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Suicide Prevention in U.S. Law Enforcement Agencies: a National Survey of Current Practices

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Abstract
Increasing attention is being paid to suicide among law enforcement officers, and how the agencies that employ these officers could prevent such deaths. This study presents the results of a national survey of U.S. law enforcement agencies' strategies for preventing officer suicide. We invited 177 agencies from across the United States to be interviewed, and 110 agreed to participate in qualitative interviews. Agencies were grouped into one of four categories based on the services they offered. Agencies offered minimal (a municipal employee assistance program), basic (mental health, critical incident response procedures, and training), proactive (in-house mental health care, embedded chaplains, substance misuse programs, peer support, screening, or health and wellness programs), and integrated services (integration of services into day-to-day operations). The results indicate that many U.S. law enforcement agencies are engaged in efforts to promote officer wellness and prevent suicide. Officers' perceptions of confidentiality may inhibit the use of in-house or contracted mental health services, while a weak or inconclusive evidence-base raises questions about common approaches like peer support or critical incident stress debriefing.

Keywords Suicide · Law enforcement · Police · Environmental scan

Introduction

The suicide rate in the United States has increased by 25% over the past 15 years; since 2012 over 40,000 persons in the United States have taken their lives each year (Curtin et al. 2016). In response to these trends, the National Action Alliance for Suicide Prevention has set a goal to reduce suicide by 20% by 2025 (National Action Alliance for Suicide Prevention Undated). One of its approaches for doing so is to encourage workplaces to be active partners in preventing suicide among their employees, recognizing that working-aged adults comprise the most suicides in the United States each year. This includes collaborating with law enforcement agencies to prevent suicide among the 765,000 law enforcement officers working in the United States today (Reaves 2011).

There are strategic reasons why prioritizing suicide prevention among law enforcement personnel is important for reducing suicides nationally. First, 88% of sworn officers working in law enforcement are men (Reaves 2015), and in the United States men have a rate of suicide four-times that of women (Canetto and Sakinofsky 1998; Centers for Disease Control and Prevention. National Center for Injury Prevention and Control 2017). It is unclear whether police work increases risk above and beyond that risk conferred by the gender profile of the workforce. A meta-analysis of 101 studies found that suicide rates for police are comparable to suicide rates in the general public (Loo 2003), a finding that has been replicated in subsequent research (Marzuk et al. 2002). More recently, however, Violanti and colleagues used national data and found higher rates of suicide among those in law enforcement (Violanti et al. 2013). The Center for Disease Control reports that in 2012 across the 17 states that were part of the National

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Violent Death Reporting System, 295 members of 'protective service' occupations (which includes law enforcement) took their lives, representing 2.4% of all suicide deaths (McIntosh et al. 2016).[1]

The importance of suicide prevention in law enforcement has been recognized for some time (IACP (International Association of Chiefs of Police) 2014), and in many cases agencies have already implemented programs to address it (Amaranto et al. 2003; Chapin et al. 2008; Nanavaty Undated; Patterson et al. 2014; Ussery and Waters 2006). However, the variability in U.S. law enforcement agencies suggests that there is likely to be diversity in their current approaches to suicide prevention, and the de-centralization of law enforcement makes dissemination of best practices challenging. There are close to 16,000 state and local law enforcement agencies in the United States, 70% of which are municipal police departments, 17% are sheriff offices (presiding over counties and independent cities with frequent responsibility for overseeing jails and prisons), and 50 are state police departments (the remainder are primarily special jurisdiction and Texas constable offices). Forty-nine percent of these agencies are small, employing 10 or fewer sworn officers, but most officers work for larger agencies with 100 or more sworn officers (Reaves 2011).

The goal of the current investigation is to better determine the types of approaches currently used by U.S. law enforcement agencies to prevent suicide among their employees. We do so using interview data collected from a purposive sample of 110 agencies designed to maximize variability in the types of services provided; thus, we do not provide estimates of how frequently different types of programs and services are offered, but rather on the breadth of the approaches currently in place.

