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POLICE OFFICER SUICIDES

**Dispelling the Myths.
Causes, Prevention, and Intervention Strategies**



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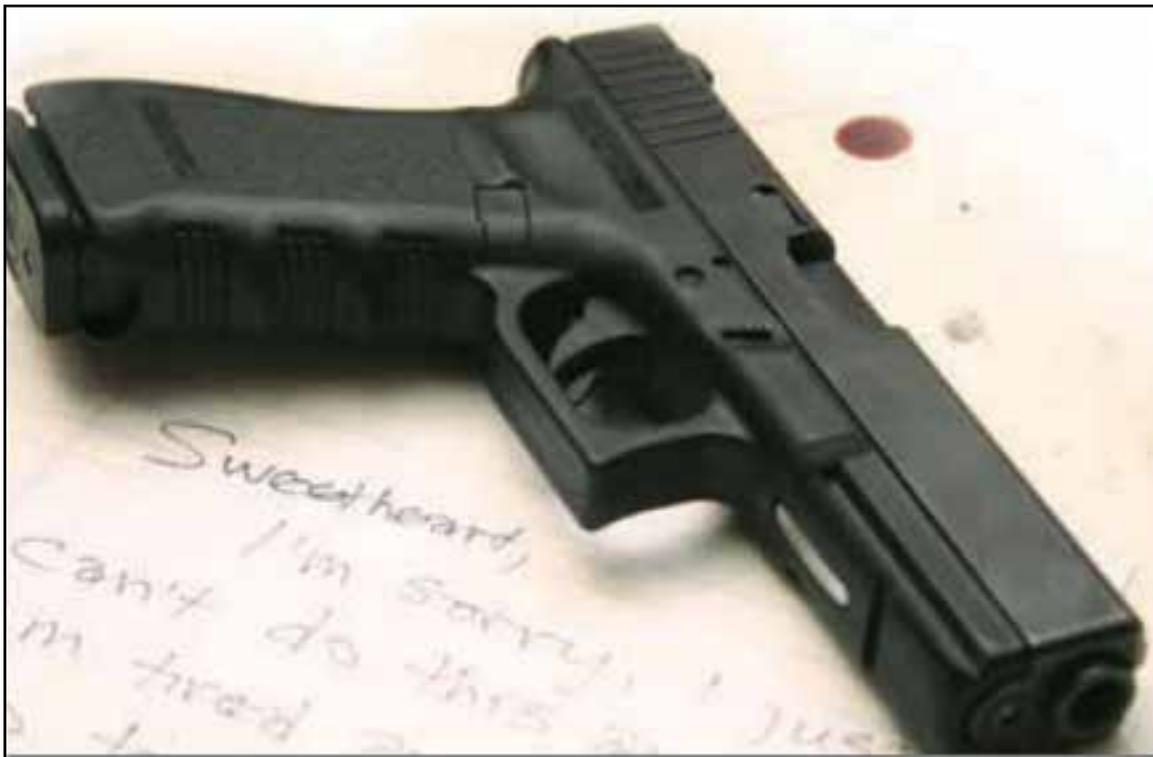
Police Officer Suicides: Dispelling the Myths Causes, Prevention, and Intervention Strategies

By ROCIC Publications Specialist Jennifer Adkins © 2014

During June 2013, an Arlington, Texas police officer who was being investigated for fraud and other charges by the FBI and state authorities committed suicide by shooting himself in a wooded area near his residence. The officer was 35 years old.

Unfortunately, this is a scenario too often reported in the media — an officer facing prosecution takes his life; a veteran cop shoots himself after 15 years on the force; a 9-11 hero ends his life after a fight with his wife.

Police officer suicides are complicated. Police work is one of the few professions that is a lifestyle, one that wears on a police officer both physically and mentally. However, while physical fitness has been a priority since the academy, departments are just beginning to talk about the mental health of officers.



Source: policesuicide.spcollege.edu

In August 2013, the International Journal of Mental Health Systems (IJMHS) released the results of a 5-year police population-based study that indicated the daily psychological stresses that police officers experience in their work put them at significantly higher risk than the general population for long-term physical and mental health effects. The study dispelled many myths associated with police officer suicides and sparked new debate about the most practical intervention and prevention solutions.

This report was compiled using resources from the International Association of Chiefs of Police (IACP), Under the Shield, the Badge of Life Program, *Law Enforcement Today*, *The Police Chief*, the St. Petersburg, Fla. College program *In Harm's Way: Law Enforcement Suicide Prevention*, and the IJMHS. Additional information on these resources can be found in the back of this report.

Disclaimer: This article is for educational purposes only and is not intended to provide specific clinical or legal advice.

5 Myths : Police Suicide

Myth #1:

More cops commit suicide than are killed in the line of duty

Current statistics show a declining suicide rate among law enforcement, while experts state the numbers are skewed and vastly underreported.

It is incorrect to say that more cops commit suicide than are killed in the line of duty. It is more correct to say that more cops commit suicide than are shot and killed by criminals, according to the Badge of Life. Also, many of these deaths should be seen as "line of duty" deaths, according to Susan L. Simons, president and founder of Under the Shield, Inc.

Often it is reported that the LEO suicide rate is two to three times as high as the general population; however, a study released in 2013 by the International Journal of Mental Health Systems (IJMHS) reported that police officers are less likely to commit suicide than an age-, race-, and gender-matched population.

The study determined a rate of 18 suicides per 100,000 officers. This suicide rate is higher than the U.S. population rate of 12:100K. However, because the majority of police officers are white

males, a more appropriate comparison group would be all white males in the U.S. population. The 18:100K suicide rate of LEOs is lower than the 2009 white male suicide rate of 22:100K. It is also lower than the rate of 33:100K by the U.S. Army in 2012.

The study shows that suicides declined from 141 in 2008 to 126 in 2012. Four murder-suicides were also noted during 2012.

