NYPD is making use of psychological autopsies, a research-based approach that attempts to better understand why someone took his or her life. Following an officer suicide, personnel try to reconstruct what was going on in the person’s mind by systematically asking a set of questions, in a consistent format, to the people with the greatest insights into the person’s life and mind—family, co-workers, and friends. Psychological autopsies contribute to the existing database of information about law enforcement suicide in general, and they help guide agencies’ prevention programs.
Importantly, law enforcement agencies of all sizes can deploy elements of the psychological autopsy; you do not need to be in a large department with specialized personnel to benefit from the approach.
- **Peer support:** Police in Boston, New York City, and other jurisdictions have developed robust peer support programs. Officers often feel more comfortable approaching a peer support counselor than a staff psychologist, so it is important for agencies to offer this option. Small departments can join together as consortiums to give officers options for peer support. The most successful peer support programs complement the services offered by agencies’ Employee Assistance Programs.
- **Routine mental health checks:** Some agencies, such as the Fairfax County, VA Police Department, are beginning to implement periodic mental health check-ups for their officers and other employees. The goal is twofold: 1) to “normalize” the act of visiting a mental health professional, thus reducing the stigma against seeking mental health care, and 2) to identify and address potential issues early on.
- **Wellness programming:** Several agencies at the meeting described their comprehensive officer wellness programs, some of which include resilience training. Wellness programs increasingly are being recognized as an essential element of police and sheriffs’ departments, not only for promoting mental and physical health and preventing suicides, but for the broader goal of helping officers to find fulfillment and happiness in their careers and their lives.
- **Making psychological services accessible:** The Los Angeles Police Department is embedding police psychologists in its field divisions, rather than centralizing all of these personnel in a single location. That way, officers get to know the professionals they can turn to if they need help, and the psychologists get to know the officers, and understand the rigors and strains of their job. These more natural, casual relationships between psychologists and officers help to break down the hesitancy and stigma that some officers feel about seeking mental health care.
- **Technological tools:** Technology can play an important role in mental health awareness and suicide prevention. For example, the American Foundation for Suicide Prevention has created an online system that gives officers a confidential way to test themselves for stress, depression, and other mental health conditions and to form an online connection anonymously with mental health clinicians in their area. An employee wellness app accessible via smartphones is being adopted by the Pinole, CA Police Department and other agencies. And the national Crisis Text Line provides law enforcement personnel with access to online counselors who have been trained on working with police officers.

These and other initiatives highlighted in this report demonstrate the focus and creativity that agencies are applying to this problem. Many of the officials who attended the PERF conference are from agencies that have not experienced an officer suicide in recent years, but they are proactively searching for new ideas in suicide prevention.

Still, the policing profession has a long way to go to be more effective in preventing suicides. According to Dr. Heyman of the Ruderman Family Foundation, fewer than 10 percent of police departments in the United States have suicide prevention training programs. “This silence translates into stigma,” Dr. Heyman said.

Law Enforcement Leaders Play a Crucial Role in Reducing Stigma

The issue of stigma permeated the discussion at our symposium. The stigma that officers face about seeking help for mental health problems is pervasive. Police and sheriffs’ departments can devote substantial resources to suicide prevention programs, but overcoming the stigma against seeking out and accepting help may be the most pressing issue facing the law enforcement profession as it grapples with the problem of officer suicide.

Three current or former officers who attended the PERF conference had first-hand experience with the issues of suicidal ideation and stigma. Retired Sergeant Brian Fleming of the Boston Police Department, Officer Andrew Einstein of the Camden County, NJ Police Department, and Officer Joe Smarro of the San Antonio Police Department each described how they had contemplated suicide, and yet felt conflicted about seeking help. But each of them eventually sought and received assistance, and all of them have gone on to positions today where they are helping fellow officers and community members cope with mental health issues. (See pp. 18–21 for profiles of the three officers.) Their brave stories demonstrated how feelings of hopelessness, despair, and stigma can be overcome.

Another serious concern about mental health treatment is confidentiality. Officers worry that if they do overcome the stigma and ask for help, word will get out to their supervisors and peers, who may then consider the officer “weak,” unfit for duty, or a poor candidate for promotion.

Thus, a critical first step for police agencies seeking to improve officers’ mental health and prevent suicides is to acknowledge that stigma is pervasive in policing, and to develop creative and effective ways to overcome or at least minimize it.

Participants at the PERF conference agreed that police chiefs, sheriffs, and other law enforcement leaders must show leadership to end the stigma against mental health care in policing.

One step they can take is to speak out, internally and publicly, on the issue, and acknowledge that suicides occur. Agencies such as the Chicago Police Department and the NYPD regularly issue news releases and post tweets about officer suicides. Those agencies and others have released videos on the issue that are disseminated to officers, encouraging them to look out for one another and to seek confidential help if needed. The LAPD produced and publicized a video on officer suicide that features Melissa Swailes, the widow of an officer who died by suicide, discussing the stigma her husband faced.⁵

“As law enforcement leaders, we need to create change in the culture and reduce the stigma against getting mental health treatment,” said Police Chief Ed Roessler of Fairfax County, VA.⁶ (Recently, Chief Roessler publicly disclosed to his department and the news media that he has dealt with PTSD and life stressors at times, and that he regularly sees a doctor to coach him on handling those feelings.) “In my 30+ years in policing, I’ve lost many friends to suicide. My officers challenged me and asked what the department was doing to prevent suicides. And it was the officers who had the answers for my department and for many of us in this room. It was producing a video to raise awareness, and reaching out to the families, and other concepts that we will be talking about today. These are going to bear fruit for

5. “Melissa Swails PSA.” YouTube. <https://www.youtube.com/watch?v=QmPKCXHJEPk&feature=youtu.be>

6. See <https://www.nbcwashington.com/news/health/First-Responders-Share-Their-Mental-Health-Battles-to-Help-Others-499986412.html>.



Phoenix, AZ Chief of Police Jeri Williams

us to save lives. But department leaders need to show leadership on this to reduce the stigma.”

Phoenix Chief of Police Jeri Williams said that all police agencies need to consider these issues. “We haven’t had a suicide in our agency since 2014, but how do I know that more people aren’t thinking about it?” she said. “So I’m looking for ways to be proactive. Should I conduct a survey? Should I do a video to send to all our employees about mental health and reducing the stigma? We have a great employee assistance unit, and I believe we have created a dynamic where officers feel welcome and able to ask for assistance, but who’s to say we’re not next? We can’t afford not to take action.”

10 Recommended Actions For Preventing Officer Suicides

Based on our research and on what experts told us at the April conference, PERF developed 10 recommendations for law enforcement agencies that provide a detailed path forward for preventing police suicides and improving officers’ overall mental health.

The recommended actions cover a wide range of approaches—from big-picture strategies, such as improved data collection and better communications, to more tactical considerations, such as periodic mental health check-ups, conducting psychological autopsies, and offering online tools for officers to assess their well-being and to obtain referrals.

It is significant that our first recommendation is to create a central repository for data on police suicide. On a range of issues, such as traffic fatalities, cancer deaths, and law enforcement line-of-duty

deaths, a critical first step in addressing the problem has been to understand it in greater detail. Knowledge and understanding begin with data collection and analysis. But today, we still do not know the full extent and nature of the problem of officer suicide.

The 10 recommendations are summarized below. For details, see Part Two of this report, beginning on page 29.

1. **Data Collection:** Obtaining more complete information about the extent and nature of police suicides needs to be a national priority. There must be a central repository for capturing and analyzing this data.
2. **Psychological Autopsies:** Agencies should conduct psychological autopsies on police suicides, and they should use that data to inform their policies, practices, and programs.
3. **Routine Mental Health Checks:** Agencies should consider requiring or, at a minimum, offering mental health checks for all employees on a regular basis, such as once a year, to reduce stigma and “normalize” a focus on mental health.
4. **Leadership from the Top:** Police chiefs, sheriffs, and other leaders need to speak out about the issue of police suicides within their agencies and in the community. Leadership from the top is crucial to getting this issue out of the shadows. The leadership by police chiefs and sheriffs must be reinforced at all levels of the organization, including middle managers and first-line supervisors.
5. **Gun Removal Policy:** Agencies should carefully structure their policies on the decision to take a firearm away from officers who are seeking mental health services, to minimize the risk of suicide, without discouraging officers from seeking help. Professional psychologists should be involved in making these decisions.
6. **Confidential Support Programs and Training:** Agencies should offer a range of programs, including EAP and peer support, to assist personnel who may need help, and they should train employees on how to access those services—and how to identify and support fellow officers showing signs of stress, depression, or behavioral crisis.

7. **Easy-to-Access Tools:** Agencies should offer confidential, easy-to-access tools (including online tools) for officers to assess their well-being and obtain referrals for assistance.
8. **Regional Partnerships:** Law enforcement agencies, especially small and mid-size departments that lack the resources of large agencies, should consider forming regional partnerships for programs such as peer support and Critical Incident Stress Management.
9. **Family Support:** Following a police suicide, agencies should reach out to surviving family members and provide support, including assistance with obtaining any available benefits, and appropriate funeral honors. Family support should be provided throughout an officer's career.
10. **Communications Plan:** Law enforcement agencies should devise a communications plan for providing information to employees and to the public following a police suicide.

A National Commitment To Suicide Prevention

The reality is that we still do not know enough about police suicide in the United States or around the world. Stigma, shame, and even denial continue to keep this issue in the shadows—and keep some officers from seeking the help that can save lives.

There is no central, national repository of information on officer suicide. And while the body of

research on this topic is growing, we still don't know enough about *why* officers take their lives—the combination of risk factors associated with their work and personal lives. That is why the developing practice of psychological autopsies is so important. Psychological autopsies will help agencies identify trends and themes and will help guide the development of appropriate prevention and wellness programs.

But anonymous information from psychological autopsies also needs to be shared nationally. This type of detailed information can be extremely valuable in identifying larger trends and issues in officer suicide, but only if it is part of a national repository that is accessible to practitioners and researchers.

We need a national commitment to expand data collection and research, which in turn will help spur development of prevention programs that will make a difference. With more data and expanded research, we will be in a better position to prevent the next suicide.

Beyond collecting and analyzing data, there must be a willingness at all levels of police organizations to talk more openly and honestly about law enforcement suicide. In promoting this dialogue, law enforcement leaders need to set the tone and create the momentum. Police personnel at all ranks will follow their lead.

It is our hope that this report will help spur the action and innovation that will make a difference in addressing this public health crisis. Lives can be saved with proactive, thoughtful approaches.

Message from New York City Police Commissioner James P. O’Neill

WHEN PEOPLE CALL FOR HELP, POLICE officers reflexively answer. They do it at a moment’s notice. They do it selflessly. And they do it with great pride in our profession’s collective mission to fight crime and keep people safe.

But when officers need help, when they must confront their own pain or process the trauma they are experiencing on the job—or if they feel alone in coping with their everyday, personal struggles—who is there for them?

As the Police Commissioner of the City of New York, I say that *we* are there for them. Each and every member of our law enforcement community has an obligation to support our colleagues and to stand with them in their toughest moments.

Nine times since January, officers in the New York Police Department have suffered and decided to take their own lives. The toll across the nation is similarly disturbing, with police suicides now outpacing line-of-duty deaths. Yet the full impact on policing, which studies say poses a higher risk for suicide than other American occupations, is not fully understood, due to irregular reporting and a lack of coherent data.

What we do know is that police suicides occur in alarming spates, as has been the case this year in New York and Chicago. Each heartbreaking tragedy, one after another, has left us reeling. It is almost incomprehensible how so many of society’s sworn protectors can be lost to their own internal crises. And,



whenever we have such a loss, a deep grief permeates every corner of our agencies.

With each death, and each accompanying round of media scrutiny and internal self-blaming, we recommit ourselves to grasping and tackling this complex issue. To do more, we must learn more. We cannot fight the problem without understanding it. So we vow to work harder to reach into our ranks, to recognize the warning signs of depression and despair, to hear our officers’ concerns, and to implore them to understand that so much help is readily available.

Admittedly, the challenges for those in our line of work can be daunting. The topic can seem uncomfortable to speak about. But we law enforcement leaders can never shrink from it. We must overcome the stigma of discussing mental health.

In group forums like the one the Police Executive Research Forum hosted in New York City in April, as well as in our own offices across the country, let us vow to openly talk about this dilemma—this mental health crisis—and pool our collective knowledge. Then we can share best practices and achieve measurable, meaningful progress.

This is a national issue that impacts each of us personally. Considering those we have lost to suicide, we will forever wonder what more we could have done to avert tragedy. Their memories will never fade. But we have a chance to enlighten ourselves, and to honor them, by finding ways to intervene and to save lives. We owe it to their families and friends, to all of our employees, and to the people we serve. We also owe it to ourselves and to the memories of our lost officers.

Success is our only acceptable outcome.

Here in New York, I am delving deeper into this complex issue and have created a new, far-reaching wellness program. My command staff has undergone training and is collaborating with the best minds in the mental health field. We have reached out to our colleagues in Los Angeles and Chicago and other places to understand their ongoing efforts to prevent future tragedies. Volunteer peer-counselors within each of our commands across our city will soon be designated and trained to listen and make themselves available whenever, and wherever, they are needed.

We have also developed an application now found on all of our officers' department smartphones that lists multiple entities—both inside and outside the NYPD—where they can turn for help.

We are forensically reconstructing the psychological factors behind each police suicide, and speaking to our officers' loved ones to gain insight into their lives—all of which helps us build more accurate and effective assistance programs that can offer timely interventions and better guide our prevention practices.

Overall, we are remaining flexible to improve our posture as time passes, information gets better, our insights deepen, and our full range of services grows into a more comprehensive and effective set of options for each of our 55,000 employees.

Ultimately, we need to erase the stigma of asking for help, which is never a sign of weakness. In fact, it is a sign of great strength. And more importantly: It's human.

After all, every police department recruits from the human race. That is what makes each one of our officers special and unique. Together—with cops helping cops—our profession will surmount this challenge. We devote our lives to helping others. But we cannot effectively do that job if we do not help ourselves first.

*NYPD Commissioner James P. O'Neill
September 2019*

Part One: Research, Risk Factors for Suicide, And Challenges

What the Data Tell Us about Suicide

The policing profession gathers extensive data on countless aspects of what it does, but we know remarkably little about law enforcement suicide. There are serious gaps in the reporting and collection of even the most basic information about the prevalence of officer suicide and the circumstances surrounding the deaths. **There is no central repository for collecting data, and law enforcement agencies are not required to report officer suicides.**

Despite underreporting and lack of information, it is becoming clear that more police officers die by suicide than as a result of line-of-duty deaths, which include shootings and other attacks against officers, motor vehicle accidents, and other types of deaths. According to Blue H.E.L.P., there were 167 verified suicides of law enforcement officers in 2018.⁷ That compares to 106 felonious and accidental line-of-duty deaths recorded by the FBI.⁸

National Statistics on Suicide

To better understand suicide among members of law enforcement, it is helpful to know some basic statistics about suicide in the United States overall.

In 2017, the most recent year for which national data are available from the Centers for Disease

Control and Prevention (CDC), suicide was the tenth leading cause of death in the United States. However, for young people (those in the age groups 10–14, 15–24, and 25–34), suicide is the second most common cause of death.⁹

Between 2001 and 2017, the national suicide rate increased by about one-third, from 10.7 suicides per 100,000 population to 14.0 per 100,000. The suicide rate for males has generally been approximately four times the rate for females, although that gap has been narrowing in recent years as the suicide rate for women increased at a faster pace than the rate for men.¹⁰

2017 Suicide Rates in the U.S., by gender (per 100,000)		
Total	Male	Female
14.0	22.4	6.1

Source: “Suicide Rates,” National Institutes of Mental Health, <https://www.nimh.nih.gov/health/statistics/suicide.shtml>

Age also is an important factor in suicide rates. For males, the suicide rate increases fairly steadily with age, with the highest rate among men ages 65 and older. For females, the highest rate of suicide occurs among those ages 45 to 54.¹¹

>> continued on page 14

7. “Verified Suicides to Date.” Blue H.E.L.P. <https://bluehelp.org/>

8. 2018 Law Enforcement Officers Killed and Assaulted. Federal Bureau of Investigation. <https://ucr.fbi.gov/leoka/2018/home>

9. “Suicide.” National Institute of Mental Health, Table 1. <https://www.nimh.nih.gov/health/statistics/suicide.shtml>

10. Ibid., Figure 1.

11. Ibid., Figure 2.

Blue H.E.L.P. Collects Data On Officer Suicides and Assists Families

Blue H.E.L.P. (Honor. Educate. Lead. Prevent.) is a national nonprofit organization whose mission is “to reduce mental health stigma through education, advocate for benefits for those suffering from post-traumatic stress, acknowledge the service and sacrifice of law enforcement officers we lost to suicide, assist officers in their search for healing, and to bring awareness to suicide and mental health issues.”¹² The organization provides training and awareness programs, a searchable database of resources, and direct support to the loved ones of those who have died by suicide.

Blue H.E.L.P. also maintains the most comprehensive dataset of national statistics on officer suicide. The organization has recorded more than 600 officer suicides between January 2016 and August 2019.¹³ Its data come from Internet searches, law enforcement surveys, information requests that Blue H.E.L.P. submits to family members in known cases of suicide, and online submissions through the organization’s website. Blue H.E.L.P. keeps the identities of individuals anonymous, unless the family of the officer specifically requests to share their story.

Karen Solomon, President and Co-Founder of Blue H.E.L.P., emphasized the need for governmental and law enforcement agencies to share incidents of suicides for the purpose of data collection. “One of the limitations we have with this data collection is that we’re a 100-percent all-volunteer organization,” Solomon said. “Our reach is really small, because it’s just five or six people working on weekends and nights. But we know about 167 suicides in 2018. How many would we learn about if we

Karen Solomon,
President and
CoFounder, Blue
H.E.L.P.



had more nationally known organizations with a large reach supporting us?”

Solomon said that Blue H.E.L.P.’s data collection is detailed. “We have 25 data collection points,” she said. “Gender, age, role, rank, number of children, whether they had sought help, whether they sought help but did not receive it, whether they were afraid they would lose their job if they asked for help, whether they had attempted suicide before. We have narratives from each of the families. We know which officers had drinking problems, financial problems, which ones parked their duty car in the garage and locked themselves in it with the engine running, which officers shot themselves multiple times because the first bullet didn’t kill them. We have an amazing amount of information, because the families really trust us, and we take their privacy very seriously.”

Solomon said that an analysis by Blue H.E.L.P. of 460 officer suicides found that the vast majority of the officers were on active-duty status at the time of their deaths.

12. “Our Mission.” Blue H.E.L.P. <https://bluehelp.org/about-us/>

13. “Verified Suicides to Date.” Blue H.E.L.P. <https://bluehelp.org/>

Duty Status	
Active	82%
Retired	11%
Medical Leave	4%
Terminated	2%
Administrative Leave	1%
Resigned	1%
Suspended	1%

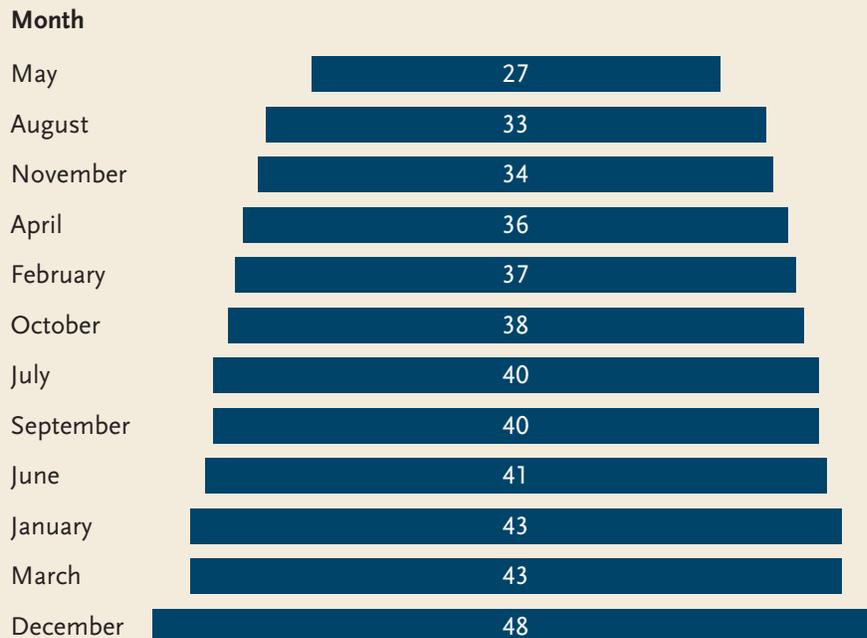
Among the 11 percent of officers who were retired when they died by suicide, more than one-third had been retired for less than a year. This suggests that special attention should be paid to the mental health of officers as they are nearing retirement and in the months immediately after they retire.

The analysis by Blue H.E.L.P. found that officers in all age brackets die by suicide. In addition, officers are more likely to die by suicide in December than in other months.

Time in Retirement by Officers Who Died by Suicide	
Less than 1 Year	38%
13 months – 3 years	21%
3-4 years	12%
5-10 years	18%
10+ years	12%

Age of Officers Who Died by Suicide		
	% of All Officer Suicides	Average Years of Service
Under 30	12%	3
30-39	23%	10
40-49	37%	17
50-59	23%	25
60+	5%	28

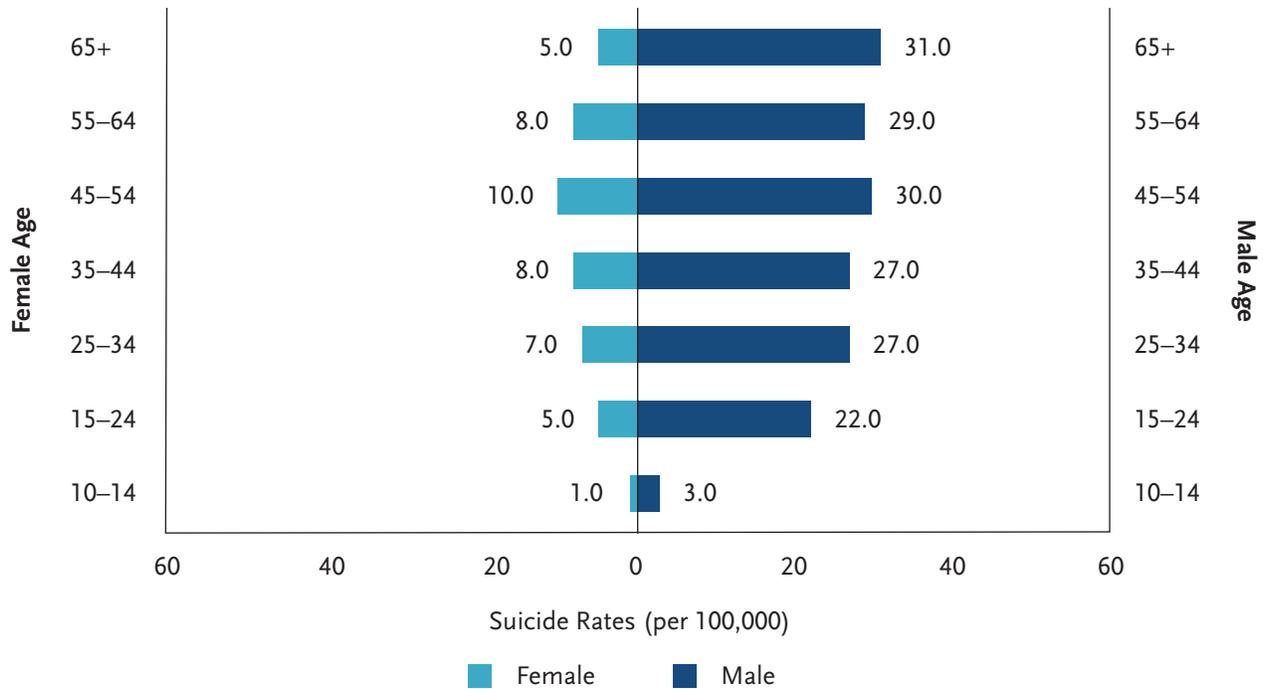
Percentages in all charts may not add up to 100 because of rounding.



Source: <https://bluehelp.org/wp-content/uploads/2019/02/Data2.pdf>

2017 Suicide Rates in the U.S., by Age and Gender (per 100,000)

Data Courtesy of CDC



Source: "Suicide Rates," National Institutes of Mental Health, <https://www.nimh.nih.gov/health/statistics/suicide.shtml>

continued from page 11

Of the 47,173 deaths by suicide in the United States in 2017, 51 percent were by firearm. For males, however, this figure is even higher. Firearms were used in 56 percent of all male suicides in 2017.¹⁴

In looking at the demographic groups with higher-than-average rates of suicide, there are connections to law enforcement. For example, men are far more likely than women to die by suicide, and men account for 87.5 percent of all sworn officers in the United States.¹⁵

In addition, by the nature of their profession, law enforcement officers have increased access to firearms as compared to the general population, and the availability of a firearm is an elevated risk factor for a potentially suicidal person. Firearms are far more

lethal than other methods, such as poisoning or cutting oneself. "[I]ndividuals who attempt suicide by using firearms are more likely to die in their attempts than those who use less lethal methods," according to a report of the Office of the U.S. Surgeon General.¹⁶

"Approximately 90 percent of suicides attempted with a gun end in death, compared to only 10 percent of suicides attempted by all other means combined," said Dr. Jerry Reed, Senior Vice President at the Education Development Center, an organization that develops solutions to public health problems and other issues. Furthermore, Dr. Reed said, "It is a myth that people who attempt suicide and survive will just find another way to take their lives later. Ninety percent of people who attempt suicide but survive do not go on to die by suicide later."¹⁷

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14. "Suicide." National Institute of Mental Health. Figure 2. <https://www.nimh.nih.gov/health/statistics/suicide.shtml>

15. Federal Bureau of Investigation, *2017 Crime in the United States*, "Table 74 – Full-time Law Enforcement Employees," <https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/tables/table-74>

16. *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*. See "Goal 6." <https://www.ncbi.nlm.nih.gov/books/NBK109921/#strategicdirection2.s6>

17. *Reducing Gun Violence: What Works, and What Can Be Done Now*. Police Executive Research Forum (2019). Pages 16–17. <https://www.policeforum.org/assets/reducinggunviolence.pdf>

Police Suicides: An International Perspective

Law enforcement suicide is an international concern. Police representatives from Canada, England, Australia, New Zealand, and Northern Ireland participated in the PERF symposium. In many ways, their countries' experiences with police suicides are similar to trends in the United States, but their responses are unique in some respects.

Australia's National Strategy Focuses on Early Intervention and Working with Families:

In January 2019, after four Australian Federal Police (AFP) officers took their lives with their service weapons, AFP Commissioner Andrew Colvin announced tighter rules on officers' access to firearms, including a requirement that officers provide a reason to check out their weapons when off duty.¹⁸

A year earlier, the Australian National Audit Office (ANAO) had conducted an audit of the AFP's management of mental health within the organization.¹⁹ One of the ANAO's key findings was that "managing employee mental health effectively is a challenge faced by policing and first responder organizations around the world," but "the AFP lacks a comprehensive and consolidated organizational health and well-being framework to enable effective management and support of employee mental health." The AFP agreed to implement the ANAO's recommendations and create a new Health and Well-Being Strategy.

At the PERF symposium, Dr. Tim Grenfell, Chief Psychologist for the AFP, spoke about this new comprehensive strategy:

It really highlights early intervention. We are aware that mental health concerns occur on a continuum, and we need to get people into care before they hit the red zone. We need

Chief Psychologist
Tim Grenfell,
Australian Federal
Police



to equip our leaders to identify early warning signs in people who are in the yellow zone.

We talk about the "mask" that people put on to hide their troubles. We need to reach out to families, because they're often the ones who see the mask slip, and they see what's really going on with the person. But that isn't an easy thing for an organization to do.

We know that we need culture change in organizations if we're going to tackle the issue of stigma. There needs to be a very large culture change. That comes from the senior leadership, and it certainly comes from the middle management, but we also need culture change from the officers themselves.

In Northern Ireland, Some Suicides Stem

from "the Troubles": Suicide is a significant problem among the general population of Northern Ireland. As of 2018, more than 4,500 suicides reportedly have been registered in the region since the Good Friday peace agreement was signed in 1998. That is more than the 3,600 people who died in bombings and other

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18. "Suicides of Australian Federal Police officers inside their workplaces prompts tighter gun rules." Australian Broadcasting Corporation. Jan. 14, 2019. <https://www.abc.net.au/news/2019-01-15/suicide-of-afp-officers-prompts-gun-rules-changes/10714804>

19. *Managing Mental Health in the Australian Federal Police*. Australian National Audit Office, March 7, 2018. <https://www.anao.gov.au/work/performance-audit/managing-mental-health-australian-federal-police>

continued from page 15

violence during the long period of conflict known as the Troubles, between 1969 and 1997.²⁰

The Police Service of Northern Ireland (PSNI) has not been immune to this crisis. “Northern Ireland is seeing a huge challenge with regard to suicides compared to the rest of the United Kingdom,” said PSNI Chief Superintendent Peter Farrar. “I think it’s a result of coming out the other side of the Troubles. And we’ve had a lot of suicides within our organization.²¹ A lot of stressors are still linked to that. So it’s hugely important for Police Service of Northern Ireland.”



Chief Superintendent Peter Farrar, Police Service of Northern Ireland

One factor contributing to suicides within the PSNI is that the agency’s officers carry firearms. “We’re the only armed police force in the whole of the United Kingdom,” Chief Superintendent Farrar said. “We are routinely armed, and those firearms are brought home. We had two officers take their lives recently. One was a senior officer; one was a constable. They both took their lives in police stations. One had had his firearm removed because of concerns about his psychological well-being, but he used another officer’s firearm to take his life.²² So now we do not allow an officer in this situation to be in the proximity of a firearm.”

In response to this growing issue, the United Kingdom in 2019 launched the National Police Wellbeing Service, a special agency whose mission is “to provide support and guidance for all police forces to improve upon well-being within their organization.” The Service “has been developed for policing, by policing, and is designed to meet the unique needs of officers and staff,” according to its mission statement.²³ “We want every member of the police service to feel confident that their well-being is taken seriously and that they are properly supported by their organization.”

20. “Northern Ireland suicides outstrip Troubles death toll.” *The Guardian*, Feb. 19, 2018. <https://www.theguardian.com/uk-news/2018/feb/20/northern-ireland-suicides-troubles-death-toll>

21. “Fears over workload pressures in PSNI as 17 officers take own lives in 15 years.” *Belfast Telegraph*, Nov. 4, 2017.

<https://www.belfasttelegraph.co.uk/news/northern-ireland/fears-over-workload-pressure-in-psni-as-17-officers-take-own-lives-in-15-years-36287922.html>

22. “PSNI ‘will learn’ from death of Insp Peter Magowan.” BBC News, March 20, 2018. <https://www.bbc.com/news/uk-northern-ireland-43472470>

23. <https://oscarkilo.org.uk/national-police-wellbeing-service/>

What We Know about Suicide Risk Factors

At the PERF conference, leading researchers presented the latest information on risk factors for officer suicide, the prevalence of mental health issues in law enforcement, and specific variables related to the problem. These researchers also called on police executives to help officers to get treatment for depression and other types of mental illness, just as they would receive care for any other medical condition they might have.

Stigma Against Seeking Mental Health Care

“Seeking help is never a sign of weakness. It’s a sign of great strength.”

— **Police Commissioner James O’Neill, NYPD**

Participants at the PERF conference said that even in police departments with strong wellness programs and mental health care services, the traditional police “culture” still equates receiving mental health care with weakness or incompetence. This stigma often blocks officers from seeking the care that they need.

“I think it’s extremely important that the officer on the street understands that he or she is supported by the organization,” said Dr. John Violanti. “One of the biggest stressors we found in our research is that

“The organization does not support me; the organization was afraid to admit that I, as a police officer, had a mental health problem.” I think that NYPD Commissioner O’Neill’s bringing this problem to the forefront by holding this conference is an excellent move.”

Research indicates that the stigma associated with mental illness occurs in two ways.

- “Social” or “public” stigma refers to a negative reaction in the general population to people with mental illness.
- “Self-perceived” or “self-stigma” involves one’s own internal prejudice against oneself for having a mental illness or needing mental health care.²⁴

For a police officer or sheriff’s deputy experiencing a mental health problem, both types of stigma can be daunting. Fear that command staff members, supervisors, and peers believe that officers who seek help are weak and unable to do their job, combined with one’s own internal feelings of incompetence and negative self-esteem, can lead to poor job performance, family and relationship problems, and a reluctance to seek help.

Some departments have seen the need for a change in police culture and have launched anti-stigma campaigns. Superintendent Justin Srivastava of the National Police Wellbeing Service of England and Wales described the plan for addressing mental

>> continued on page 21



“Think about how difficult it is for officers to get treated for depression without compromising their career in some way. The officer doesn’t want to come forward. The family protects the officer’s privacy and helps the officer avoid getting help for the illness, even though the illness could potentially threaten the officer’s life. And even if the depression isn’t life-threatening, it certainly affects how well they perform on the job. And they feel terrible. That’s not good for anyone’s morale.”

— **Dr. John Mann, Columbia University Medical Center**

24. Corrigan, Patrick, Watson, Amy. (2002). “Understanding the impact of stigma on people with mental illness”; *World of Psychiatry*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489832/>

Stories of Three Officers Who Have Experienced Suicidal Thoughts— and What We Can Learn from Them

At the PERF conference, three officers recounted their own experiences with mental illness and suicidal thoughts. Each story is an example of how the work of policing can impact an officer's mental state, and the hopelessness that can result. PERF is grateful to these officers for confronting the stigma of mental illness and encouraging their fellow officers to seek assistance.

Sgt. Brian Fleming, Boston Police Department, retired

I'm a retired Boston police sergeant. I was appointed on March 30, 1983. I started on a walking beat like all the rookies did back then, but I was accepted to the SWAT team as a young officer.

So I was doing well, but there was a secret that I had. I was doing drugs and drinking heavily. The drugs were killing me. I was filled with guilt, remorse, shame. I told myself a thousand times I was going to stop. I had been exposed to 12-Step programs and clinicians.