On the other hand, there is research suggesting law enforcement suicides are more likely to be underreported or misclassified as accidental deaths than suicides, according to the IACP. This misclassification may occur to protect the family, other survivors, or the agency from the stigma of suicide. Simons stated:

"In my professional opinion, police suicides are of epidemic proportions, second only behind our US Military."

Departments need to understand that police suicides do not have to be self-inflicted, stated Simons. Officers often place themselves in situations where death is inevitable, which means the numbers are higher than what they seem.

For example:

An officer enters a residence to answer a domestic violence call, and he is not wearing a vest. He is shot and killed. This could be an act of suicide, and the reason it would be done this way is for the family to receive benefits. Or, a trooper, during winter, hits the pilings off the Interstate, running 80mph with no indication of applying the brakes. Assumptions are made that he hit black ice or fell asleep. Again, there is no way of knowing what was in the officer's mind at the time but we have to consider

Why do officers commit suicide?

- Psychological/physical pain
- Depression
- Anxiety
- Relationship problems
- Being under investigation

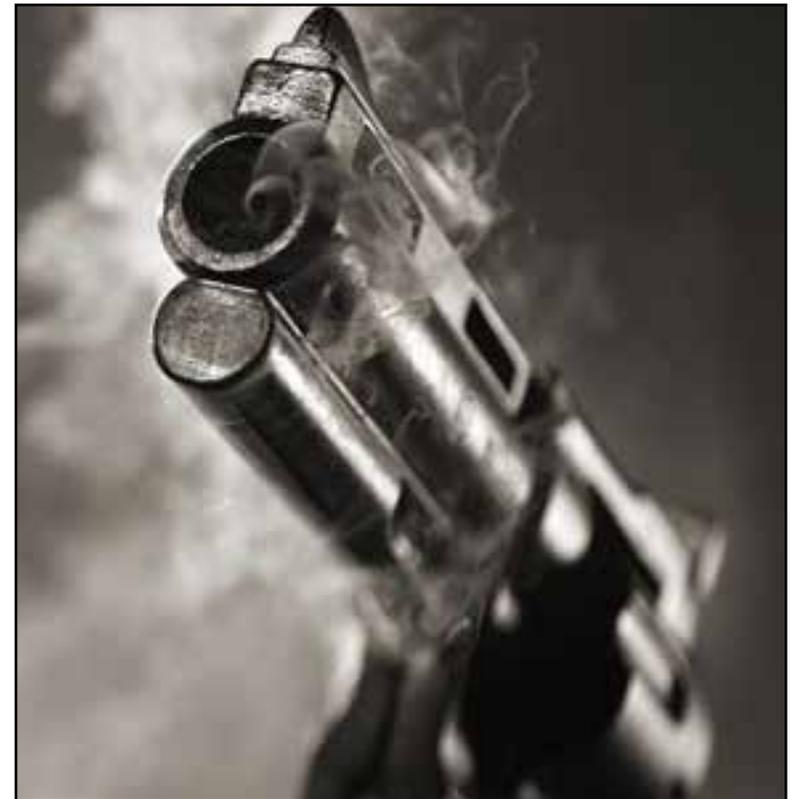
Source: policesuicide.spcollege.edu

that it could be an act of suicide, explained Simons.

Many departments keep poor records on suicide statistics, especially suicidal attempts. Suicide is not openly discussed by police; officers tend to view suicide as dishonorable, according to the IJMHS study.

"I personally know of one officer who tried to commit suicide and the chief came out with a statement that the

officer was cleaning his/her weapon," said Simons. "This chief's explanation was insulting to every officer in the department, not to mention insulting to the training academy given the officer's attempt was two shots into his/her side."



Myth #2:

Retiree suicides are ten times higher than active officers

The IJMHS research indicates that suicide rates among law enforcement are 8 times higher for active duty-working officers compared to retired officers. Dr. John Violanti, retired New York State Trooper who conducted the study, stated this finding challenges the common assumption that separated or retired officers are an increased risk for suicide. The myth that retiree suicides were ten times higher than active officers came from an invalidated 1980s study.

In 2012, an increase in suicide was seen among officers with 15-19 years of service. Suicide among officers of lower rank (below sergeant) was the most common (88.7 percent). Approximately 11 percent of suicides were military veterans.

Suicides appeared to cluster more in the 40 to 44-year-old age group, consistent with white male middle-aged persons in the general population. This is an increase in age from 35-39, suggesting that the infusion of younger officers into law enforcement is resulting in an increased acceptance of emotional self-care and therapy, according to the IJMHS.

“Without accurate records maintained on police suicides, it is hard to say if younger officers coming into the force is impacting the numbers but we also have to consider many law enforcement officers are returning veterans, which could lead to an increase in these numbers,” said Simons. (It is estimated that 22 veterans commit suicide per day, according to a Veteran Affairs report released in January 2014.)

In addition, police officer suicides occurred at a rate of 92 percent (males) and 6 percent (females).

Myth #3:

The “biggest stressors” in police work are the administration

The Badge of Life program stated that this myth could be true only if you mean “stress” and not “trauma.” Stress is a part of every day – often to an unhealthy level for cops. Trauma happens to you and is an injury to the brain that causes PTSD. The Badge of Life website states:

“For many officers, police administration — the sergeant, the chief, departmental policies, internal affairs — are a constant irritant that seems to be there every day. This can lead to chronic stress, which can cause headaches, stomach problems, insomnia, anxiety, and even depression.”

In addition, Simons stated that during 20 years of training all levels of law enforcement throughout the country, LEOs *always* told her the number one stressor in law enforcement is supervisors. She speculated that the number two stressor would be personal issues or the fear of being sued/fired over doing the job. But she stated that even if personal problems do arise, they are usually due to the job.

Definition of Stress

Stress is change. **Stressors** are the activating event that brings about the change. **Stress reaction** is based on the person’s perception about the change.

Source: *Under the Shield, Inc.*

On the other hand, the IJMHS research points at personal problems as being the foremost stressor (83 percent), with work-associated legal problems ranking second (13 percent).

The IJMHS concurred that relationship difficulties play a large role in police suicide. In fact, Simons suggested that if we really wanted to lower the number of suicides among law enforcement, it is essential to train the spouses/significant others about the law enforcement lifestyle. “They are

Suicide risk factors and indicators

1. Threats to harm oneself
2. Prior suicide attempts
3. Disturbance in sleep, appetite or weight
4. Thinking is constricted — there’s an attitude of all or nothing, or issues are black and white
5. Risk-taking behavior has increased
6. There is a plan and a means to carry out a suicide
7. The person is emotionless and/or numb
8. Anger and/or agitation
9. Sadness and/or depression
10. Hoplessness, with no orientation toward the future, or the giving away of valued possessions
11. Problems at work/home
12. Recent loss (of status or a loved one)
13. The person is under investigation
14. Social isolation and/or withdrawal
15. Increased consumption of alcohol/drugs

Source: *policesuicide.spcollege.edu*

5 Myths : Police Suicide continued

5 Myths : Police Suicide continued

the other half of this lifestyle,” she said. “Spouses do not know what to do or who to turn to. I have seen spouses come in to a department with all signs that their loved one is suicidal, only to be told that it is personal and the department can not do anything about it.

*“This is a lifestyle whether we like it or not.
We must begin to accept this and train for it,
which means spouses as well.”*

“I have dealt with many officers who were suicidal because of a marriage or relationship that fell apart, and they felt like it was their fault. In reality, many of them were the system’s fault because we are not properly training spouses.” Simons said that it has to be a spouse or former spouse of an LEO who needs to provide the training to other spouses. It never works for spouses to be taught by officers, she said.

Suicide rates are also associated with shift work, inconsistencies in the criminal justice system, alcohol and substance abuse, personal legal troubles, and a negative public image.

The risk for suicide appears greater at small agencies that may not have a peer support organization or access to trained mental health providers who specialize in treating LEOs, according to the IACP. The workload is often more intensive, with one or two officers per shift handling all calls. Further, there is a lack of anonymity that can be an issue in a small agency. LEOs will often be recognized while off duty, and may fear being seen entering a therapist’s office. Additionally, smaller agencies may have limited budgets for training/programs that enhance wellness or psychological self-care.

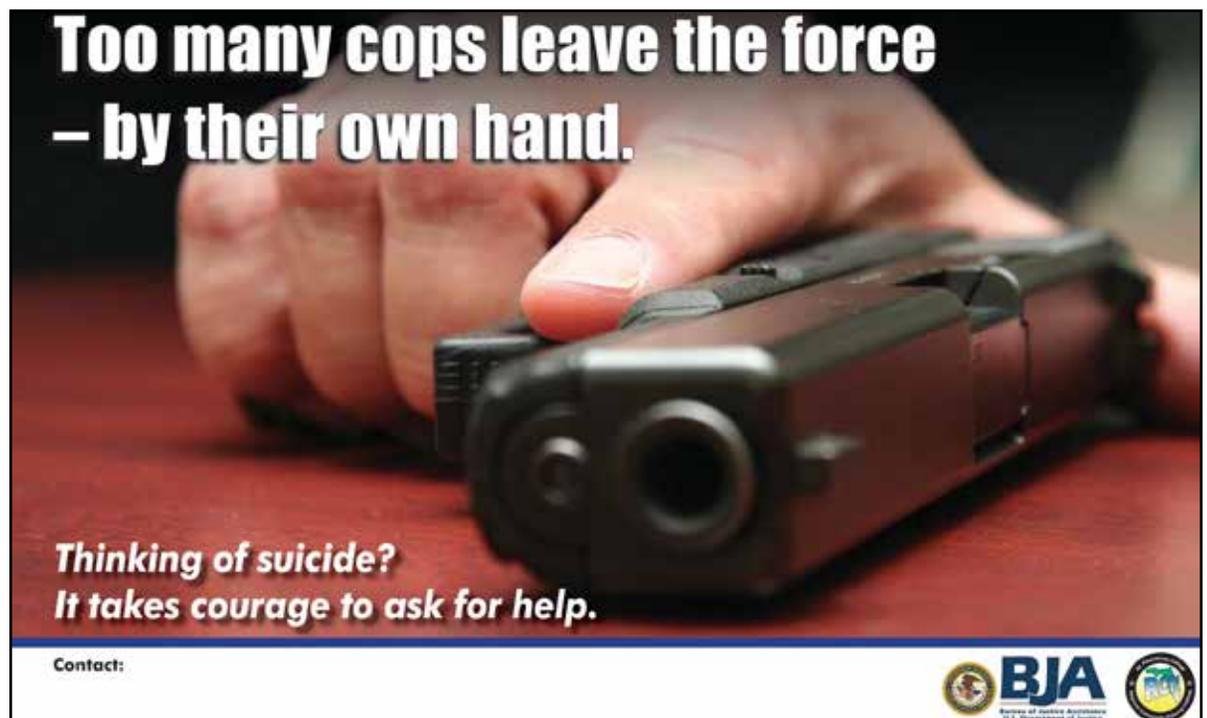
- A** Ask. Do not be afraid to ask, “Are you thinking about hurting yourself?” or “Are you thinking about suicide?”
- I** Intervene immediately. Take action. Listen and let the person know he or she is not alone.
- D** Don’t keep it a secret.
- L** Locate help. Seek out a professional, a peer support person, chaplain, friend, family member or supervisor.
- I** Involve Command. Supervisors can secure immediate and long-term assistance.
- F** Find someone to stay with the person now. Don’t leave the person alone.
- E** Expedite. Get help now. An at-risk person needs immediate attention from professionals.