I came home one day in 1985, a nice sunny day, and I took out my .38 snub nose and put it to my head, with my finger on the trigger. I wanted to die. All the stuff about getting help disappeared from my mind; I had tunnel vision. I sat there and I put the gun down and put it back up to my head again. I did it several times. I will never forget that feeling of hopelessness and despair and depression. I had a moment of clarity when I thought of my mother. We had just lost my father. I put the gun down. I knelt down and asked God to help me. Then I went on my way, and continued with the drugs and alcohol.

A month later, I got help—in the form of an overdose. I nearly died from that overdose, and because of it, I was terminated by the Boston Police Department. But I was introduced to the department's Peer Support Unit. It was then called the Stress Unit. It was run by Ed Donovan, who many of you may know, and Ed met me at the door and taught me how to live sober for the last 34 years.²⁵ I fought and got my job back. I went back to SWAT and the motorcycle unit, both as an operator and later as a supervisor, and spent five years as a range-master.

In 2010, I became Director of the Peer Support Unit, 25 years after I had walked into that Unit, helpless and hopeless and a mess. After we had the Boston Marathon Bombing in 2013, we had a lot of officers calling the Peer Support Unit. I have used my experiences to help start the LEADER program at McLean Hospital in Boston (see page 44), and to provide peer support training to police departments nationwide. I retired from the Police Department in 2015.

I know what it feels like for officers when they walk into a peer support unit for the first time. I will never forget that. We need cops to be able to seek help without fear of reprisal.

Brian Fleming,
retired Boston
Police Department
sergeant and
former director of
the department's
Peer Support Unit



25. "PO Ed Donovan, Former Director of Boston PD Stress Unit." <https://www.linkedin.com/pulse/po-ed-donovan-former-director-boston-pd-stress-unit-brian/>

Officer Andrew Einstein, Camden County, NJ Police Department²⁶

On May 5, 2012, I was supposed to die. I had planned on committing suicide by an overdose. I put a bottle of pills on my nightstand, and after going out, I was going to take those pills and go to sleep for the last time. Luckily, I drank too much, and my friends put me on my couch, where I woke up the next day.

At that time, I had been back from a military deployment in Afghanistan for about five months. I was working for the Police Department in Riverton, a small town in southern New Jersey. I was having problems with a brain injury caused by a grenade and PTSD associated with combat in Afghanistan. I was afraid to ask for help. I thought that if I reached out and said, “Hey, I’m not okay,” they would take my badge and gun.

I had been a cop since I was 18 and a Marine in the Reserves. Being a cop was my entire life. It was hard for me to keep my depression a secret, but I did it well, and it almost cost me my life. Shortly after my suicide attempt, the chief of that small town realized that I was struggling, and he reached out. He said, “I want to ask you a question. I want you to know I’m here to help you. I’m not here to hurt you.” He asked me if I had



Officer Andrew Einstein, Camden County, NJ Police Department

a drinking problem or an anger problem. We went back to the station, had a long talk, and because of him I started getting help. I saw doctors for the traumatic brain injury. I started talking about what had happened, and I started getting better. As I started getting better, I realized it was okay to say, “I’m not okay.”

I left that small department for a bigger agency, where I was sent to work in the Crisis Intervention Team. And I realized that I was suffering a lot of the symptoms that our CIT consumers were dealing with. I began teaching at CIT, specifically about police and veteran suicide, and telling my story.

One night in 2015, after we buried Sergeant Robert Wilson,²⁷ I wasn’t having a great night. I started to drink, and I knew that because I was drinking and I had my service weapon accessible, I needed to put the gun somewhere. Not that I was suicidal, but having the gun there, I didn’t want to make a rash decision later on that night. I asked my wife to hide it. She locked it up somewhere.

A few months later, I used that story as an example while teaching a CIT class, and the night after that, my administration showed up, pulled me off active duty, and sent me for a fitness-for-duty evaluation. I was told I couldn’t talk about the incident. No one in my department knew, not even my partner or my supervisor.

That whole week while I waited to go to the doctor, I couldn’t help but think that I had gotten help to get better, to save my job, and to be a better cop, but all this was potentially causing my career to end. I was sitting there thinking, I preach to these cops about asking for help, and I tell them, “Raise your hands and say you’re not okay.” And here my department was coming after my job.

>> continued on page 20

26. For additional background, see “A Warrior’s Voice: Andrew Einstein.” *American Grit*, Feb. 22, 2017. <https://www.americangrit.com/2017/02/22/warriors-voice-andrew-einstein/>. Also, “Surviving Until Tuesday.” *Jersey Man*, July 23, 2019. <https://jerseymanmagazine.com/surviving-until-tuesday/>

27. “Philadelphia officer shot to death while buying a gift for his son.” *CNN*, March 7, 2015. <https://www.cnn.com/2015/03/07/us/philadelphia-policeman-killed/index.html>

continued from page 19

But I passed the fitness-for-duty, returned to active service, met with the administration, and we hashed it out. I don't work for that agency anymore, and I'm grateful to be with the Camden County Police Department now. And I'm grateful for their support on this subject of officer suicide.

It starts with the administrators. Frontline cops look after each other, but if the administration doesn't support talking about it and getting rid of that stigma, cops are still going to be killing themselves.

Officer Joe Smarro, San Antonio Police Department

I was born in Virginia, raised in upstate New York, and I'm a survivor of childhood physical abuse and sexual abuse. I joined the Marine Corps and had two combat tours. When I left the Marine Corps, I joined the police department in San Antonio. At 34 years old, I had three divorces and four kids from three women, and I finally realized there was a problem.

But we talk about having masks, not just to hide our problems from other people, but from ourselves. It was easy for me to believe that I was okay, because I had a job, I was gainfully employed, and I was relatively healthy. So it was easy for me to pretend that everything was all right. But really, I knew it wasn't all right.

Addiction has many forms. I'm diagnosed with PTSD. I'm diagnosed with depression. I am a huge advocate for therapy and treatment. I still go to therapy every month.

And so, can you be medicated and do this job of being a police officer? Yes. Can you go to therapy and do treatment? Yes.

I work full time right now in a mental-health unit that responds to calls involving

Officer Joe Smarro,
San Antonio Police
Department



people with mental illness. I'm one of 13 officers in the unit, and I think our stories are our power. A story is what connects us.

I've been fortunate to get publicity in San Antonio for the work that we've been doing. Byron Pitts from ABC Nightline came down and did a piece. There's an eight-minute segment that you can see online.²⁸

Byron asked me, "Do you see yourself in a lot of the people you're responding to on these calls?" And he asked me if I've ever considered suicide. My answer to both questions was yes. I suffered for years with suicidal ideation. I was very open with sharing that, knowing it was a national news story, because for me it's important that police officers know, that first-responders know, that military veterans know there is nothing unique about me being a police officer, having been diagnosed with depression and PTSD.

The most unique part of it is my willingness and ability to share my story to hopefully inspire others. That said, there's still a large amount of disconnection and stigma within our profession.

We just finished an award-winning documentary called "Ernie & Joe" that filmed my personal and professional life and my partner's life for two and a half years.²⁹ We've been screening it at film festivals around the country, and it's doing really well. It's about the work we're doing

28. "The Deadly Consequences When Police Lack Proper Training to Handle Mental Illness Calls." *ABC News*, Sept. 30, 2015. <https://abcnews.go.com/US/deadly-consequences-police-lack-proper-training-handle-mental/story?id=33023577>

29. *Ernie & Joe: A Film by Jenifer McShane*. <https://ernieandjoethefilm.com/>

in mental health, and about the humanity in law enforcement. HBO has purchased the documentary and it will be released nationwide on November 19, 2019.³⁰

I think we've gotten far away from remembering the purpose of what we're all doing this for. It's a problem when we don't feel like we can go to work and say, "Hey, I'm not okay." It should be okay not to be okay. But it's not okay to stay that way.

Police officers need to be supported in our efforts. We have to be supported knowing that if we show up and are having a bad day, you aren't going to immediately disarm us and send us home or put us behind a desk. We should have hope that you're going to support us, encourage us, and follow up with us, because yes, depression is treatable. There is hope.

continued from page 17

health stigma in 43 police forces across England and Wales. The Wellbeing Service began by conducting workshops for Chief Constables and other executives on well-being initiatives. From there, they moved on to line managers, teaching them about the well-being agenda and the detrimental effects of stigma. After completing these workshops, the National Police Wellbeing Service conducted a survey which found that officers' willingness to disclose issues about mental well-being increased from 40 percent to 65 percent.

"We've started to push an anti-stigma campaign from the top down, and from the bottom up," said Superintendent Srivastava. "We have a long way to go, as everyone else has, but we've made a good start."

Masking

Often when a person dies by suicide, even the colleagues who regularly interacted with the person express shock and confusion. At the PERF conference, Dr. Antoon Leenaars, a psychologist who served as president of the American Association of Suicidology, shared results from an unpublished study indicating that among the general public, 60 percent of suicidal people reported wearing a "mask" to hide their true feelings.

He said that based on other sources of information, such as the observations of others, this number is likely as high as 90 percent. A suicidal person may intentionally mask emotions. In other cases, they may not comprehend the seriousness of what they are experiencing, so they may appear to be fine.

Considering the stigma associated with seeking mental health treatment in policing, it is likely that "masking" is even more prevalent among police officers.

Cumulative Effects of Trauma

Police officers often are exposed to multiple levels of trauma in the course of their jobs. Dr. Miriam Heyman of the Ruderman Family Foundation cited research indicating that police officers witness an average of 188 critical incidents over the course of their careers.³¹

"The psychological research says that you need to pay attention to the cumulative nature of stress," Dr. Heyman said. "The second, third, or fourth time that someone experiences a traumatic event has more impact on the person's well-being than the first time. Each encounter with trauma wears down a person's psychological reserve."

Considering the degree to which officers are exposed to critical incidents, is important to understand the prevalence of depression, alcohol abuse,

30. HBO Movies. "Ernie & Joe." <https://www.hbo.com/documentaries/ernie-and-joe>

31. Chopko, Palmieri, and Adams (2015). *Critical incident history questionnaire replication: frequency and severity of trauma exposure among officers from small and midsize police agencies*. Journal of Traumatic Stress. 2015 April. <https://www.ncbi.nlm.nih.gov/pubmed/25808672>

and posttraumatic stress disorder (PTSD) among officers.

Depression

Research has shown that depression is strongly correlated with suicide. According to Dr. John Mann of Columbia University Medical Center, the CDC reports that 78 percent of suicides were preceded by an untreated psychiatric illness, and in 60 percent of those cases, the illness was depression. Despite much effort to de-stigmatize getting help and treatment for depression, most suicide is the result of untreated depression. Mann estimates that one out of every 15 police officers is currently experiencing depression, or will at some point in their lives.

According to the Ruderman Family Foundation, officers have depression at rates significantly higher than the general population.³² One study examined disparities in the health of police officers compared to the general population and found that 12 percent of officers had depression, compared to 6.8 percent for the general population.³³ That is why it is important that wellness programs in police agencies extend beyond the limited goal of preventing suicide, to include the overall mental and physical health and well-being of police officers.

At the PERF conference, Dr. Antoon Leenaars, a Canadian psychologist and researcher on suicidality, compared the brain to other organs of the body, such as the heart or liver. “If you don’t take your medication for heart disease or high blood pressure, you’re going to have problems doing your job in policing,” he said. “It’s no different for the brain. And when depression is treated, the suicide risk drops dramatically.”

Dr. Mann emphasized that depression is an illness; it is not something that can be fixed by a colleague telling you to cheer up. “Depression is not an optional state of mind that you can just wish away,” he said. “When it’s interfering with people’s relationships, job performance, and quality of life, it is an

Dr. John Violanti,
University at
Buffalo



illness. It is part inheritable. It has a biology. Just as you cannot fix a broken leg by willpower, you can’t get rid of depression just because you want to, and you cannot prevent it from coming on.”

The researchers at the meeting said that police culture regarding mental health needs to shift, so that providing treatment for depression and other mental health issues is considered a normal part of officer wellness. According to Dr. Mann, when depression is treated, not only does the suicide rate decline, but the amount of sick leave is reduced, overall job performance is improved, and family relationships improve.

Alcohol Abuse and PTSD

“According to our research, the combined impact of PTSD and increased alcohol use led to a ten-fold increase in risk of suicide ideation.”

— **Dr. John Violanti, University at Buffalo**

High levels of exposure to traumatic events among police officers are associated with higher rates of PTSD and alcohol abuse. Together, these two factors can dramatically increase the risk of suicide.

When depression is left untreated, alcohol and drugs are often used to self-medicate. According to Dr. Violanti, 25 percent of police officers have

>> *continued on page 25*

32. *The Ruderman White Paper on Mental Health and Suicide of First Responders*. 2018. https://rudermanfoundation.org/white_papers/police-officers-and-firefighters-are-more-likely-to-die-by-suicide-than-in-line-of-duty/

33. *Health Disparities in Police Officers: Comparisons to the U.S. General Population*. 2011. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4734372/>

The Impact of Organizational, Operational, Occupational, and Family Variables on Officer Suicide

At the PERF conference, retired New York City Police Department psychologist Dr. Tom Coughlin presented a framework for looking at the problem of officer suicide. He suggested considering four major categories of variables that contribute to suicide among law enforcement: organizational, occupational, operational, and family.

- **Organizational variables** are the ways that police agencies are run that may have a negative impact on police officers' mental well-being. Karl Roberts, Professor and Chair of Policing and Criminal Justice at Western Sydney University in Australia, said that repeated exposure to lower-level stresses from work experiences, such as bureaucratic management styles, unfair decision-making by managers, arbitrary rules, and carrying out work for which officers were not adequately trained, were risk factors for officer suicide.³⁴
- **Occupational variables** include work hours, mandatory overtime, and understaffing. Dr. Roberts noted that shift work and erratic work hours are factors related to officer suicide. Chief Anthony Holloway of the St. Petersburg, Florida Police Department said that his agency conducted a study of night shifts and suicidal ideation. The agency examined almost 20 years of shift work and found significant associations between night shift work and increased suicidal thoughts. Researchers believe that in shift work, a person's circadian rhythm is disrupted, leading to a decreased ability to make good

decisions. "When you have trouble making decisions, you can make a bad decision, and one of those bad decisions can be to take your own life," Chief Holloway said.

- **Operational variables** are factors in the nature of police work, including repeated exposure to traumatic events, that can contribute to officer suicide. Researchers have found that critical incidents often leave officers feeling helpless and out of control. This can negatively impact one's self-image, especially among officers who define their identity largely by their status as police officers. Another operational variable is the general police culture of keeping emotions in check, being strong, and showing no weakness. This mentality contributes to a stigma against asking for help, especially help with mental health.
- **Family variables** include stresses on a police officer's personal life. The stresses of police work can have a negative impact on family and personal relationships.

Dr. John Violanti said that perhaps surprisingly, it is family variables that figure most prominently in police officer suicides. "The number one factor in suicides is relationship problems," he said. "Is the officer's family understanding about the work that the officer does? We need to educate families about what this job is, and how it can affect spouses and family members. The family is the best support that an officer can have in times of trouble."

34. Roberts, Karl. "Police officer suicide: it's not just about workplace stress, but culture too." Feb. 27, 2019. <https://theconversation.com/police-officer-suicide-its-not-just-about-workplace-stress-but-culture-too-76710>

Suicide Among Retired Officers

Little research exists about suicides by retired police officers. One retrospective mortality cohort study of working and separated/retired police officers found that working officers had a suicide rate 8.4 times higher than that of retired officers.³⁵ An analysis by Blue H.E.L.P. of 460 officer suicides found that 11 percent involved retirees.

However, there are potential risks that come into play after law enforcement officers retire. Dr. John Violanti of the University at Buffalo has examined risk factors specific to retired officers:³⁶

- **Police officers may have residual trauma from their time on the job.** Officers encounter disturbing situations such as homicides, domestic violence, child abuse, accident fatalities, and other incidents far more often than most other people. The effects of witnessing these events can emerge at any time, even years later in life.

The violent and traumatic nature of police work can alter an officer's physiological state long-term. Even during routine work, police officers must be constantly on guard and ready to respond to any situation. This is what draws some

people to the job in the first place, but after years in policing, officers may have a hard time physiologically relaxing from their hypervigilant state.

- **For many officers, leaving the force means losing a main source of social support and camaraderie.** After years of being around colleagues, believing in a shared mission, and working together in high-stress situations, retired officers can experience an intense sense of isolation and letdown. The adjustment to civilian life can be difficult, even for officers who looked forward to retirement.

Therefore, law enforcement agencies should pay special attention to officers who are soon retiring. Having resources available to help officers plan for retirement and adjust to the next part of their lives can be helpful. PERF recently produced a book about this topic: *Chapter 2: How Police Chiefs and Sheriffs Are Finding Meaning and Purpose in the Next Stage of Their Careers.*³⁷ Although the book focuses primarily on law enforcement executives, it provides guidance for law enforcement personnel at all ranks as they prepare for retirement.