Things to Do

Consider the following if you’re with a suicidal individual (not necessarily in this order):

1. Ask permission to secure weapon(s), including backup(s)
2. Immediately contact your Employee Assistance Program (EAP) representative
3. Identify someone who can provide on-scene support
4. Do not leave person alone
5. Assess if your safety is in jeopardy
6. Assist individual with meeting responsibility until the situation is stabilized

Source: policesuicide.spcollege.edu



**Too many cops leave the force
– by their own hand.**

**Thinking of suicide?
It takes courage to ask for help.**

Contact:



Myth #4: Someone in the agency “should have known”

No departments reported that they noticed warning signs of potential suicide, and 96 percent of officers appeared to have slipped completely under the radar, according to the IJMHS. This highlights the ability of an officer to maintain a façade before his peers, even while his mental health deteriorates.

Since LEOs often develop considerable skills in masking signs of distress or trouble, they are less likely to display many of the standard signs and symptoms related to impending suicide. They also have immediate access to a highly effective means of suicide — 96 percent of LEOs commit suicide with a firearm. A collaborative article in the *Police Chief* magazine stated:

“The idea of dying by gunshot is not horrifying and strange; it is familiar and known.”

Law enforcement has its own code of conduct and subculture. Many officers still feel a need to disguise signs of psychological distress for fear of reduced duty, loss of promotional opportunities, and job loss by their leaders. Police officers also hold unrealistically high expectations for themselves, according to the IACP. There is pressure to always be right, be in control, and they are forced to make life-and-death decisions in a split second. And then their decisions are scrutinized in court for months and sometimes years.

LEOs may also fear the consequences of admitting to emotional problems. Although younger officers appear more comfortable with psychological assistance, even they may be discouraged from seeking assistance if the agency involved does not provide the assistance, does not make assistance well-publicized or easily accessible, or creates an environment that pairs seeking assistance with weakness, failure, shame or job consequences.

Supervisor Responsibilities

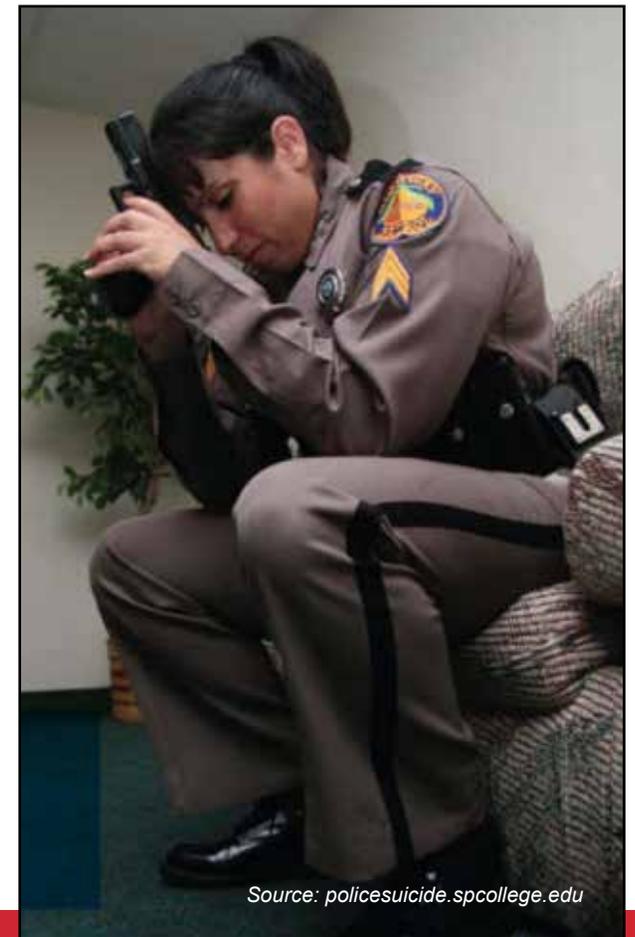
- Obtain suicide prevention training for your agency.
- Make sure that information about suicide prevention is available to line staff.
- Be aware and encourage the use of resources such as chaplains, peer support, Employee Assistance Programs (EAP).
- Ensure that your subordinates feel they will be given assistance and support when they bring a problem forward.

What you can tell your line staff

- When you suspect someone is having suicidal thoughts, reach out as soon as possible.
- Ask the person if he/she is thinking about suicide. Your asking him/her will not make him/her go out and do it.
- It is courageous and appropriate to take steps necessary to help a coworker who is at-risk for suicide.

Source: policesuicide.spcollege.edu

Law enforcement is a lifestyle where personal and professional come together without separation. Simons refers to this as the “Psychological Garbage Can.” The **Psychological Garbage Can** can fill up with issues at home, such as financial stress and health of family members, as well as professional garbage such as poor supervision, policies, and overtime. Add to that the pain and suffering encountered every day, split-second decisions demanded by the public and supervisors, having their hands tied by policies and procedures — all this impacts officers psychologically and makes for a very full “garbage can.”



Source: policesuicide.spcollege.edu

5 Myths : Police Suicide continued

5 Myths : Police Suicide continued

Myth #5:

Mental health has nothing to do with physical health

Suicide rates are not the only health facts reported in the IJMHS study. The research also indicates:

- 40 percent of the officers studied were obese, compared to 32 percent of the general population (possibly attributed to shift work as a contributory factor in an increase in metabolic syndrome).
- 25 percent of the officers were affected by symptoms of the metabolic syndrome compared to 18.7 percent of the general population. Metabolic syndrome includes symptoms of abnormal obesity, hypertension, insulin resistance, type 2 diabetes, and stroke.
- Officers (male and female) experience poor sleep quality and indicated the highest level of self-reported stress.
- Officers have an increased risk of developing Hodgkin's lymphoma and brain cancer after 30 years of service.

Dr. Violanti concluded that 15 to 18 percent of working police officers also have undiagnosed symptoms of PTSD. An additional number of officers can be expected to be suffering from anxiety that falls short of PTSD yet seriously affects their work and home lives. According to the Badge of Life, for every suicide, thousands of officers continue to work, untreated and suffering from work-related anxiety disorders. PTSD is not always caused by "one big event" but could be attributed to cumulative stress.

The highest rates of police suicide are recorded in California and New York. Craig T. Steckler, Chief of Police (retired), Fremont, Calif. P.D., stated in an article of *Police Chief* magazine:

"In reality, officer mental health is an issue of officer safety, and we should treat it as such. From body armor and seatbelt-use policies, to self-defense and verbal judo training, we can all list a variety of measures available to ensure our officers' physical safety. But what are we doing to actively protect and promote their mental and emotional health? Sadly, in many cases, it is not enough."

Police Officer Suicide: How to Cope, How to Heal Practical Police Psychology with Dr. Laurence Miller

I'm not going to pretend to give you a formula, because there isn't one, but there are some things you can do to help one another get through this and honor the memory of your deceased comrade.

Talk about it. I know, takes a real genius to recommend that one, right? But I mean talk productively. Try to understand what happened, without recrimination. I'm not saying spill your guts to people you don't know well, but among a group of your trusted colleagues, try to achieve what psychologists call cognitive control: coming to a rational understanding of what took place so you'll feel better prepared for next time. In essence, this is not dissimilar to the kind of operational debriefing many special units do following an officer-involved shooting or hostage crisis. Know what went right and what went wrong.

Alcohol. Okay, let's live in the real world here. We all know that most of these discussions are not going to take place over soy milk and Gatorade. Retiring to your local tavern for your group therapy is not necessarily a bad thing, as long as the alcohol is used moderately and constructively to oil the mechanism of self-expression in a supportive atmosphere, not self-destructively to drown feelings by getting totally smashed or drinking alone and stewing in one's solitary grief. However, if alcohol has been your particular demon in the past, don't compromise your recovery by placing yourself at risk.

Clinical services. By this I mean anything that might involve the participation of a licensed mental health professional, including a formal critical incident stress debriefing or individual psychotherapy. Most of the time, these measures won't be necessary, but if they are, don't be afraid to avail yourself of anything that might help.

Grief leadership. The brass should provide a model of constructive mourning of the deceased officer. They should be the ones who exemplify the fact that normal expressions of grief don't make you a weak person and that showing your honest feelings in a dignified way is actually a sign of respect for the deceased and for each other. Police leaders take note: your people will take their cue from you as to what is an appropriate and healthy response to a comrade's suicide and what constitutes dysfunction and dishonor. Departmental leadership should also be proactive in advising their people on how to deal with the media.

Families. Without being intrusive, offer your support to grieving family members, but don't be surprised if you find your helping efforts initially spit back in your faces by distraught, grieving families who are funneling their pain and anger against the department who "drove" their loved one to this. In that case, just let them know you're there if they need you and back off. Crises that family members will have to endure in the coming weeks or months include harsh recriminations by others who may want to blame them for the officer's suicide, intense media scrutiny, possible legal action, and coping with children's reactions to the death. Ideally, the department should have some kind of program for families dealing with line of duty deaths and this should not discriminate as to cause of death.

Source: policeone.com

Prevention Strategies

Recent adoption of departmental strategies to reduce suicide may account for the decreased number reported in 2012, according to the Badge of Life. There is increased use of peer support programs, a reduction in the stigma among officers regarding the topic of mental health, and officers are proactively engaging in psychotherapy. Others argue that we still have a long way to go before departments openly adopt practical mental health support programs.

“First we have to find a way to communicate to officers that it is okay to ask for help, and then we have to make sure that when they do ask for help it is given to them by someone who understands their lifestyle,” said Simons. “I have always struggled with the fact that many departments in this country use the term ‘counseling’ when referring to a form of discipline for an officer, and then they wonder why officers are resistant to seeking ‘counseling’ from those who are trained to help them with this lifestyle.”

The main strategies recommended in police suicide prevention are:

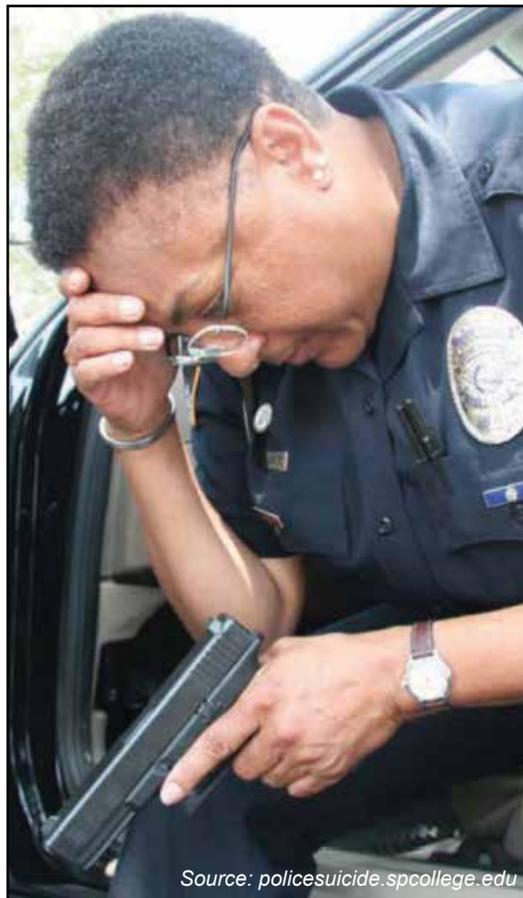
- **Annual Mental Health Checks**
- **Stress Management Training**
- **Peer Support Programs**

Tips for Coping

- Cherish your family
- Congratulate yourself on victories
- Create an outside hobby
- Celebrate the good things in life
- Eat healthy and exercise regularly
- Remember your priority in life

Your job should not be your first priority. It should not define who you are, but rather be something that you do.