35. Violanti, J. M., Gu, J. K., Charles, L. E., Fekedulegn, D., Andrew, M. E., & Burchfiel, C. M. (2011). Is suicide higher among separated/retired police officers? an epidemiological investigation. *International journal of emergency mental health*, 13(4), 221–228. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4700539/>

36. Violanti, J. M. (2007). *Police Suicide: Epidemic in Blue*. Springfield, IL: Charles C. Thomas.

37. <https://www.policeforum.org/chapter2>

serious problems related to alcohol, and using alcohol to cope with the stress of the job has been culturally accepted among police officers for a long time.³⁸

Post-Traumatic Stress Disorder occurs when a person is exposed to traumatic events. The prevalence of PTSD is estimated at approximately 15 percent of police officers in the United States.³⁹ When PTSD is combined with alcohol abuse, the risk of suicidal ideation increased 10 times in police officers.⁴⁰ Strategically intervening in the treatment of depression, PTSD, and substance abuse is necessary for suicide prevention and overall officer wellness.

Availability of Firearms

“Most people who kill themselves do it at home. In a lot of these cases, they’re depressed, they have a fight with their spouse, and these little things trigger the decision to kill themselves. People may think about suicide for a while, but they usually make the decision to actually kill themselves only minutes before. And the most lethal method is a gunshot wound. The chance of survival of a self-inflicted gunshot wound is far less than for other methods of suicide. One of our goals in suicide prevention is to deflect people from the most lethal methods.”

— Dr. John Mann, Columbia University Medical Center

A unique risk in officer suicide is the occupational requirement to carry a firearm. Whether on duty or off duty, most police officers in the United States have 24-hour accessibility to their weapon. Many agencies require their sworn personnel to carry their service weapons while off duty.

According to Dr. Violanti, police officers are 6.4 times more likely to die by suicide with a gun than are members of any other occupation. In studies examining suicide among law enforcement officers

and military personnel, 95 percent of police officers who died by suicide used a firearm, compared to 59 percent of military officers. And 90 percent of officer suicides occurred away from the workplace, which is twice the rate for military officer suicides. Dr. Violanti’s research indicates that 24-hour access to a gun means it is easier for someone to make an impulsive decision to take their life.⁴¹

This combination of factors in policing—stress and trauma on the job, depression, alcohol, PTSD, and accessibility of firearms—dramatically increases the risk of suicide by officers.

Warning Signs

Individuals who experience suicidal thoughts often exhibit warning signs. It is important for police leaders to understand that there are warning signs specific to officer suicide.

The American Foundation for Suicide Prevention identifies three categories of general warning signs that indicate a person might be suicidal—talk, behavior, and mood.

- Suicidal persons may talk about feeling hopeless, being a burden to others, feeling trapped, and having unbearable pain.
- They may exhibit behaviors that signal risk, such as increased use of alcohol or drugs, withdrawing from activities, isolating themselves from friends and family, sleeping too much or too little, or giving away prized possessions.
- Finally, a suicidal person’s mood is likely to show marked changes, including increased depression, anxiety, irritability, and sometimes a feeling of relief/sudden improvement that may indicate a person has decided to take their life.⁴²

Due to the nature of their job, police officers may demonstrate some warning signs more dramatically than others. Detective Jeff Thompson, the NYPD’s

38. Violanti, J. M. (2007). *Police Suicide: Epidemic in Blue*. Springfield, IL: Charles C. Thomas.

39. Violanti, John M. (2018), “PTSD among Police Officers: Impact on Critical Decision Making.” U.S. Department of Justice, Office of Community Oriented Policing Services. <https://cops.usdoj.gov/html/dispatch/05-2018/PTSD.html>

40. Violanti, John M. (2004), *Predictors of Police Suicide Ideation*; <https://www.ncbi.nlm.nih.gov/pubmed/15385182>

41. Violanti, J. M. (2007). *Police Suicide: Epidemic in Blue*. Springfield, IL: Charles C. Thomas.

42. “Risk Factors and Warning Signs.” American Foundation for Suicide Prevention. <https://afsp.org/about-suicide/risk-factors-and-warning-signs/>

Mental Health and Wellness Coordinator, reported that by conducting psychological autopsies (see pp. 31–34) and reviewing cases of officer suicide, he has found that alcohol abuse, feelings of hopelessness, and concerns about being a burden to others are the warning signs that are more evident in police suicides. An NYPD graphic (at right) displays additional warning signs of officer suicide and how they may be demonstrated.

Turning Research into Action

Research, as well as the personal experiences of people such as the three officers who shared their experiences at the PERF conference, confirms that suicides are seldom the result of a single overriding factor, such as work stress, exposure to trauma, substance abuse, or relationship issues. In almost every instance, it is a combination of risk factors that leads people to take their lives.

For police chiefs, sheriffs, and other executives looking to prevent officer suicides in their agencies, understanding the multitude of risk factors and being able to recognize the warning signs are critical.

The 10 recommended actions that follow (see page 29) are designed to help law enforcement executives and others better address the complexity of officer suicide.



Officer Suicide Warning Signs

- The officer is talking about suicide or death, and even glorifying death.
- Officer is giving direct verbal cues such as “I wish I were dead” and “I am going to end it all.”
- Officer is giving less direct verbal cues, such as “What’s the point of living?”, “Soon you won’t have to worry about me,” and “Who cares if I’m dead, anyway?”
- The officer is self-isolating from friends and family.
- The officer is expressing the belief that life is meaningless or hopeless.
- The officer starts giving away cherished possessions.
- The officer is exhibiting a sudden and unexplained improvement in mood after being depressed or withdrawn.
- The officer is neglecting his/her appearance and hygiene; exhibits a deteriorating job performance.
- The officer displays behavior changes that include appearing hostile, blaming, argumentative, or they appear passive, defeated, and hopeless.
- Officer openly discusses that he/she feels out of control.
- The officer is aware that they are going to do something that will ruin his/her career, but that they don’t care.
- The officer acts reckless and/or carries weapons in a reckless, unsafe manner.
- The officer has recent issues with alcohol and/or drugs.

(From Chae & Boyle, 2013)

Source: <http://nypdnews.com/areyouok/>

A Montréal Police Program Reduced Officer Suicide Rate by 79 Percent

Many police and sheriffs' agencies are launching programs designed to provide mental health care and other assistance to officers and to prevent suicides. Few initiatives, however, have been rigorously evaluated to determine the impact on the prevention of officer suicides. One program that has undergone an evaluation is *Together for Life*, a program of the Montréal Police Service.

Started in 1997, the *Together for Life* program was created to prevent suicide among members of the Montréal Police Service. To do so, the program worked to educate officers on how to cope with suicide and how to develop mutual support among members of the agency, and to provide officers with resources.

The program consisted of four components:

- **Department-wide training:** More than 87 percent of the department's officers received a half-day of training that consists of information on the nature of suicide, how to identify risk factors, and how to assist a colleague in need.
- **Suicide prevention resources:** Members of the department were provided with access to a telephone hotline where they could find assistance in dealing with issues that could cause stress, including traumatic incidents encountered on the job; dependencies (alcohol, gambling, etc.); relationship problems; and LGBTQ issues. The hotline was staffed by volunteers, and all calls were completely anonymous.
- **Training of supervisors and union representatives:** Supervisors and union representatives received a full day of training by psychologists, focusing on improving their

ability to identify officers at risk of suicide and how to intervene.

- **Publicity campaign:** A coordinated publicity campaign sought to enhance officers' awareness of the program. This included articles in internal newsletters, posters in each unit, and a brochure.

Dr. Brian L. Mishara and Dr. Normand Martin evaluated the program's implementation in 2000-2001 and its impact in 2010.⁴³ In comparing the suicide rate for the Montreal Police Force for the eleven years prior to the program's implementation and the twelve years following its implementation, the researchers **found a decrease in the police suicide rate of 79 percent.** A similar decrease was not seen in the suicide rates of other police agencies in the Province of Quebec (the suicide rate *increased* 11 percent in the other agencies). The researchers found that the decrease in the suicide rate in Montreal, and the difference between the outcomes in Montreal and the other agencies in Quebec, were statistically significant.

For the evaluation of the program's implementation, the researchers examined each of the four components. The training aspects of the program appeared to be the most successful. Among the officers who received the department-wide training, 96 percent found the sessions to be useful, 97 percent thought that the format was suitable, and 99 percent stated that they would recommend the sessions to a colleague. Similarly, the targeted training for supervisors and union representatives was highly rated, with participants noting higher awareness of risk factors and a greater confidence in

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43. Mishara, Brian L. and Martin, Normand. (2012). "Effects of a Comprehensive Police Suicide Prevention Program," *Crisis*, 33(3): 162-168. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3380405/>

continued from page 27

identifying difficulties in their officers. “The trainers were well received because they ‘spoke the language’ of the police milieu and were not seen as outsiders,” the researchers noted.

The researchers theorized that one of the main components of the program’s success was its wide reach within the agency. Nearly everyone in the agency, from the highest-ranking leaders and supervisors to the union officials and patrol officers, was exposed to some aspect of the program. As a result, there was a cultural shift in the agency’s perception of suicide.

“In the past, officers would joke about ‘eating their gun’ when things got really tough,” the researchers said. “Now, it appears that officers do not joke about this quite as often, and that they frequently mention available sources for help.”

“Furthermore, part of the emphasis of the training was that a suicide is not an event affecting only the suicidal individual, but also involves and profoundly affects the entire community,” the researchers said. “One of the effects of this program was that suicidal behavior is seen as less acceptable because of its implications for the rest of the force.”

Part Two:

10 Recommended Actions to Prevent Suicide Among Police Officers

FOLLOWING ARE 10 RECOMMENDED ACTIONS that police agencies can take to prevent officer suicide. These are intended to guide law enforcement agencies in creating or changing policies, developing programs, and providing resources to address the issues of officer mental health and suicide. The recommendations are based on research, the guidance of experts and mental health practitioners, and the experience of law enforcement professionals.

Recommended Action 1: Data Collection

Obtaining more complete information about the extent and nature of police suicides needs to be a national priority. There must be a central repository for capturing and analyzing this data.

Blue H.E.L.P., an all-volunteer nonprofit organization, has done an excellent job of collecting detailed data about officer suicides.⁴⁴ The group maintains a database that relies on Internet searches, law enforcement surveys and information requests, online submissions through its website, and interviews of family members of officers who have taken their own lives. (See pages 12–13 for more information about Blue H.E.L.P.) But despite the group’s best efforts, we know that the extent of the problem is underreported.

An issue as important as police officer suicides should not be dependent solely on volunteer efforts to gather essential data about the problem. **The federal government should take a leadership role in collecting and analyzing information through a national, comprehensive data collection effort.** A federal program would have greater resources and legal authority to require or create incentives for agencies to report data.

A central repository of information will allow researchers and policing professionals to know the full extent and nature of the problem, so they can develop and implement policies and programs to prevent officer suicide.

Currently, police and sheriffs’ departments are not required or even encouraged to report information about officer suicides to the federal government or other official entity. The Centers for Disease Control and Prevention (CDC) collect death certificate information, but only 25 states contribute to that system. Furthermore, suicides are often misclassified under some other cause of death. In some cases, officer suicides are reported as natural deaths. One research study found that 17 percent of police suicides were misclassified.⁴⁵

An organization called Badge of Life collected data on police officer suicides for six years, but announced in 2018 that it would no longer do so. “Underreporting, non-reporting, misdiagnosing by

44. “Law Enforcement Suicide Statistics.” Blue H.E.L.P. <https://bluehelp.org/service/statistics/>

45. O’Hara, Andrew F. et al. International Journal of Emergency Mental Health (2013). *National police suicide estimates: Web surveillance study III*. <https://www.ncbi.nlm.nih.gov/pubmed/24187885>

the medical examiner or coroner and stigma remain the problems to analyzing the true data,” the organization said.⁴⁶ Badge of Life has called for mandatory reporting of officer suicides to a national repository, such as the CDC or the National Institute of Mental Health.

The U.S. Department of Justice, Bureau of Justice Assistance is working toward the creation of a national database in partnership with Blue H.E.L.P., the International Association of Chiefs of Police, the National Law Enforcement Officers Memorial Fund, and other policing organizations. That effort needs the support of policymakers and law enforcement leaders.

“We need to have the entire country, all 50 states, contributing to data collection. Major groups who collect data on police, such as the FBI, can help us know the true extent of police suicide in this country. Legislation is necessary to enact such a collection policy.”

— **Dr. John Violanti, University at Buffalo**

National Occupational Mortality Surveillance (NOMS) Program; National Violent Death Reporting System (NVDRS)

NOMS and NVDRS are two reporting programs that fall under the Centers for Disease Control and Prevention (CDC). The NOMS program specifically monitors changes in cause of death by occupation or industry.⁴⁷ This data is derived from death certificates issued by state vital statistics offices and includes all men and women employed in a specific occupation or industry ages 18–90. The data is limited, however, in that it does not include all states for all time periods.⁴⁸

In comparison, the NVDRS is a much more comprehensive data set. It is the only state-based reporting system that gathers data on violent deaths and their circumstances from multiple sources into one anonymous database. Data is collected from all 50 states, Puerto Rico, and the District of Columbia,

and from several sources including law enforcement, medical examiners, toxicology, and death certificates. However, the major limitation of NVDRS is that the data cannot be broken out by subgroups. There does not appear to be a way to look at suicides for law enforcement (or any occupation) using NVDRS data.⁴⁹

There are general limitations for both programs. Misclassification of death is a concern with deaths by suicide. A death may be reported as “undetermined” or under a different classification altogether (e.g., a motor vehicle accident) if the true cause is unknown. It is also important to note that both data sets are only as good as what is reported to them or to the state vital statistics offices.

46. “Our Position on Suicide Statistics.” Badge of Life. <https://badgeoflife.org/statistics-position>

47. See “Law Enforcement Suicide: A National Analysis” Violanti, John; Robinson, Cynthia; and Shen, Rui. *International Journal of Emergency Mental Health and Human Resilience*, Vol. 15. No. 4. <https://s3.amazonaws.com/destination-zero/Law%20Enforcement%20Suicide%20A%20National%20Analysis.pdf>

48. “National Occupational Mortality Surveillance (NOMS).” The National Institute for Occupational Safety and Health. Centers for Disease Control and Prevention. <https://www.cdc.gov/niosh/topics/noms/default.html>

49. “National Violent Death Reporting System.” Centers for Disease Control and Prevention. <https://www.cdc.gov/injury/wisqars/nvdrs.html>

Recommended Action 2: Psychological Autopsies

Agencies should conduct psychological autopsies on police suicides, and they should use that data to inform their policies, practices, and programs.

When an individual takes his or her life, family members and friends often ask “why?” Researchers and mental health practitioners have created a tool that can help provide answers, with the goal of developing empirically based suicide prevention programs.

This tool, known as the “psychological autopsy,” is a structured format for gathering information that helps to recreate the psychosocial environment of an individual who has died by suicide. The goal is to better understand the reasons for the subject’s death.⁵⁰

Psychological autopsies, which are relatively new to policing, hold promise for unlocking some of the mysteries of police officer suicides.

Dr. Melinda Moore, a licensed psychologist, assistant professor in the Department of Psychology at Eastern Kentucky University, and board member of the American Association of Suicidality (AAS), said that the concept of psychological autopsies is rooted in the late 1950s and early 1960s, when Dr. Theodore Curphey, the medical examiner for Los Angeles County, called upon Dr. Edwin Schneidman and his colleagues at the Los Angeles Suicide Prevention Center to develop a way to help understand why some individuals take their lives. Dr. Moore explained:

Dr. Schneidman founded the study of suicidology, and also founded the American Association of Suicidology. He coined the phrase “psychological autopsy” and is known for developing and refining this best practice, which is about reconstructing the

>> continued on page 34

Elements of a Psychological Autopsy

The Law Enforcement Psychological Autopsy used by the New York City Police Department presents information, assessments, and recommendations about a suicide in a single report, in 13 sections:

1. Identifying information and a short summary of findings, including analysis of a) why the person died by suicide b) why the suicide was committed by the means it was committed, and c) why the suicide was committed on the particular day it happened.
2. Details of the death/attempt.
3. Possible contributing risk factors and/or warning signs.
4. Description of the decedent’s personality and lifestyle.
5. The decedent’s typical pattern of reaction to stress and emotional incidents.
6. The role, if any, of alcohol and/or drugs in the overall lifestyle of the decedent and his/her death (recently and historically).
7. The nature of the decedent’s interpersonal relationships.
8. Any changes in the decedent’s habits and routines before death.
9. Information related to the positive “life side” of the subject and why the protective factors did not prevent the suicide.
10. Assessment of intention and rating of lethality.
11. Reaction of interviewees to the decedent’s death and how they think it could have been prevented.
12. Special features to the case.
13. Recommendations.

50. Collective Expert Reports. “Suicide: Psychological autopsy, a research tool for prevention.” (2005) <https://www.ncbi.nlm.nih.gov/books/NBK7126/>

How the NYPD and LAPD Use Psychological Autopsies

At the PERF conference, Dr. Jeff Thompson,⁵¹ a detective with the New York City Police Department, and Dr. Denise Jablonski-Kaye⁵² of the Los Angeles Police Department explained how their agencies have been conducting psychological autopsies and how other departments can use this tool.