Source: policesuicide.spcollege.edu



Source: policesuicide.spcollege.edu

What interferes with helping a colleague in need?

I was afraid to ask about suicidal thoughts.
You can't give someone the idea to commit suicide.

What if I'm wrong?

Cops have good instincts when it comes to reading people. If you are getting a feeling that somebody may hurt him/herself — trust your gut!

If he/she really is suicidal, I won't be able to stop him/her.

Suicidal thoughts are often impulsive and temporary. If you can get the person past the impulse and to proper assistance, he or she will often recover and go on with life.

Suicidal people want to die!

Most people thinking of suicide want a way out of intolerable physical or emotional pain. Some part of them wants to live and you can help them find a way to do it.

If I say something, that person's career is over.

Think in terms of necessary and sufficient force. Intervene as much as is necessary to keep the person alive and get him or her assistance.

If the person is suicidal but cooperative with seeking help, confidential counseling or voluntary inpatient care may be enough.

If, however, the person is uncooperative and/or imminently suicidal, a supervisor may become the necessary force you need to get help. While involving the department may result in the individual being relieved of duty, the person still has a good chance of getting his or her job back once the problems are resolved. The possibility of losing a job should not outweigh a person losing his/her life!

Source: policesuicide.spcollege.edu

Annual Mental Health Checks

The Badge of Life program proposes training focused on putting officers in charge of their own mental health, beginning at the academy and every year thereafter through voluntary, confidential “mental health checks” with a therapist of their choice. The Badge of Life website states:

“Suicide prevention is important, but it’s only one part of the formula. It can never be enough that we sit and wait until officers are in crisis before we act. We have to do something before they get there.”

An **annual mental health check** is voluntary. Departmental mandates have been tried and failed, according to the Badge of Life. The idea of the mental health check is to once per year go to a therapist with the same mindset you would go to an annual checkup at a doctor’s office or annual teeth cleaning at a dentist’s office.

Why would a department want to encourage mental health checks?

It’s not just about suicides. It’s about emotional survival for all police officers. Departments should consider a reduction in:

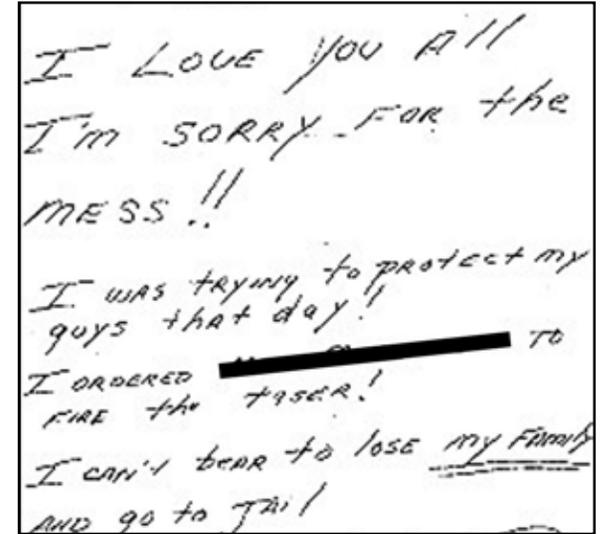
- Officer deaths from shootings and accidents
- Lawsuits
- Complaints
- Sick leave
- Alcoholism
- Substance abuse
- Criminal/other behaviors
- On and off-job injuries
- Divorces
- Grievances
- Resignations
- Morale problems

Source: badgeoflife.com

The police career is one of the most toxic, dangerous, violent and traumatic in the world, according to the Badge of Life. Officers deal with “unhealthy” on the streets and then go home and try to lead a healthy home life. But because it is a lifestyle, the reverse also applies — things have to be healthy at home or it can impact them on the job as well, said Simons. Officers deal with stress and trauma on a continuous basis and it wears on them.

“What you don’t take care of today may lodge in your subconscious and make the difference of a few seconds five years from now. It happens. It may also mix with the screams from last month and the spitter from Labor Day and the dead kid at the lake two years ago and the wreck when you were off duty...and leave you wondering why you’re arguing with your spouse more, lately. One of the first places job stress shows up is in the home,” states the Badge of Life website.

Many officers are nervous about seeing anyone they feel is connected to their department and prefer to seek an outside therapist. An outside therapist would generally cost a normal co-pay on your insurance. Discuss confidentiality with your therapist and get it in writing. Generally, you are protected unless you are a danger to yourself or others, or involved in elder or child abuse, according to the Badge of Life. Also, if you were to file a claim for a stress-related injury, you would be expected to allow access to your medical records. For information on how to select a therapist and additional resources, go to BadgeofLife.com.



Suicide note and funeral of an NYPD officer who committed suicide on his 46th birthday after an incident where an emotionally disturbed person he ordered Tasered fell off a fire escape and died. Note photo source: badgeoflife.com. Funeral photo source: nydailynews.com



Prevention Strategies continued

Stress Management Training

Simons is a supporter of Critical Incident Stress Management Peer Support and runs one of the most active teams in Alabama. She said:

“One problem I have seen throughout the country are the departments that have their own teams and debrief their own. Officers are hesitant to speak openly in front of people they work with or may have to work with in the future.”



“My team in Alabama is spread all over the state and if there is an incident in the southern part of the state I bring in team members from the north and vice versa.” Simons offers mental advocacy and stress coaching through law enforcement’s associations/unions in order to “balance the playing field with the Employment Assistance Programs and other mental health resources offered solely through the employer.” Officers are more receptive to self-help services if they are part of their association membership benefits, she said.