Dr. Jeff Thompson, NYPD:

Preventing suicides is not just about proactively reaching out to officers who may be struggling. With prevention must come reflection—looking back and learning as much as we can from these tragic incidents, when an officer dies by suicide. The psychological autopsy is an instrument that can help us figure that out.

A psychological autopsy is like good detective work: What exactly is a psychological autopsy? It's not a sheet where you have 80 questions that you ask in a certain order. It's more like how great detectives do investigatory work, where they follow the leads as they emerge. But the psychological autopsy helps you make sure you're asking all the right questions.

The instrument we're using in the NYPD, which I developed at Columbia University Medical Center/New York State Psychiatric Institute with the American Association of Suicidology, is specific to law enforcement. We try not to make it overly academic or burdensome, because we're practitioners. We're not doing this for the purpose of publishing articles in academic journals. That's important for others to do, but it's not what most of the people in this room do.

It's never about assigning blame: When you interview family members or friends, one of the first things you'll hear is that the suicide was unexpected and shocking. But if you interview enough people, eventually they end up telling you about risk factors and warning signs that were present. Of course, we don't

do this to blame anybody. We don't tell friends and family members, "You missed this. You should have noticed that." But it is useful for us to know whether there were certain signs of depression and the potential for suicide, so we can raise awareness of those factors among our officers and their families.

We want to understand why the person died by suicide, why by those means, and why on that particular day. Quite often, people have been in a world of hurt for a long time, but there was an impulsivity that led them to suicide on that one day. **It can help prevent suicides if you try to find out what happened on that one day.**

Psychological autopsies can be done in-house: We don't bring in an external psychologist to conduct psychological autopsies. I'm trained to do it, as are several others in the NYPD. It's important to make sure that whoever does the autopsies in your agency has a solid foundation of understanding suicide, of knowing the risk factors and warning signs and the different things that can contribute to it, and ultimately realizing it's not one single thing. When you interview people, you need to know what to look for.

We work very closely with our Force Investigation Division, which is required to investigate officer suicides. We don't step

Detective
Jeff Thompson,
NYPD Mental
Health and
Wellness
Coordinator



51. Dr. Thompson is a certified Psychological Autopsy Investigator, a trainer with the American Association of Suicidology, an Adjunct Associate Research Scientist with the Columbia University Medical Center, an NYPD detective, and NYPD's Mental Health and Wellness Coordinator.

52. Dr. Jablonski-Kaye has served as a police psychologist in the Los Angeles Police Department's Behavioral Sciences Services Unit since 2004.



Dr. Denise
Jablonski-Kaye,
Los Angeles Police
Department

on their toes or interfere with their work. We work very closely with them and help them understand the mindset behind suicide, to help them with their investigation. We work together to gather data, interview more people, and collect more in-depth information. These detectives are great at what they do, and they have told me that they feel they are better able to do these investigations with the benefit of our psychological autopsies.

Psychological autopsies reveal themes and patterns: When you do psychological autopsies for multiple cases, you see themes start to emerge. It's often about relationship issues with a spouse or significant other. A relationship problem might be the tipping point that leads to a suicide, but it's not the sole reason the officer took their life.

In my experience, I have never come across an officer suicide that was about one single thing. It's always a combination of things, and this analysis helps you figure that out.

Agencies of all sizes can conduct psychological autopsies: You may be thinking, "The NYPD has more than 50,000 employees. How can I implement this in a small or midsize agency?" You definitely can. You don't necessarily need the gold standard of a certified psychological autopsy. You can train your investigators and everyone involved in suicide prevention on these skills.

But it's not a one-off training; you have to stay sharp with it. You need that continuing education. Whether it's going to the annual conference of the American Association of Suicidology, or attending programs by other good organizations, it's important to continue to work with these people who have been

doing this for many years. They will help you. They can help you modify or adapt the program for a law enforcement context, or to fit whatever your needs are.

Reasons to learn this skill: The last thing I want to discuss is why your agency should use the Law Enforcement Psychological Autopsy. First and foremost, we owe it to that fallen brother or sister. We have to find out what happened in their life, what was going on with them in those days and minutes that led them to kill themselves. I think everybody in this room agrees that we need to find that out.

We also owe it to their families and to their coworkers. Psychological autopsies help to ensure that your mental health programs and proactive, preventive outreach efforts are grounded in solid research and data. In the NYPD, we promote four key elements to help officers stay resilient against the stresses of policing: sleeping well; eating well; regular exercise; and socializing with family and friends.

Dr. Denise Jablonski-Kaye, LAPD:

Agencies of any size can take advantage of psychological autopsies. Here's what I compare it to: Any agency here in this room, if you had a tactical operation that didn't go the way it was supposed to go, and you lost an officer as a result, you would certainly debrief that. You would want to look at what didn't go well, what you could have done better, and what you will do differently in the future. I think the psychological autopsy is equivalent to that. We lost an officer, but in a different way. We need to take a close look at how and why that happened.

Also, small and medium-size police agencies have investigative personnel. You have detectives. You have a lot of people who know how to ask questions, how to uncover information. I think it is absolutely possible, if you provide some training, you set aside some personnel, and you ask them to do this kind of investigation.

Why do we want to find out what happened? Because we want to fix it, and we want to know what we can do in the future that can make a difference. The information that we gather, we use to inform our training.

proximal and distal causes of the individual's death by suicide.

We are trying to understand the risk factors that may have contributed to the individual's death. Or in other cases, a psychological autopsy aims to uncover the most likely manner of death where the death is equivocal and is left undetermined by the medical examiner or coroner.

This procedure has been refined and perfected over the years. Since 2011, the American Association of Suicidology has offered training in conducting psychological autopsies.⁵³ The training leads to becoming certified as a psychological autopsy investigator.

Dr. Moore said that psychological autopsies essentially are designed to answer four important questions:

- Why suicide?
- Why suicide at this time?
- Why by this method?
- How could this suicide possibly have been prevented, in your opinion?

“We have trained a broad range of professionals in this approach, nationally and internationally. I hope that those of you in policing who have not been trained in psychological autopsy will consider it,” she said.

For individual agencies, psychological autopsies can help identify trends and themes, and thus support the development of officer wellness and suicide prevention programs for the agency.

For the profession as a whole, psychological autopsies have benefits as well. If anonymous, non-identifiable data from psychological autopsies were reported to a central repository, researchers, practitioners, and policymakers would have access to more extensive and detailed data about risk factors and warning signs. This information could be used to identify larger trends in officer suicide and to guide decisions on policy and resources.

Dr. Melinda Moore,
American Association
of Suicidology



Recommended Action 3: Routine Mental Health Checks

Agencies should consider requiring or, at a minimum, offering mental health checks for all employees on a regular basis, such as once a year, to reduce stigma and “normalize” a focus on mental health.

In stressing the importance of officer wellness, many law enforcement agencies have looked at ways to improve officers' physical well-being. Some agencies have expanded this to also address officers' mental well-being by mandating regular mental health checks. For example, the Plymouth, MN Police Department implemented the “Check Up from the Neck Up” program, which requires officers to meet with a mental health practitioner at least once per year. Additional visits beyond the mandated yearly check-in are provided at no cost.⁵⁴

Some agencies that participated in the PERF conference may soon adopt this approach. The Las Vegas Metropolitan Police Department (LVMPD) is working with its union to negotiate a Health and Wellness Day and establish mental health assessments on the same day as annual physicals. The Lansing, MI Police Department is considering adding a yearly officer wellness check-in with a police psychologist, in addition to the resources it already makes available to officers experiencing crisis. The Voorhees, NJ Police Department is developing a program that would provide officers with automatic yearly visits to a police psychologist.

53. American Association of Suicidology. “Psychological Autopsy Certification Training.” <https://suicidology.org/training-accreditation/pact/>

54. “Plymouth Police take unique steps to address officers' mental health.” KARE11-NBC. January 9, 2019. <https://www.kare11.com/article/news/plymouth-police-take-unique-steps-to-address-officers-mental-health/89-e639e912-42a8-4f2d-8006-5dd50fe980d3>



FAR LEFT: Dr. Miriam Heyman, Ruderman Family Foundation

LEFT: Director Jon Adler, Bureau of Justice Assistance, DOJ

Dr. Miriam Heyman of the Ruderman Family Foundation endorsed the recommendation of mental health checks for police officers. “I think that mental health checkups should be routine, if not mandatory, perhaps annually, especially following critical incidents,” she said. “I acknowledge that mandatory checks might be challenging for departments to implement, but I’d encourage everyone to think about a step they can take right now, such as *offering* these checks at every annual review. I think that could be a first step that would lead to even greater progress.”

Implementing effective mental health check programs

Some participants at the PERF conference cautioned that if agencies plan to implement a regular mental health check program, they need to ensure that the effort is comprehensive, substantive, and well thought out. The process cannot be perfunctory, such as a checklist of questions that can be completed in a few minutes, because that can undermine the credibility of the entire program.

“We do comprehensive mental health checks for a lot of our members in high-risk roles. When it’s done well and comprehensively, it works great,” said Chief Psychologist Tim Grenfell of the Australian Federal Police. “But if it’s just going to be a tokenistic process, the members will just check ‘no’ to all the questions about whether they have felt depressed, etc., and you’re not in a better position as an organization. In fact, you’ve compromised the organization, because you have a false sense of assurance about what’s going on.”

Agencies need to consider how the program will be structured and implemented. Are check-ins mandatory or voluntary? If mandatory, how often

should they occur? Who will oversee the check-ins? Will they be uniform throughout the agency or vary depending on a person’s rank and role within the agency?

Another key question to consider is how the agency will respond to officers who present a need during these check-ins. Officers will likely be concerned that revealing problems during a check-in could result in them being removed from active duty, which could make them less likely to be honest during these sessions.

Jon Adler, Director of the U.S. Justice Department’s Bureau of Justice Assistance, said that police leaders need assurances from mental health experts that an officer receiving treatment for depression can continue to serve:

If the mental health experts can tell the chief of police with confidence that a law enforcement officer can serve effectively, that will help us to smash the stigma. But we will need to have those assurances.

Dr. John Mann of Columbia University Medical Center said that psychologists can offer police chiefs guidance about which officers can continue their regular assignments:

Police work is stressful. And you can’t reduce the stress that officers have to work under, because that’s the job. They take risks that the average person does not have to take.

But police officers will respond to treatment for depression like everyone else does. As psychologists, our goal is to keep the ones that we think are a suicide risk out of depression. The suicide risk drops dramatically when people’s depression gets better. And when a depressed person is feeling cheerful and okay, they can cope with stress the same as anybody

>> continued on page 37

Fairfax County, VA Survey Led to Mandatory Mental Health Checks

Concerned about the rising number of police officer suicides in the United States and locally, the Fairfax County, VA Police Department (FCPD) decided to field a short internal questionnaire to collect information anonymously about officers' well-being, how their work may be affecting them, and the types of assistance they would like to have available. Department officials were so surprised by the response rate—60 percent of officers completed the questionnaire—that they decided to expand the survey to other first responders and to other jurisdictions throughout Virginia.

The FCPD worked with the United States Marshals Service, Behavioral Analysis Unit, and the Fairfax County Coalition of Police Local 5000 to administer the survey, collect the data, and analyze the results. In all, nearly 5,000 first responders from 26 agencies—police, fire and rescue, and public safety communications—completed the Virginia Public Safety Mental Health Pilot Survey.⁵⁵

The survey analysis focused on two key groups:

- Those who reported having suicidal thoughts within the last year.

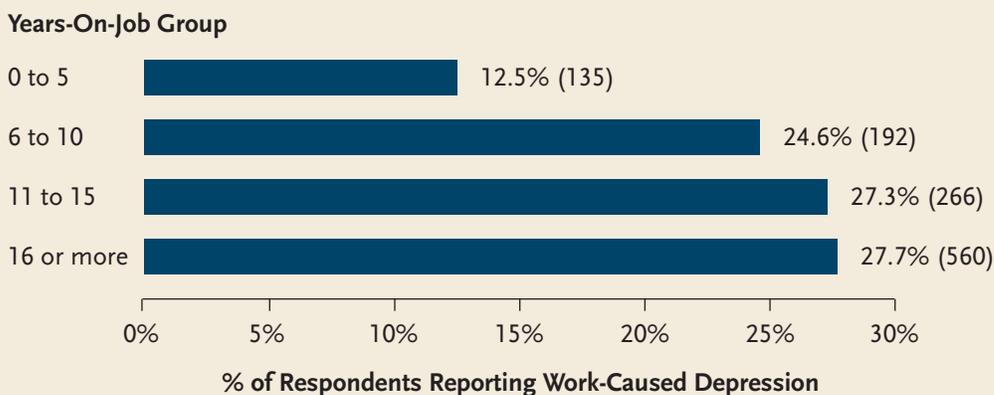
- Those who indicated that working in their profession has caused symptoms of depression.

While not representative of the entire Virginia public safety community, the survey did produce some startling results. For example, 7.8 percent of respondents reported having had suicidal thoughts in the past year. In addition, 23.7 percent said they suffered some degree of depression as a result of their work. The survey also found that the percentage of first responders reporting work-related depression rose with experience, with a sharp increase from 0 to 5 years on the job (12.5%) to 6 to 10 years (24.6%).

Jaysyn Carson, the FCPD's Director of Incident Support Services, said that after the FCPD received the survey results, the department implemented mandatory mental health checks. So far, the results of that policy change have been positive, he said:

Because we're trying to reduce the stigma against seeking mental health care, I think the biggest thing we can do as leaders is mandatory mental health checks, because

Is a particular year-on-job range more likely to report work-caused depression?



55. Available at <http://fcop5000.org/wp-content/uploads/2019/08/2019-Fairfax-County-Police-Pilot-Survey-Summary.pdf>.

everybody has to go through them, so there's no stigma attached to it.

We have found that very few officers are not talking in these sessions. And we've seen a huge difference with our people. We're

seeing a lot of self-reporting now by officers seeking counseling, and we're seeing reporting of others who may be experiencing stress or depression, because we have these policies in place.

continued from page 35

else. Our goal in treatment is to make them as resilient as the person who hasn't had recurrent episodes of depression.

Charles Ramsey, former Police Commissioner in Philadelphia, endorsed the idea of mental health checkups for all police employees, but noted that because this is new ground, it is not yet clear how this idea will be implemented:

I believe that there ought to be regular mental health checkups for police officers, and that includes everyone, including the Police Chief. Most of our conversation deals with line officers, but I'm here to tell you it's an enormous amount of stress when you're at the top of the organization, too.

And so it needs to be top to bottom. That's also how you get rid of the stigma. If everybody has to go through it on a regular basis, it takes away the stigma.

*One way to help officers feel a little more at ease about periodic mental health checks would be to give it a different name. **Instead of calling it a mental health checkup, call it something like a "periodic debriefing," in which officers are debriefed about the stressful incidents they have experienced, and how they are feeling.***



"All of us have to take the stance as law enforcement leaders that we need to create change in the culture and reduce stigma, and we need to do this for the rest of our lives."

— **Chief Edwin Roessler, Fairfax County, VA Police Department**

Recommended Action 4: Leadership from the Top

Police chiefs, sheriffs, and other leaders need to speak out about the issue of police suicides within their agencies and in the community. Leadership from the top is crucial to getting this issue out of the shadows. The leadership by police chiefs and sheriffs must be reinforced at all levels of the organization, including middle managers and first-line supervisors.

The stigma that many police officers feel about seeking help for mental health issues cannot be eliminated without forceful leadership from the top down. Effective policies and procedures related to officer wellness and suicide prevention require leaders who are fully supportive of these programs and who are willing to speak out on the issue.

In an effort to "normalize" the concept of mental health treatment, Chief Edwin Roessler of the Fairfax County (VA) Police Department and Superintendent Eddie Johnson of the Chicago Police Department have led by example, speaking openly about their own decisions to seek mental health care. Chief Roessler has publicly discussed his experiences in obtaining counseling. In 2018, the Fairfax County Police Department began showing a video to officers at roll calls that features a number of first responders

telling their stories about depression and thoughts of suicide.⁵⁶

In Chicago, Superintendent Johnson has discussed his decision to seek counseling when he was a sergeant, and like Chief Roessler, has directed the viewing at roll calls of a video that the Chicago Police Department created encouraging officers to seek mental health treatment. “We have to always let them know we have their back. Go get treatment and the help you need, your job is waiting for you when you get back,” Superintendent Johnson said.⁵⁷

Middle managers and first-line supervisors also must be involved in the planning, development, and support for mental health and suicide prevention programs. Sergeants, lieutenants, and captains are in daily contact with officers, so they often are the first to notice signs that an officer may be having difficulty coping with stresses. First-line supervisors and middle managers should be trained to know and understand the signs of mental illness and stress, so they will be sensitive to these indicators and skilled at noticing them and helping subordinates to obtain assistance. Like executive-level leaders, middle managers and first-line supervisors also must be willing and able to talk about the issue of police suicide and be intimately aware of the suicide prevention resources that are available to agency personnel.

It is also important to teach supervisors how to avoid actions that may unnecessarily add to the stresses imposed on their subordinates. According to research conducted by Dr. John Violanti, one of the biggest stressors among police officers is that they do not feel supported by their superior officers. Many officers reported feeling that their organization was afraid to even acknowledge that some officers have mental health problems. Driving this fear among agency leaders is a lack of knowledge about depression, PTSD, and suicide among police.

Dr. Violanti and other researchers stressed the importance of education at all levels of police and

sheriffs’ agencies, but particularly at the middle management level.

Recommended Action 5: Gun Removal Policy

Agencies should carefully structure their policies on the decision to take a firearm away from officers who are seeking mental health services, to minimize the risk of suicide, without discouraging officers from seeking help. Professional psychologists should be involved in making these decisions.

The availability of firearms in the law enforcement profession presents a unique risk factor that must be carefully considered when developing agency policies on fitness-for-duty and suicide prevention.

Suicide prevention programs for the general public often have components designed to keep firearms away from anyone who is considered at risk for suicide, because firearms are far more lethal than other means of suicide. As noted earlier, approximately 90 percent of suicides attempted with a gun end in death, compared to only 10 percent of suicides attempted by all other means combined.⁵⁸

Furthermore, in the world of policing, the risks from firearms are especially high. Because police officers in the United States generally have access to firearms both on-duty and off-duty, they are at a much higher risk of dying by suicide with a firearm.⁵⁹

However, taking a firearm away from a police officer is a much more complicated issue, because carrying a firearm is usually a necessary part of a police officer’s job. Participants at the PERF conference offered a range of perspectives on this question and agreed that it is a difficult issue to resolve.

>> *continued on page 40*

56. “First Responders Share Their Mental Health Battles to Help Others,” *NBC4 Washington*, Nov. 7, 2018. <https://www.nbcwashington.com/news/health/First-Responders-Share-Their-Mental-Health-Battles-to-Help-Others-499986412.html>

57. “Chicago Police Department releases video to encourage officers to seek mental health help.” ABC7 Eyewitness News, April 9, 2019. <https://abc7chicago.com/health/cpd-releases-video-to-encourage-officers-to-seek-mental-health-help/5240621/>

58. Dr. Jerry Reed. Quoted in *Reducing Gun Violence: What Works, and What Can Be Done Now*. Police Executive Research Forum (2019). Page 16. <https://www.policeforum.org/assets/reducinggunviolence.pdf>

59. Violanti, J. M. (2007). *Police Suicide: Epidemic in Blue*. Springfield, IL: Charles C. Thomas.

How Chicago Addressed a Technicality in Illinois Law That Was Affecting Officers Seeking Mental Health

At the PERF conference, First Deputy Superintendent Anthony Riccio of the Chicago Police Department described a unique situation in Illinois law that was negatively impacting officers who sought mental health care, and how a change in department policy addressed the issue:

First Deputy Superintendent Anthony Riccio, Chicago Police Department



In Illinois, in order to carry a gun, you need a Firearms Owner's Identification Card (FOID) issued by the state. If you receive mental health treatment, that card is revoked, which means you can no longer lawfully carry a gun.

There's an exception under the law for police officers on duty. But when you're off duty—if you work part-time in a security job, or if you're just on your way home—that exemption no longer applies.

So if the state revokes your FOID and you can't carry a gun anymore, the Police Department was putting you in a no-pay status. So you lose your paycheck, and after 30 days you lose your health insurance. It was absolutely a horrendous policy.

We had a recent incident involving a female officer who put a gun to her head while she was at home and threatened to kill herself. Her daughter called us, the SWAT team responded, our negotiators talked her down, and she went into the hospital for inpatient treatment. When she came out, her FOID card was revoked and she went on no-pay status, so her problem became much worse.

And in addition to worsening the problem for this officer, we were sending a message to 13,000 other officers that if you go in for mental health treatment, the state's going to take away your ability to carry a gun, and we're going to take away your paycheck and your health insurance.

So Superintendent Johnson immediately changed the policy, and said, essentially, that if you go in for mental health treatment, and you find that your FOID card is revoked by the state as a result of that, we will put you in a modified duty assignment. You won't be able to carry a gun, but you'll still get your paycheck and health insurance. And when you get your issues resolved and get your FOID card back, we'll restore you to full duty.

There's still some stigma attached to that, but at least we've removed the biggest obstacle, I believe, which is the loss of a paycheck.

Taking away the gun of an officer who is seeking mental health services may remove the most likely instrument of death if the officer becomes suicidal. Dr. John Mann of the Columbia University Medical Center cited a study of the Israeli Defense Forces (IDF). Prior to 2006, members of the IDF carried their weapons home with them. But knowing that the risk for suicide increases when a person is at home, the IDF adopted a new Weapons Availability Reduction Policy that year, requiring that officers keep their weapons locked at work when they are off-duty. This change, combined with other components of the IDF's suicide prevention program, decreased the suicide rate by nearly half.⁶⁰

On the other hand, some participants at the PERF conference expressed concerns that removing an officer's firearm could do more harm than good. Removing an officer's firearm may threaten his or her sense of identity and purpose in the organization, as well as the officer's career and even paycheck. Removing the gun could also have the counterproductive effect of increasing the officer's feelings of depression or hopelessness, and the fear of losing their weapon could keep some officers from seeking help.

A number of police officials also noted that in most cases, it is not difficult for an officer to acquire a firearm from another source.

Whether and when to remove an officer's gun is an extremely difficult decision, requiring sensitivity and expertise. There is a need to balance the threat that a firearm may pose to a troubled, potentially suicidal police officer against the damage to the officer's mental state that may occur if the department takes the officer's gun away.

Unintended consequences can occur when a department removes an officer's firearm—or when the department fails to do so. This may appear to be a “no-win” situation, but departments must try to make the best decision based on the facts in each case.

Professional psychologists should be involved in helping to make these decisions, because they have a better understanding of the risk factors of suicide. Clinicians at the PERF conference noted that there is a difference between an individual dealing with depression, anxiety, or PTSD and someone who is a threat to himself or herself. They also stressed that any policy changes related to gun removal should not put additional obstacles in the way of officers coming forward and seeking help.

And in no case should an officer's paycheck, health insurance, or other employment benefits be put at risk because the officer sought mental health care. Officers whose guns have been taken can be placed on modified duty and should continue to receive mental health care. When a psychologist determines that an officer's mental state has improved and the officer is no longer considered a threat to himself or herself, the officer can return to regular duty, armed with a firearm.

Setting a high threshold for taking an officer's firearm:

Dr. Denise Jablonski-Kaye, police psychologist with Los Angeles Police Department, said, “My threshold for recommending gun removal is very high. As I sit and talk to an officer, maybe they have some problems, maybe they even have some suicidal ideation, but if I don't believe that they're an imminent threat to themselves, I won't recommend that their gun be taken. They're going to be getting help from me, and I'm going to use whatever resources I have to embrace this person and make sure that they'll be safe. In that situation, I do believe that at that moment in time, it may cause more damage to remove the gun, than to allow them to continue to have the gun and be in treatment.”

60. Shelef, Leah.; Laur, Lucian; Raviv, Gil; Fruchter, Eyal. (2015); *A military suicide prevention program in the Israeli Defense Force: a review of an important military medical procedure*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5329935/>

Recommended Action 6: Confidential Support Programs And Training

Agencies should offer a range of programs, including EAP and peer support, to assist personnel who may need help, and they should train employees on how to access those services and how to identify and support fellow officers showing signs of stress, depression, or behavioral crisis.

“Who can understand what a police officer is going through, better than another police officer?”

— Sergeant Mark Freire, Boston Police
Department Peer Support Unit

Oftentimes, the people who are best equipped to understand the stresses of policing, the experiences of officers, and the mental health issues that many officers face are officers themselves.

However, in most police departments, officers are not adequately trained to identify or recognize signs of stress, depression, or behavioral crisis in their fellow officers. Ensuring that all personnel are trained in mental health awareness and are familiar

with the services and programs that an agency offers is an important component of an agency’s suicide prevention effort.

Another key component is offering a range of support services that are accessible to and trusted by agency personnel. The most common types of psychological support programs in police departments are:

- Employee Assistance Programs (EAP),
- Peer Support Units (PSU), and
- Critical Incident Stress Management (CISM) groups.

These resources offer professional support to officers, civilian employees, and often to families. Within all programs, ensuring confidentiality is essential.

Employee Assistance Programs (EAP)

Employee Assistance Programs are the most common type of support program. They are employer-sponsored, and while some EAPs offer a wide range of services, others are more limited in what they can provide.



Commissioner O'Neill ✓
@NYPDONeill

Follow

This is a mental-health crisis. And the NYPD & the law enforcement profession as a whole absolutely must take action. We must take care of each other; we must address this issue — now. Please take my statement at right to heart & help yourself, your loved ones, & your colleagues. ↓

NYPD-SPECIFIC

- Employee Assistance Unit: [646.610.6730](tel:646.610.6730)
- Chaplains Unit: [212.473.2363](tel:212.473.2363)
- POPPA (independent from the NYPD): [888.267.7267](tel:888.267.7267)

OUTSIDE OPTIONS

- NYC WELL: Text, call, & chat www.nyc.gov/nycwell
- Lifeline: 800.273.TALK (8255)
- Crisis Text Line: Law enforcement officers can text BLUE to 741741 (non-law enforcement can text TALK to 741741)
- Call 911 for emergencies

Source: <https://twitter.com/NYPDONeill/status/1139690484207538176>

June 14, 2019

In less than 10 days’ time, the NYPD has lost three of its own to suicide: a respected chief, an experienced detective, and — today about 3:50 p.m. outside the Staten Island precinct at which he worked — a promising, 29-year-old police officer with six years on the job. This is a mental-health crisis. And we — the NYPD and the law enforcement profession as a whole — absolutely must take action. This cannot be allowed to continue. Cops spend so much of their days assisting others. But before we can help the people we serve, it is imperative that we first help ourselves. There is no shame in seeking assistance from the many resources available, both inside and outside the department. Accepting help is never a sign of weakness — in fact, it’s a sign of great strength. Please, connect yourself or your friends and colleagues to the assistance that is so close by. We must take care of each other. We must address this issue — now — because it will not go away on its own. We must speak out. And we must end this crisis, together. The resources (you can call for yourself or make a confidential referral for someone else) are:

For example, participants at the PERF conference noted that some EAPs are well equipped to handle substance abuse issues and relationship problems, but not the level of depression or PTSD that can result in an officer becoming suicidal.

Charles Ramsey, former Police Commissioner in Philadelphia, said that police chiefs must investigate the capabilities of their EAP program, and determine whether it has the resources and capability to manage the types of psychological issues that officers have:

Some EAPs are not equipped to handle the kind of psychological trauma that we're talking about here. Some EAPs are good if you have a drinking problem or you need marriage counseling, but they weren't originally created to deal with what we're talking about here. I'm not saying that all EAPs fall in that category, but as a chief, you need to know the capabilities and limits of your EAP, so that when you direct officers toward assistance, you're directing them properly.

In Philadelphia, we had a series of police officers killed in the line of duty. I lost five in a nine-month period. So we formed a partnership with the behavioral health section of the University of Pennsylvania Hospital system, and we were able to send people there for the kind of counseling that they needed. Our EAP would have been overwhelmed.

Still, EAPs are an important component of a suicide prevention effort. A major benefit of EAPs is that they can use their institutional reach to provide mental health care information and resources to officers. In doing that, EAPs can “normalize” the concept of officers seeking mental health care.

NYPD: Blanketing the agency with EAP information. The NYPD Employee Assistance Unit (EAU) has adopted the strategy of placing a variety of pamphlets and informational materials at 150 police facilities throughout the city. Officers can find a menu of resources within the NYPD and with external organizations.

NYPD Lieutenant Janna Salisbury explained the benefits of this approach:

Having all these materials at 150 locations provides a very inconspicuous means of allowing cops to access our material. We make it easy to pick up a brochure. We have worked to spread the word about

the variety of ways in which officers can get assistance, either in person, over the phone, and for our younger members who prefer electronic means, we have text resources.

*We make it personal. We put the names of individual Employee Assistance Unit peer counselors on these materials, so people know who they can talk to. **We have found that it's a lot easier for people to call and ask for help if they can ask for a person by name.***

We also put Employee Assistance Unit contact information on plastic key tags for all our department vehicles. The NYPD has 9,500 vehicles, so the EAU information is literally the first and the last thing that officers have in their hands when they go out on patrol. We've gotten great results from these strategies in terms of normalizing peer support and the resources we provide.

Recently an officer told me that he had had one of our pamphlets in his pocket for six days, and that just touching the pamphlet every day helped him get up the nerve to give us a call, and it saved his life.

LAPD: Decentralizing behavioral health services. The Los Angeles Police Department has taken a different approach to increase officers' access to behavioral health services. The 16 psychologists assigned to LAPD's Behavioral Science Services (BSS) program spend approximately half of their time in the field, as opposed to a central facility. Each psychologist is assigned a specific field division so that he or she can get to the know the personnel in that division.

LAPD Psychologist Dr. Denise Jablonski-Kaye described this staffing arrangement:

Previously, our psychologists would go out in the field only after a critical incident, such as a line-of-duty death. So the officers basically saw us as “the people who come out when something bad happened.” But now we're out there all the time, and we're just a part of the divisions. We go to the roll calls, we do ride-alongs, we walk around the division with the detectives and motor patrol folks.

They just see us as colleagues. They might talk to us about the Dodgers—or about their daughter they're having some problems with, or a personal health problem, or a relationship issue. And later, if they really need to come in and get help, they



“Without confidentiality, you’re not going to get officers to take advantage of the resources an agency has.”

— **Charles Ramsey, former Commissioner, Philadelphia Police Department**

know what it feels like to talk to us, and they’re comfortable with it.

I think deploying our psychologists out to the field has removed some of the stigma and has made it easier for officers to come in on a voluntary basis when they have some personal problems.

The BSS also offers confidential counseling services to officers’ spouses, domestic partners, and significant others at no cost.

Maintaining Confidentiality

To be effective, EAPs need to be staffed with specially trained clinicians who can understand and address the psychological stresses that police officers experience. Confidentiality is a significant concern that officers may have about EAPs. Because EAPs are employer-sponsored, officers may fear that anything they discuss will get back to their command staff.

In a document about Employee Assistance Programs for federal law enforcement agents, the U.S. Department of Health and Human Services (HHS) notes that licensed EAP providers are bound by confidentiality laws.⁶¹ “This means that information disclosed in counseling is confidential and protected by law,” the HHS guidance states.

However, the HHS guidance document lists nine exceptions to the confidentiality rules for federal employees, including the following:

- “When disclosure is allowed by a court order.”
- “Information can be disclosed to the Department of Justice for the purpose of defending your agency and/or its employees in litigation when the litigation relates to your use of the EAP.”
- “Information can be disclosed if you pose a danger to yourself or others, or threaten to commit a serious crime.”
- “Information can be disclosed to your direct supervisor, under the Drug Free Workplace Program, if you are tested and receive a verified positive drug test result.”

First Deputy Superintendent Anthony Riccio of the Chicago Police Department said that his department has taken a novel approach to ensure confidentiality of EAP counseling:

Everyone talks about how EAP counseling is protected by HIPAA,⁶² but Freedom of Information laws can be very powerful. And if you’re involved in an incident that results in a lawsuit, a judge can say “I want the notes from the EAP.” The judge simply issues an order, and HIPAA goes out the window. We’ve seen judges do that all the time.

So our EAP counselors do not take notes. You can go in there and lay out whatever your issues are, whether it’s alcoholism, or PTSD, or domestic problems, and there will be no notes to be shared with anyone later. We’re getting the word out about this.

61. “Law Enforcement Employee Assistance Program FAQs.” Federal Occupational Health, U.S. Department of Health and Human Services. <https://foh.psc.gov/whatwedo/EAP/Law/FAQ.asp>

62. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides certain confidentiality protections about individuals’ health information. See “Summary of the HIPAA Privacy Rule,” U.S. Department of Health and Human Services. <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>

We want to completely de-stigmatize getting mental health treatment, and we think this will move us in a better direction.

Peer Support Units

Peer support programs are generally staffed by volunteer officers, active and retired, who are well-positioned to understand the work-related stresses that officers face, such as repeated exposure to traumatic incidents. In some cities, peer support units are part of the police department, but in other cities, peer support organizations are entirely separate from the department.

Sean Smoot, Director and Chief Counsel for the Police Benevolent and Protective Association of Illinois, urged police chiefs not to hesitate to push their departments toward offering peer support or other forms of help to troubled officers:

Officers are more apt to do peer-to-peer counseling. Some of the most successful programs are national hotline programs for officers, because there is that confidentiality. So if the question is, “What can you do as administrators?” my answer is, “You have to make it very clear to your employees that if they need help, you want them to go get the help, and there will be no adverse employment implications for them, period. And if they get peer support, you don’t need to know about it.”

I’ve gotten a lot of pushback from chiefs and supervisors, saying, “Hey, if an officer is a danger, they are a time bomb. I need to know that so I can intervene.” No, you don’t need to intervene, because that person is going to get help. That time bomb is being defused. If you intervene, there are five other time bombs that are never going to get defused, because those other officers will never go to seek the help they need.