“Personally and professionally, I am very frustrated by the fact that many of the chiefs’ associations around the country are resistant to trainings such as those I offer through Under the Shield: Warrior Survival: At Home and On the Streets,” said Simons. “Many of the so-called suicide prevention courses for law enforcement are simply a check in the checkbox and not solution-based trainings. Simons’ training encompasses sleep issues, family/relationship issues, depression, anxiety, addictions, health issues, suicide prevention, and other stress-related symptoms.

Stress management training helps minimize:

- Absenteeism
- Diminished Productivity
- Employee Turnover
- Direct Medical Costs
- Legal & Insurance Fees
- Workers’ Compensation Claims
- Workplace Violence

Under the Shield

For information on training offered by Under the Shield, call (480) 641-6150, email susan@undertheshield.org, or go to undertheshield.org.

More information on this resource is at the back of this report.

The training also covers pre-incident education, debriefing, demobilizations, defusings, crisis management briefings, and peer-to-peer support.

Peer Support Programs

The IACP encourages law enforcement agencies to endorse and develop peer support programs. Generally if an officer is in crisis, if they are going to talk to anyone, they will probably first choose another officer, according to the IACP. A trained peer support person has already established credibility and is often more accepted by the law enforcement officer than a mental health professional.

Departments should promote the idea that seeking help is a sign of strength and can be a step toward becoming an improved and healthier officer, suggested the IACP. Officers should be trained in healthy self-care rather than maladaptive coping strategies such as excessive alcohol consumption, eating, and distancing. Training should be done at the academy level, through in-service training, and to all levels of supervisors and field training officers. Dr. Violanti recommended that agencies prepare for trauma before it happens, not wait until after the damage has been done.

Department administration should raise awareness about the motivations and risk factors for suicide so fellow officers will recognize them when they see them. Raise awareness about what steps to take when a fellow LEO is thinking about suicide, including spreading the word about available resources: peer support personnel, mental health professionals, employee assistance programs, law enforcement-related suicide help lines, chaplains, family, and friends. Read the IACP guidelines beginning on the next page.

Prevention Strategies continued

Peer Support Guidelines

Ratified by the IACP Police Psychological Services, Boston, Massachusetts, 2006

Definition

1. A peer support person (PSP), sworn or non-sworn, is a specifically trained colleague, not a counselor or therapist. A peer support program can augment outreach programs such as employee assistance programs and in-house treatment programs, but not replace them. PSPs should refer cases that require professional intervention to a mental health professional.

Administration

1. A formal policy statement should be included in the departmental policy manual that grants peer support teams departmental confidentiality to encourage the use of such effective support services. Department policy may be affected by the levels of legal privilege and confidentiality that apply to PSPs at the state level as well as state-imposed limitations to confidentiality. PSPs shall not be asked to give information about members they support. The only information that management may receive about peer support cases is the anonymous statistical information regarding the utilization of a PSP.
2. It is helpful to use a steering committee in the formation of the peer support program to provide organizational guidance and structure. Participation by relevant employee organizations and police administrators is encouraged during the initial planning stages to ensure maximum utilization of the program and to support assurances of confidentiality. Membership on the steering

committee in subsequent stages should include a wide representation of involved sworn and non-sworn parties as well as a mental health professional licensed in the department's jurisdiction.

3. It is beneficial for PSPs to be involved in supporting individuals involved in critical incidents, such as an officer-involved shooting, or any situation in which an officer is injured or killed. PSPs also make an invaluable addition to group interventions in conjunction with a licensed mental health professional. This includes PSP help for those in the outer circles of involvement (i.e., those who knew the principals but were not on the scene). However, the IACP Psychological Services Section's Officer-Involved Shooting Guidelines recommend that a confidential post-shooting individual intervention be conducted by a licensed mental health professional.
4. In order for the department that has a PSP team to meet the emerging standard of care of police psychological practice, the department should ensure that the PSP team includes clinical oversight and a continuing relationship with a licensed psychologist or licensed mental health professional who is qualified to provide supervision and consultation to the PSP team in clinical matters as needed. The role and scope of the overseer is to be mutually determined by the agency and the mental health professional.
5. A peer support program shall be governed by a written procedures manual that is available to all personnel.
6. Individuals receiving peer support may voluntarily choose or reject a PSP by using any criteria they believe are important.
7. Management may provide noncompensatory support for the PSP program.
8. Departments are encouraged to train as many employees as possible in peer support skills. Peer support team size varies throughout agencies depending on the size and resources available to each agency. The number of peer supporters depends on many variables: the crime level and geographical area covered by the agency; the number and size of divisions within a department; who is transferring, retiring, or promoting; and, of course, the budget.
9. Ideally, peer support teams will have enough trained and accessible members to provide services to all sworn and nonsworn department personnel, across all shifts and divisions. Team size needs to be manageable by program leaders or coordinators.
10. Larger departments are encouraged to disseminate PSPs across divisions, shifts, and sworn and nonsworn personnel throughout the agency. Conversely, smaller departments may need to combine resources with adjacent agencies, par-



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ticularly for training and critical incident support. Many critical incident response teams already exist across services (police, fire, paramedics, dispatchers, and so on). Additionally, building interagency team relationships is beneficial for major incidents where the agency's PSPs themselves are close to the incident and may desire support (in such cases as officer death or suicide).

11. Finally, long-term team planning also needs to balance the impact of transfers, promotions, and retirements on the team size and availability.
12. A peer support program coordinator who has a block of time devoted to program logistics and development should be identified. This individual would coordinate peer support activation, make referrals to mental health professionals, collect utilization data, and coordinate training and meetings.
13. The peer support program is not an alternative to discipline. A PSP does not intervene in the disciplinary process, even at a member's request.

Selection/Deselection

1. PSPs should be chosen from volunteers who are currently in good standing with their departments and who have received recommendations from their superiors or peers.
2. Considerations for selection of PSP candidates include, but are not limited to, previous education and training; resolved traumatic experiences; and desirable personal qualities, such as maturity, judgment, and personal and professional credibility.