The Boston Police Department’s Peer Support Unit

Boston’s Peer Support Unit has autonomy within the department, so it can develop most of its policies and procedures on its own authority, but it also has the strong support of the department’s highest leaders. Housed in its own building, the Boston PSU is assigned to the Police Commissioner’s office under direction of the Office of the Chief, which gives the unit an important sense of protection under the department’s highest command.

The Peer Support Unit is staffed by all-volunteer, sworn officers who are trained through the International Critical Incident Stress Foundation.⁶³ These volunteers are protected by the same confidentiality guidelines as licensed clinicians under Massachusetts state law. The Peer Support Unit includes the Critical Incident Stress Management Team, which responds to particularly traumatic events and also assists in monitoring the wellness of officers throughout the year.

The PSU’s resources include a psychologist, a Licensed Clinical Social Worker (LCSW), addiction services officers who are licensed drug and alcohol counselors and who have had their own issues with sobriety or addiction, and Alcoholics Anonymous meetings for law enforcement officers only. To help ensure that officers need not fear that seeking peer counseling will result in a fitness-for-duty investigation, there are no communications between the department psychiatrist and PSU.

NYPD’s POPPA Program

The Police Organization Providing Peer Assistance program (POPPA)⁶⁴ operates independently of the New York City Police Department. It was founded in 1996 to establish protocols for assisting officers, following 26 suicides of officers between 1994 and 1995.⁶⁵ The organization is composed of approximately 200

63. The mission of the ICISF is “to provide leadership, education, training, consultation, and support services in comprehensive crisis intervention and disaster behavioral health services to the emergency response professions.” <https://icisf.org/> Critical Incident Stress Management (CISM) is “a method of helping first responders and others who have been involved in critical incidents that leave them emotionally and/or physically affected by those incidents. CISM is a process that enables peers to help their peers understand problems that might occur after an event.” <https://icisf.org/about-us/>

64. <http://poppanewyork.org/>

65. “History: The First Ten Years.” POPPA. <http://poppanewyork.org/about/history/>

Boston's LEADER program

First responders often face traumatic situations as part of their job. It can be difficult for people who are not first responders to understand these challenges, and as a result, first responders may find it difficult to relate to mental health treatment programs. However, there are specialized programs designed to address the unique needs of first responders.

One such program is the Law Enforcement Active Duty Emergency Responder (LEADER) program, which is operated by McLean Hospital in Massachusetts.⁶⁶ The LEADER program stemmed from concern for first responders in the wake of the Boston Marathon

bombing in April 2013. Program staff members, led by Dr. Joseph Gold, are trained in the unique aspects of first responder and military employment that can result in depression, PTSD, and addiction.

Programming includes specialized inpatient, residential, partial hospitalization, and outpatient programs, including detox and AA meetings. Topics covered in the treatments include stress management, family impact, resiliency, sleep habits, and pain management. Participants in the LEADER program are also able to access other services at the hospital as needed.

active and retired uniformed officers who volunteer their time as Peer Support Officers (PSO). It also maintains a network of 120 clinicians who are trained to work with police officers.

POPPA focuses its support on trauma and the stress that police officers face, particularly since the terrorist attacks of September 11, 2001. The program is dedicated to helping officers manage PTSD, marital problems, substance abuse, and depression by providing services in the areas of intervention, prevention, self-care, and resiliency.

While POPPA has functioned primarily as a confidential, 24/7 hotline, it also offers a Trauma Response Team that can quickly respond to critical

incidents, such as horrific crime scenes, accidents, or officer fatalities. To address the unique issues of retired officers, POPPA also established a separate Retiree Hotline in 2006, which is staffed by nearly 100 retired officers in New York and nine other states. Most recently, POPPA is working with the NYPD to provide resiliency training, including suicide prevention and self-care, to 25,000 officers.

At the PERF conference, POPPA Director John Petruccio described how peer assistance works in New York City, and how it complements the EAP and other services offered by the NYPD:

POPPA is an alternative to Employee Assistance Unit, so officers can choose where they would have a comfort level for getting assistance. I believe that peer support is one way to go, to get officers to segue into mental health treatment.

For example, there are checklists you can use to see if you have indicators of depression. But if an NYPD employee administers the checklist to a troubled officer, the officer will probably look at it and say, "Have I been depressed in the last five days? Absolutely not"—even if he has been depressed, because the officer may be unsure what will be done

>> continued on page 47



Director John Petruccio,
Police Organization
Providing Peer
Assistance (POPPA)

66. "LEADER: Specialized Mental Health Services for First Responders." McLean Hospital: Harvard Medical School Affiliate. <https://www.mcleanhospital.org/programs/leader>

The Role of Resilience in Combating Suicide

Resilience, or ego-strength, is defined as a person's capacity to adapt successfully to risk and adversity. Resilience is the ability to adjust to challenging life experiences. The suicidal mind lacks resilience.

— Dr. Antoon Leenaars

Police departments should consider resilience training as a key component of a suicide prevention program. When officers are provided with wellness and stress management skills, they are better equipped to cope with both critical incidents and day-to-day work stresses that are common in policing.

At the PERF conference Dr. Antoon Leenaars, past president of the American Association of Suicidology, explained how the concept of resilience is critical to understanding suicide prevention:

The common stimulus of suicide is unendurable psychological pain. The enemy of life is pain. The suicidal person is in a



Dr. Antoon A. Leenaars, Psychologist and past President, American Association of Suicidology

heightened state of intense mental anguish. It is especially the feelings of hopelessness and helplessness that influence many suicidal people.

Many officers who die by suicide have symptoms of post-traumatic stress disorder. Many suffer from mood disorders or bipolar disorders. The important thing to remember is that the suicidal person experiences unbearable pain, and they have weakened resilience.

Resilience is often thought of as a naturally occurring component of an individual's personality, but people can be trained on skills to strengthen and promote a resilient mindset.

Sherri Martin, chair of the National Officer Wellness Committee of the Fraternal Order of Police, said that building resilience is especially important for police officers.

"One of the best ways for police agencies to get at the problem of suicide is to get in front of it and do resilience training," Martin said. "Attack the problem before it starts. Unfortunately, some officers are not going to use the services that are available after they're already in trouble. So we need to do something to get in front of it, so that they never get there in the first place."

with that information if he admits to having felt depressed.

But POPPA can administer a survey through a peer support group and say, “Hey, just take this home with you. I don’t want you to fill it out right now, but take it home and see what resonates with you.” We’ve done this many times, and we’ve gotten good feedback from it.

We also work very well with the Police Department. We complement each other’s services. Sometimes I tell someone who calls us, “You may be better calling the department service.” And some of the NYPD service people have done the same with us. It’s all about getting help to the cop.

Our goal is to get the cops to accept the professional help from the clinicians. Peer support provides the transition for them to do that. We don’t want to slow down the process.

We’re not counselors; we’re cops. So with anyone who comes to us, our main objective is that if they need help, we want to get them to the professional. We meet them where they are, at their level, and from there, we can say, “Listen, I know Dr. So-and-so. You may want to see him. He’s been trained by us.”

Recommended Action 7: Easy-to-Access Tools

Agencies should offer confidential, easy-to-access tools (including online tools) for officers to assess their well-being and obtain referrals for assistance.

Police and sheriffs’ departments are working to reduce the stigma associated with officers’ seeking mental health care. But until stigma is erased, law enforcement agencies should give officers options for obtaining help anonymously. Self-help tools can serve as initial steps for officers to take as they build the courage to seek more intensive, in-person help.

At the PERF conference, participants discussed different tools—online, mobile, and text-based—for connecting officers with mental health services.

American Foundation for Suicide Prevention Interactive Screening Program

The American Foundation for Suicide Prevention (AFSP) developed an online tool called the Interactive Screening Program (ISP) that provides a confidential way for individuals to take a brief Self-Check Quiz for stress, depression, and other mental health conditions, and if they wish, to obtain information about treatment resources.⁶⁷

At the PERF conference, Maggie Mortali, Senior Director of AFSP’s Interactive Screening Program, explained that the program provides a way for police officers to connect *anonymously* with their own police department:

The Interactive Screening Program is used by a wide range of different organizations, including law enforcement agencies. AFSP partners with the law enforcement agencies to provide a customized website, which includes a stress/depression questionnaire and allows officers to anonymously engage in the platform and get connected with peer support officers or Employee Assistance Program in their agency.

The officer then receives a personal response from someone in the EAP or peer support program, which includes information about the mental health services that are available to them. Then it’s up to

Maggie Mortali, Senior Director, Interactive Screening Program, American Foundation for Suicide Prevention



67. “Interactive Screening Program.” American Society for Suicide Prevention. <https://afsp.org/our-work/interactive-screening-program/>

them to decide if they want to follow up and obtain services.

The entire connection is anonymous, managed by our system. So it allows people to take a self-check quiz and learn about treatment options, while maintaining their anonymity.

Brian Fleming, a retired Boston Police Department sergeant and former Director of the department's Peer Support Unit (see page 18), described how the AFSP program works in the Massachusetts Coalition of Police (MASS COP), the largest law enforcement union in Massachusetts:⁶⁸

We talk about confidentiality, and officers' fear of punishment and losing their job if they step forward and ask for mental health assistance. This online service of AFSP addresses those concerns.

In Massachusetts it's called Peer Support Quiz.⁶⁹ Any officer can go to the website, where they create a user name and a password. And then they can take

an 11-page questionnaire and hit the "submit" button. This is not an emergency response program; it's intended to help people long before they get the point of an emergency.

Within approximately 24 hours, we will send them a personalized email, based on how they answered the questionnaire. This is still all anonymous. We tell them about services that are available, and then it's up to them to decide if they want to take the next step and contact us directly for services. We can also dialogue with them continuously, all under the veil of anonymity.

This was started in 2012, and in the first year, we had 60 officers who took the online test. Six of them came in for services. I remember one of those first six officers who came into my office—you talk about masking problems! He had thought about suicide, he talked about alcohol problems, he did two tours in Iraq. So I expected him to look like someone in bad shape. But he comes in looking fit as a fiddle,

Interactive Screening Program: Self-Check Quiz

The screenshot displays the 'Peer Support Quiz' interface. At the top, there is a navigation bar with 'Welcome' and 'Quiz' buttons. Below this, the 'Self-Check Quiz' section features a progress indicator with 12 pages, where page 1 is currently active. A message states: 'No questions on this Quiz are required. Please skip any question you do not want to answer.' The main content area contains a table with the following structure:

During your time as a police officer, have you been exposed to any of the following job-related events?	No	Once	Two or more times
Line of duty death/s	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suicide/s of colleague	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Serious work-related injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Multi-casualty/disaster/terrorism event/s	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Event/s with a high degree of threat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Significant event/s involving children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other overwhelming, distressing event/s	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

On the right side of the interface, there are two informational boxes:

- Emergency Contacts:**
 - National Suicide Prevention Lifeline (800) 273-TALK (8255)
 - Copline National Law Enforcement Officers Hotline (800) 267-5463 (available 24/7)
 - Safe Call Now (206) 459-3020. Safe Call Now is a resource for public safety employees to speak confidentially with officers, former law enforcement officers, public safety professionals and/or mental healthcare providers who are familiar with your line of work.
- Mental Health Services:**
 - McLean Hospital LEADER Program: (617) 855-3141 (available 24/7). The LEADER (Law Enforcement, Active Duty, Emergency Responder) Program at McLean Hospital provides specialized mental health and addiction services, designed specifically for men and women in uniform.

68. See "Massachusetts Police Union Takes Steps to Stop Officer Suicides." Officer.com. April 4, 2017. <https://www.officer.com/command-hq/news/12322558/massachusetts-police-officers-take-steps-to-stop-suicides-among-their-ranks>

69. Massachusetts Coalition of Police Peer Support Quiz. <https://www.masscoppeersupportquiz.org/welcome.cfm>. This is a live site where officers can obtain assistance. To see the questions in the Peer Support Quiz without requesting assistance, go to <http://www.peersupportquiz.org/welcome.cfm>.

Cordico Shield Mobile Wellness App and Crisis Text Line



spit-shine polish on his shoes, smiling from ear to ear.

So that's the type of situation that can be uncovered when officers are able to use an anonymous service to explore options for assistance.

Cordico Shield mobile wellness app

In addition to online tools, mobile apps are another way to improve access to mental health support and resources. Cordico, a company that specializes in wellness technology products, offers wellness apps for law enforcement officers, firefighters, and other first responders.

The law enforcement app, called Cordico Shield,⁷⁰ gives officers access to a wide range of wellness programs and services on their phone or other mobile device. For example, the “Wellness Toolkit” on the app includes information about family support, financial fitness, healthy habits, psychological first aid, marriage guidance, and other topics. The app also includes a variety of self-scoring assessment tools, allowing officers to quickly obtain feedback about their wellness.

At the PERF conference, Pinole, CA Chief of Police Neil Gang explained why he recently decided to provide the Cordico Shield app to all of his officers:

We're a small agency in the San Francisco Bay area, and we think we found something that's going to be a crucial part of the puzzle for us in creating a

culture of wellness. We issue cell phones to all our employees, and we're putting this officer wellness app on each phone. It is confidential and anonymous. It's all about proactive prevention, and this provides on-demand access, 24/7/365, to powerful stress management and resilience tools in the hands of all of our employees. It drives early awareness and solutions to stress-related problems and hopefully will change outcomes.

The app also provides a way for officers to “vet” therapists, and to get rapid, confidential and easy access to support services and resources; from rookie to retirement, all in one place under one platform.

And the last part, which we think is crucial, is that it provides a HIPAA-encrypted teletherapy. Participating therapists have to provide their cell phone number, so officers are not calling a third party, they're calling the therapist directly. We feel that this will eliminate some of the obstacles to people reaching out to get help.

We are also bringing officers' family members in and including them in the orientation process, and providing resources as well as access to this app to spouses and significant others.

Crisis Text Line

The Crisis Text Line was developed in 2013 as a free, 24/7 resource for persons in crisis to seek help via text messages to trained counselors.⁷¹ Individuals can text 741741 from anywhere in the United States

70. Cordico Shield. <https://www.cordico.com/shield/>

71. <https://www.crisistextline.org/>

and be connected to a volunteer who been trained in reflective listening, collaborative problem-solving, and crisis management.

Recently, this service has been expanded to address the specific needs of law enforcement officers. Officers can text the word “Blue” to 741741 and receive confidential support from personnel specifically trained in policing issues. Because the Crisis Text Line is not connected to any one police agency, but is a national program, some officers may feel more comfortable initiating contact with this service. To date, the Crisis Text Line has exchanged more than 3,000 messages with officers and initiated active rescues of individuals at imminent risk of suicide.

Recommended Action 8: Regional Partnerships

Law enforcement agencies, especially small and mid-size departments that lack the resources of large agencies, should consider forming regional partnerships for programs such as peer support and Critical Incident Stress Management.

Not every police departments or sheriff’s office has the resources to address the issue of officer suicide on its own. In these instances, multiple agencies in a region can collaborate on suicide prevention and wellness programs to serve officers in their area.

Not only does a regional program increase the availability of resources, it can provide a greater sense of anonymity for those looking to connect with a mental health service provider. Part of the stigma contributing to officer suicide is the fear officers have of telling someone they know about their problems. Regional partnerships can provide officers with resources that are not directly connected to their own agency if they are concerned about confidentiality.

Southeastern Massachusetts Law Enforcement Council

One example of a regional partnership is the Southeastern Massachusetts Law Enforcement Council, a collaborative effort of 30 police departments in Massachusetts. The agencies pull together resources and officers when requested for critical incidents in the region. One of the group’s resources is a peer support Critical Incident Stress Management unit. When

requested, officers trained for the unit are sent to another agency to assist in debriefing after a traumatic event.

Prince William County, VA Wellness and Resiliency Unit

Collaborations can include other emergency service organizations as well. In 2016, Prince William County, VA established a Wellness and Resiliency Unit amid growing concern about the well-being of all first responders in the county. The Police Department partnered with the Department of Fire and Rescue, Public Safety Communications, and the Community Services Board to create the unit. It is a stand-alone entity managed by the county government and is not required to report up the chain of command within individual departments.

The Prince William County unit focuses on the holistic wellness of first responders, providing resources for physical, social, and spiritual wellness. Services include a Peer Support program, a Peer Fitness Advisor team, and a volunteer Chaplain Program. A behavioral health specialist is assigned to serve each department in the coalition. Through the Wellness and Resiliency Unit, police officers have access to services that go beyond those offered by their agency’s Employee Assistance Program.

Western New York Police Hotline

A telephone hotline can be developed as a regional partnership, as is the case with the Western New York Police Hotline. This 24/7 hotline began in 2008 and is sponsored by the Western New York Stress Reduction Program. Trained “police peers” are on call for any current or former officers and their families.

Many officers would rather talk to a fellow officer about personal problems than someone with no law enforcement experience. The hotline serves as a confidential way for officers to get assistance from their peers, but not necessarily someone they may know in their own agency. This is especially useful for small agencies where everyone is familiar with one another.

The Fraternal Order of Police is working to take this concept to a national scale.

“Officers often say they don’t want to use a peer counseling program in their own department

because they are concerned that someone will find out,” said Sherri Martin, Chairperson of the FOP National Officer Wellness Committee. “So the FOP is developing a system that will allow officers to contact a peer in another part of the country who doesn’t know anything about them or their situation, so they can have that level of confidentiality.”

Recommended Action 9: Family Support

Following a police suicide, agencies should reach out to surviving family members and provide support, including assistance with obtaining any available benefits, and appropriate funeral honors. Family support should be emphasized throughout an officer’s career.

While police suicide is not a new problem, law enforcement agencies often are uncertain of how to classify these deaths in terms of death benefits and funeral honors, and also how to interact with families after a suicide.

Former Philadelphia Police Commissioner Charles Ramsey said that agencies should not wait until they have an officer suicide to think carefully about how they will respond if an officer dies by suicide:

It’s important to think about what you will do if an officer takes their own life. How do you classify it internally? I’ve heard some people say it should be considered a line-of-duty death. What about the funeral? In Philadelphia, we didn’t treat it any differently than if an officer died of a heart attack or cancer. If cops from the unit want to form an honor guard, that’s fine. If the family wants the officer to be buried in uniform, we don’t have a problem with that. We’ll provide an escort to the cemetery, but it is not a full-blown honors funeral.

If your agency is fortunate enough never to have had a suicide, you need to be thinking about these issues now and working through them, because there is no one answer to it. Even if you don’t treat a suicide as a line-of-duty death, that doesn’t mean you can’t take care of the family. It doesn’t mean you shouldn’t show empathy, visit the family, and see to it they get whatever support they can get. You should do that in any case.

Dr. Denise Jablonski-Kaye of the Los Angeles Police Department said that she has found that family members of officers who died by suicide usually want to be involved in what happens afterwards, including during the process of conducting a psychological autopsy:

We interview family members, and it is very difficult for them to talk about it, but it is also therapeutic for them. They want to talk about it; they need to talk about it. They need to have somebody who is willing to listen to them and share their pain.

Consider that the families know that their loved one died a stigmatized death, and they may have their own level of shame and guilt about not having prevented it. They often feel isolated—that they have just been cut off by the department. So they really appreciate the fact that the department has not completely ended the relationship with them.

Karen Solomon, the president and co-founder of Blue H.E.L.P., said that her organization is another resource that can support families in the aftermath of a suicide:

We send the families care packages, and they get a customized note from one of our families who has lost an officer to suicide. In one case, a 17-year-old girl was left behind without parents or any support, so we connected her with another family in her area who had lost a member to suicide, and she now has a new family.

Shame on every department that does not take care of the families, that does not embrace them after a suicide. I am asking every one of you here today to check on every family who has lost an officer to suicide in your department. Go see if they are okay and ask them what they need. Let them know that the service of their officer mattered.

While family support in the aftermath of an officer suicide should be part of any police agency’s suicide response efforts, it is also critical that resources and support be readily available to families throughout an officer’s career. As noted by Dr. Antoon Leenaars, people struggling with mental health issues often wear masks. It may be easier for a police officer to put on a façade at work, but it is often family members and close friends who are the first to see behind that mask.

Given the important role they can play in suicide prevention, family members need to be educated on risk factors and warning signs, and they need to have a safe place to report concerns and get support. In many agencies, family support is part of their overall officer wellness programs. For example, the St. Petersburg, FL Police Department employs a full-time clinical psychologist who is available to spouses and children of law enforcement personnel.

Recommended Action 10: Communications Plan

Law enforcement agencies should devise a communications plan for providing information to employees and to the public following a police suicide. Agencies should be careful about what details they release and what language they use in discussing suicide.

“Speaking publicly about officer suicide is something new for anybody with gray hair on their head in this room. When we were young officers and there was a critical incident, a police-involved shooting, or you witnessed something horrific, the attitude was that everyone should ‘just suck it up and get back out there.’”

— **First Deputy Superintendent Anthony Riccio, Chicago Police Department**

In the past, police officer suicides were rarely discussed publicly. Today, in an effort to reduce the stigma against seeking mental health care and to highlight the help available to officers, more police agencies are commenting publicly on officer suicides. In doing so, they are also raising awareness of mental health resources available to officers.

For example, following the death of several officers by suicide, the Chicago Police Department started announcing the passing of officers who died by suicide via Twitter. In January 2019, CPD Chief Communications Officer Anthony Guglielmi, announcing that an officer died by suicide, tweeted a video encouraging officers to seek help if they are in crisis. Such communications signal a shift in how the law enforcement profession addresses suicide.

Following a spate of officer suicides in the NYPD, both Commissioner James O’Neill and



Anthony Guglielmi ✓
@AJGuglielmi

Follow

Devastated to share news of another #ChicagoPolice officer tragically ending their life yesterday after battling personal hardships. The pressure of being a police officer today cant be understated & we must do everything we can to support those who make our communities safer.



10:15 AM - 2 Jan 2019

Source: <https://twitter.com/ajguglielmi/status/1080527907003469824>

Chief of Department Terence Monahan have spoken forcefully about the tragic events—both internally and publicly, via social and traditional news media. Their messages were twofold: 1) seeking help for depression and other mental health issues is a sign of strength, not of weakness; and 2) officers need to look out for one another and take advantage of the range of resources that the NYPD makes available to its personnel.

In discussing suicide, it is important for agencies to use appropriate language and to consider the impact on families and others who may be contemplating suicide.

“The number of suicides around the country has gone up since 1999. We have 47,000 lives lost each year to suicide. That is 129 per day,” said Colleen Creighton, Executive Director of the American Association of Suicidology. “We will all benefit if we can share the stories of people who struggled but found help. We need to consistently convey the message that ‘It’s okay not to be okay. It’s okay to seek help.’”

Choose your messages carefully, because the wrong words can be dangerous: When developing a communications plan for addressing officer suicides, it is important to balance the desire to destigmatize mental health issues against potentially

sensationalizing suicide. At the PERF conference, Colleen Creighton described several practices that police agencies should adopt when publicly speaking about suicide:

- Avoid the expression “committed suicide,” because it has connotations to the phrase, “committed a crime.” Instead, suicide should be viewed as being related to a medical condition. It is more sensitive, and more direct, to say that a person “died by suicide.”
- Never refer to “a failed attempt” or an “unsuccessful” suicide.
- Graphic images should not accompany any communications about an officer suicide, as this can sensationalize the death.
- It is unnecessary to provide information to the public about the method of a suicide. As Creighton said, “If you look back to the death of Robin Williams, there was an uptick in suicides that could be related to news coverage about it. His age

range saw a 33-percent increase in the number of suicides by suffocation following his death, which is the way he died.”

- Information from suicide notes should not be publicized, to protect the privacy of the family.
- Avoid any public speculation as to the causes of a suicide. Experts on suicide say that there is rarely one clear reason as to why an individual died by suicide; usually there were multiple factors. And in any case, it may take a significant amount of time to determine the possible causes.

More detailed recommendations on how to provide public information about suicides can be found online at ReportingOnSuicide.org.⁷² This website was developed through a collaboration of suicide prevention and public health organizations, including the American Foundation for Suicide Prevention and the American Association of Suicidology, as well as journalism schools and experts on Internet safety.

Thoughtless news coverage can increase the likelihood of additional suicides

“More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration, and prominence of coverage. Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death. Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.”⁷³

72. Reporting on Suicide.” <http://reportingonsuicide.org/recommendations/#dodonts>

73. “Recommendations for Reporting on Suicide.” <http://reportingonsuicide.org/recommendations/>

Conclusion: Action to Prevent Police Officer Suicides Is Overdue

WHEN MOST PEOPLE THINK OF “OFFICER SAFETY,” they have in mind the protection of officers from violent offenders, traffic crashes, or other dangerous encounters. Not enough attention is paid to officers’ own well-being. **But the reality is that suicide is the No. 1 officer safety issue. More officers die by suicide than are killed in the line of duty, and the suicide risk for officers exceeds that of the population as a whole.**

Despite the tragic toll that suicide takes on the policing profession, we still do not know the true extent and nature of the problem. The data on police suicide is not accurate or comprehensive because there is no central repository for collecting and analyzing the information. There is a growing body of research on police suicide, but we still don’t know enough about the risk and protective factors specific to officer suicide.

Because officer suicide is now the No. 1 officer safety issue, we need to make suicide prevention a national priority.

This report documents the mental health crisis in police agencies across the United States and around the world. It points out that the causes of suicides by officers are complex. They include the daily stress of police work and the frequent exposure to traumatic incidents, such as horrific crime scenes and accidental deaths. Such trauma has a cumulative effect over time, wearing down an officer’s “psychological reserve.”

Shift work, erratic hours, and frustration with the bureaucratic structures of some police agencies can place additional strains on an officer’s well-being.

And when officers die by suicide, investigators often find that the officer was having problems with family relationships. Importantly, there is almost never just “one reason” why someone decided to take their life; it is almost always a combination of reasons.

Another major factor in officer suicides is that officers have access to firearms. Among the general population, approximately 90 percent of suicides attempted with a gun result in death, while only 10 percent of all suicides attempted by other means end in death. Firearms are simply in a category all their own in terms of lethality—and police officers have access to guns all the time.

The situation is not hopeless: Perhaps the most positive piece of information to emerge from the PERF conference was that PTSD and depression—conditions that contribute to many suicides—can be successfully treated. The experts said that depression is not an attitude that can be fixed by telling a depressed person to “cheer up.” It is a medical condition that can be treated, just as diabetes can be treated with insulin injections or high cholesterol can be treated with statin medications. With treatment, police officers can live with and manage depression, preventing it from worsening to the point where a person feels suicidal.

As evidenced by the more than 300 people who participated in the PERF conference on police officer suicides, many law enforcement agencies and experts on suicide are actively working to address this crisis. This meeting was a step in bringing the discussion out of the shadows, breaking down the stigma against seeking mental health care, and sharing information

and resources. The challenge now is to continue the momentum and put the information and recommendations from this report into action.

10 recommended actions, with varying degrees of difficulty: Some of the 10 recommendations in this report are relatively straightforward. For example, we need better data about law enforcement officer suicide. Nonprofit groups such as Blue H.E.L.P. are assembling a good deal of information and sharing data with the policing profession and the public. The establishment of a national repository of information on officer suicide is essential to support research and targeted prevention programs. Fortunately, the U.S. Justice Department’s Bureau of Justice Assistance is leading the effort to stand up a national database of suicide incidents.

Other recommendations in this report are more challenging. When a police agency learns that an officer is under stress and feeling very depressed, it seems logical that the agency should take the officer’s firearm away and place the officer on modified duty. However, that may have the unintended consequence of worsening the officer’s depression—or preventing the officer from seeking help in the first place. Law enforcement agencies need to find ways of protecting officers’ safety in these situations while ensuring that the officer receives mental health treatment to address the problem directly.

One recommendation seems fairly uncomplicated at first glance, but actually is more challenging: implementing routine “mental health check-ups” for all officers. The idea is that periodically, perhaps as part of each employee’s annual review, the employee would have a consultation with a psychologist who is trained to understand the stresses of policing and to see through any “mask” that the officer may be using to hide feelings of depression or other serious mental health issues. The actual check-up is relatively straightforward. The more difficult part is to have adequate systems in place to ensure that officers who are flagged in the check-up process can immediately be offered the treatment resources that they need, and their job security will not be threatened.

The policing profession also needs to find ways to break down the wall of stigma that is preventing many officers who need help from seeking it. Many of the policies and programs discussed in this report will help to achieve this goal, such as the regular “check-ups” described above, peer support programs and other resources that allow officers to feel assured of confidentiality, and online screening and assistance tools.

But breaking down the stigma about mental health will require more than policies and programs. The culture of policing on this issue needs to fundamentally change. An officer who seeks medical help for depression or PTSD should not be ostracized any more than an officer who seeks help for back pain or asthma.

Finally, individual police chiefs and sheriffs need to be vocal and tenacious in speaking out about officer suicide. This is one issue where a top-down approach is essential. Across the country, police agency leaders are speaking passionately—and sometimes quite personally—about this issue and its impact on families, their agencies, and communities. This report includes the stories of police officers and executives who have spoken publicly about their own challenges with mental health, and how they have overcome those challenges. These chiefs and sheriffs are lifting the curtain on an issue that has been in the shadows for too long.

Sadly, the tragedy of police suicides will not stop while the policing profession works on developing solutions, but that should only strengthen our resolve to find those solutions. The profession owes it to our fallen officers and their families, and to all current officers, families and communities not only to provide the mental health care that officers may need, but also to create a new culture that redefines what true strength of character looks like.

As NYPD Police Commissioner James O’Neill said, “Seeking help is never a sign of weakness. It’s a sign of great strength.”

About the Police Executive Research Forum

THE POLICE EXECUTIVE RESEARCH FORUM (PERF) is an independent research organization that focuses on critical issues in policing. Since its founding in 1976, PERF has identified best practices on fundamental issues such as reducing police use of force; developing community policing and problem-oriented policing; using technologies to deliver police services to the community; and developing and assessing crime reduction strategies.

PERF strives to advance professionalism in policing and to improve the delivery of police services through the exercise of strong national leadership; public debate of police and criminal justice issues; and research and policy development.

The nature of PERF's work can be seen in the reports PERF has published over the years. Most of these reports are available without charge online at <http://www.policeforum.org/free-online-documents>. All of the titles in the *Critical Issues in Policing* series can be found on the back cover of this report and on the PERF website at <https://www.policeforum.org/critical-issues-series>.

In addition to conducting research and publishing reports on our findings, PERF conducts

management studies of individual law enforcement agencies; educates hundreds of police officials each year in the Senior Management Institute for Police, a three-week executive development program; and provides executive search services to governments that wish to conduct national searches for their next police chief.

All of PERF's work benefits from PERF's status as a membership organization of police officials, who share information and open their agencies to research and study. PERF members also include academics, federal government leaders, and others with an interest in policing and criminal justice.

All PERF members must have a four-year college degree and must subscribe to a set of founding principles, emphasizing the importance of research and public debate in policing, adherence to the Constitution and the highest standards of ethics and integrity, and accountability to the communities that police agencies serve.

PERF is governed by a member-elected President and Board of Directors and a Board-appointed Executive Director.

To learn more about PERF, visit www.policeforum.org.



About the Motorola Solutions Foundation

The Motorola Solutions Foundation is the charitable and philanthropic arm of Motorola Solutions, the leading provider of mission-critical communications, software and video solutions that help build safer cities and thriving communities. The Motorola Solutions Foundation makes strategic grants, forges strong community partnerships and fosters innovation by funding programs in public safety education, disaster relief, employee programs, and education,

especially science, technology, engineering, and math. In supporting public safety education, the Foundation focuses on supporting families of fallen public safety officers, advancing the education of public safety professionals and supporting community public safety education programs. The Motorola Solutions Foundation provides over \$11 million in support to over 250 charitable organizations and universities in over 30 countries annually.

**For more information on the Motorola Solutions Foundation,
visit www.motorolasolutions.com/foundation.**

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APPENDIX:

Participants at the Critical Issues Meeting, “Suicide Among Members of Law Enforcement Agencies”

April 2, 2019, New York City

Participants’ titles and affiliations are those at the time of the meeting.

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Reducing Gun Violence: What Works, and What Can Be Done Now

Promoting Excellence in First-Line Supervision: New Approaches to Selection, Training, and Leadership Development

The Police Response to Homelessness

The Changing Nature of Crime and Criminal Investigations

The Revolution in Emergency Communications

ICAT: Integrating Communications, Assessment, and Tactics

Guiding Principles on Use of Force

Advice from Police Chiefs and Community Leaders on Building Trust: "Ask for Help, Work Together, and Show Respect"

Re-Engineering Training on Police Use of Force

Defining Moments for Police Chiefs

New Challenges for Police: A Heroin Epidemic and Changing Attitudes Toward Marijuana

The Role of Local Law Enforcement Agencies in Preventing and Investigating Cybercrime

The Police Response to Active Shooter Incidents

Civil Rights Investigations of Local Police: Lessons Learned

Policing and the Economic Downturn: Striving for Efficiency Is the New Normal

An Integrated Approach to De-Escalation and Minimizing Use of Force

Improving the Police Response to Sexual Assault

How Are Innovations in Technology Transforming Policing?

Labor-Management Relations in Policing: Looking to the Future and Finding Common Ground

Managing Major Events: Best Practices from the Field

Is the Economic Downturn Fundamentally Changing How We Police?

Guns and Crime: Breaking New Ground By Focusing on the Local Impact

Gang Violence: The Police Role in Developing Community-Wide Solutions

Violent Crime and the Economic Crisis: Police Chiefs Face a New Challenge – PART I

Violent Crime and the Economic Crisis: Police Chiefs Face a New Challenge – PART II

Violent Crime in America: What We Know About Hot Spots Enforcement

Police Chiefs and Sheriffs Speak Out on Local Immigration Enforcement

Violent Crime in America: "A Tale of Two Cities"

Police Planning for an Influenza Pandemic: Case Studies and Recommendations from the Field

Strategies for Resolving Conflict and Minimizing Use of Force

Patrol-Level Response to a Suicide Bomb Threat: Guidelines for Consideration

Violent Crime in America: 24 Months of Alarming Trends

A Gathering Storm—Violent Crime in America

Police Management of Mass Demonstrations

Exploring the Challenges of Police Use of Force

Challenge to Change: The 21st Century Policing Project



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We are grateful to the
Motorola Solutions Foundation
for its support of the
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