3. A procedure should be in place that establishes criteria for deselection from the program. Possible criteria include breach of confidentiality; failure to attend training; or loss of one's good standing with the department.
4. PSPs should be provided with the option to take a leave of absence and encouraged to exercise this option, should personal issues or obligations require it.

Consultation Services from Mental Health Professionals

1. A peer support program must have a procedure in place for mental health consultations and training. Ideally, this consultation should be available 24 hours a day.
2. PSPs should be aware of their personal limitations and should seek advice and counsel in determining when to disqualify themselves from working with problems for which they have not been trained or problems about which they may have strong personal beliefs.

Confidentiality

1. Departments should have a policy that clarifies confidentiality guidelines and reporting requirements and avoids role conflicts and dual relationships.
2. PSPs must respect the confidentiality of their



3. Limits to confidentiality should be consistent with state and federal law as well as departmental policy, and usually include threats to self, threats to others, child and elder abuse, and serious violations of the law. Additional exceptions to confidentiality may be defined by specific state laws or department policies (such as sexual harassment and worker's compensation). These should be well defined in the PSP manual, including procedures in the event one of these rare exceptions to confidentiality should occur.
4. It is essential that PSPs advise members of the

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level of confidentiality and legal privilege that they can offer. PSPs must demonstrate knowledge of the limitations to these protections in their department as well as knowledge of how they might be affected by potential federal proceedings.

5. PSPs must not provide information obtained through peer support contact to supervisors and should educate supervisors of the confidentiality guidelines established by the department. Agencies should not use PSPs in internal affairs investigations.
6. A PSP must not keep written formal or private records of supportive contacts other than non-identifying statistical records that help document the general productivity of the program (such as number of contacts).



Role Conflict

1. PSPs should avoid conflicting peer support relationships. For example, PSPs should avoid religious, sexual, or financial entanglements with receivers of peer support. PSPs should receive training related to handling the intense feelings that can develop between PSPs and receivers of peer support.
2. PSPs, who are also supervisors, should be trained to be sensitive to potential role conflicts involved in providing peer support, including those that could affect future decisions or recommendations concerning assignment, transfer, or promotion. PSPs should therefore not develop peer support relationships with supervisors or subordinates.
3. A trained PSP should know when and how to refer peers, supervisors, or subordinates to another PSP member, chaplain, or mental health professional to avoid any potential conflicts of interest. This includes recognition that a large number of contacts between a PSP and any one individual may be an indication that a referral is needed.
4. Supervisors may have additional requirements regarding the reporting of issues such as sexual harassment, racial discrimination, and workplace injury that may place the supervisor or the agency in jeopardy if the procedures are not followed. PSPs cannot abdicate their job responsibility as officers or supervisors by participating in the program. Each agency must evaluate supervisor responsibilities and the viability of having supervisors as PSPs.

Training

1. The steering committee shall identify appropriate ongoing training for PSPs.
2. PSPs should be required to advance their skills through continuing training as scheduled by the program coordinator.
3. Relevant introductory and continuing training for PSPs could cover the following topics:
 - Confidentiality
 - Role conflict
 - Limits and liability
 - Ethical issues
 - Communication facilitation and listening skills
 - Nonverbal communication
 - Problem assessment
 - Problem-solving skills
 - Cross-cultural issues
 - Psychological diagnoses
 - Medical conditions often confused with psychiatric disorders
 - Stress management
 - Burnout
 - Grief management
 - Domestic violence
 - AIDS
 - Suicide assessment
 - Crisis management
 - Trauma intervention
 - Alcohol and substance abuse
 - When to seek mental health consultation and referral information.

Prevention Strategies continued (IACP Peer Support Guidelines)

NEED HELP NOW?

Call 1-866-COP-2COP
1-866-267-2267

Call 1-800-273-TALK
1-800-273-8255

Additional Resources

First Responder Support Network
www.frsn.org

Emergency Ministries
www.emergencyministries.org

LE Peer Support Network
www.lepsn.org

Wounded Badge
www.woundedbadge.com

Wives Behind the Badge
www.wivesbehindthebadge.org

I Love a Cop - Book
www.theblueline.com/iloveacop.html

Fraternal Order of Police
www.grandlodgefop.org

National Police Suicide Foundation
www.psf.org

The Pain Behind the Badge
www.thepainbehindthebadge.com

Office of Justice Programs
www.ojp.gov/newsroom/suicideweb.htm

These and other resources can be found at
ROCIC.RISS.Net/Publications/Police_Suicides.aspx

Sources of Information & LEO Resources

Sources of Information

International Association of Chiefs of Police
Preventing Law Enforcement Officer Suicide - CD

- Developing a Suicide Prevention Program
- Sample Suicide Prevention Materials
- Training Materials & Presentations
- Sample Funeral Protocols

Theiacp.org/Preventing-Law-Enforcement-Officer

In Harm's Way Toolkit
Law Enforcement Suicide Prevention

- Reproducible Materials
- Rolling Backup Program
- IJMHS Articles & Other Publications/Presentations
- Speakers & Training Events

Policesuicide.spcollege.edu

Badge of Life
Psychological Survival for Police Officers

- Stress Management Strategy
- Online Training Videos
- Survivor Stories

Badgeoflife.com or Policesuicidestudy.com



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Susan Simons is considered to be one of the nation's leading experts in Stress Management for Law Enforcement. Simons is the President/Founder of Under The Shield, Inc., a non-profit business providing free counseling and other support services to emergency services personnel and their families. Simons was an Associate Professor at Herzing College in Birmingham in Alabama's first Bachelor of Science Degree in Homeland Security and Public Safety. She has a Bachelor's Degree in Criminal Justice and a Masters Degree in Science in Counseling and Human Development. For more information on Simons and her training programs, go to www.undertheshield.org.

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