Methods

Sample

Our sampling approach derives from situational analysis (Clark 2005) and employs maximum variation sampling. In this process, sampling is done iteratively (in the present study, in five waves) to maximize heterogeneity with respect to relevant themes or characteristics that evolve during the interview process. The interview team met weekly to discuss themes that emerged and decide upon the selection criteria for each subsequent wave of agencies to sample. The first sampling wave was constructed using two techniques: (1) purposive convenience sampling, starting with nine agencies where project team members had established relationships, and (2) stratified random sampling, starting with 32 agencies: 8 randomly selected from each of four geographic regions from the United States using the most recent Census of State and Local Law Enforcement Agencies (CSLLEA, 2008, n = 15,320 state and local law enforcement agencies; 2862 in the Northeast region, 5236 in the Midwest, 5418 in the South, and 1804 in the West) (Reaves 2011). The second sample wave included 7 agencies that were mentioned by interviewees during the first round of interviews as collaborators or model programs and an additional 25 were randomly selected from the 2008 CSLLEA. During the second round of outreach to law enforcement agencies, our response rate was lower than our target (70%), due mostly to the inability to contact representatives from 4 agencies with 10 or fewer sworn officers with full arrest powers. Thus, we restricted our subsequent sampling to agencies with more than 10 officers with full arrest powers. We also noted low representation of agencies reflecting rural areas, and thus, in Wave 3, we targeted agencies with at least 10 sworn officers and selected 36 agencies with four from each of the 9 rural designation areas; we also contacted 3 additional agencies we learned about during earlier interviews. In Wave 4, we selected representatives from state police agencies in the 10 states with, as of 2015, the highest overall suicide rates. We also learned that the agencies with the most robust and varying programs across U.S. law enforcement agencies were the largest police departments, so we sought interviews with the 25 agencies with the largest number of full time sworn officers with full arrest powers that we had not already interviewed. In the first four waves, we heard that law enforcement officers assigned to correctional facilities faced significant amounts of stress, and thus, invitations for Wave 5 of interviews were sent to the 30 sheriff departments with the largest jail populations, based on the most recent Census of Jail Facilities, administered in 2006 (Stephen and Walsh 2011).

In total, 110 (62.1%) of the 177 agencies we invited to participate in our interviews completed an interview. Forty-six did not respond to our request after repeated attempts to contact a representative of the agency, 16 refused, and 4 were deemed ineligible because they had too few full-time sworn officers with full arrest powers. We interviewed agencies representing 30 states across all geographic regions of the United States, in a range of urban (81% of our local police departments were from urban areas vs. 74% of the overall US sampling frame) and rural areas (almost all our primary state agencies have jurisdictions that include very rural areas). The Sheriffs' offices were a mix of urban and rural, with half from counties with dense urban centers and the other half located in more rural areas. The total response rate was 62% (response rate by wave = 71%, 43%, 51%, 89%, 53%, respectively).

[1] In comparison, the occupation category with the highest number of suicides was construction and extraction, which had 1324 of suicide deaths, representing 10.8% of all such deaths.

Our final sample resembles the total population of law enforcement offices (see Table 1), but is not representative, as this was not our aim. Our ranges mostly overlap with the sampling from the most recent information collected from a nationally representative sample of law enforcement agencies (Reaves 2015), but our median values tend to skew in the higher side of the range because we found more diversity of programming and approaches to suicide prevention in larger agencies.

Outreach

We followed a standard protocol to invite law enforcement agency participation. We first sent a letter by Federal Express to the agency director or chief describing the project, our request for a one-hour interview with personnel most informed about the department's workforce wellness concerns and initiatives, and a list of topics to be discussed. In cases where research team members had a prior relationship with a selected agency, that team member made the initial contact. Within 5 business days of receipt of the mailed letter, we made phone calls to the agency to schedule an interview. Often the head of the agency to whom we had sent our materials referred us to the personnel who were most involved with department wellness matters (e.g., psychological services divisions, human resources offices, directors of peer support programs and individuals charged with workforce health and wellness initiatives). In other instances, we conducted our interview directly with the sheriff or the chief of police. Repeated calls were made and email messages were sent to try to obtain an interview with every sampled agency. All procedures and materials were approved by our Institutional Review Board.

Analysis

All interviews were conducted by one of 9 members of the interview team and were scheduled to last an hour, though some took less time and some took twice as long. The protocol was developed with contributions from the entire project team. The first interview was conducted in-person, and led to some slight modifications to improve interview flow. The protocol included two broad domains: (1) mental health and suicide concerns within the agency; (2) mental health promotion and suicide prevention programs and resources. Analyses on the first of these domains is presented elsewhere (Saunders JB, Kotzias V, Ramchand R. The evolving nature of police stress: the impact of the socio-political environment (under review)). For the second of these domains, questions were asked about each initiative the agency was engaged in related to mental health promotion and suicide prevention, including questions about the program's intent, who manages it (i.e., department staff, contracted EAP, etc.), the population it serves, how it is resourced (finances, staff), utilization, any evaluation of it, and future plans for the program. If not mentioned by the interviewee, prompts were then asked about trainings, policies on firearms, screening initiatives, peer and gatekeeper programs, etc. Finally, questions were asked about the agency itself (i.e., agency culture, work load, etc.). The entire protocol is included in Supplementary Digital Content 1. Except in a handful of instances in which interviews were conducted in-person, most were conducted by telephone. Detailed notes were taken during the interviews, and if the interviewee consented, the interview was recorded.

When all interviews were complete, the interview team met and agreed on eight general categories of services: mental health services, peer support, promotional materials, training, chaplains, screening, crisis response, and other. Interviewers then categorized which services were offered in the agencies they interviewed. Next, one researcher (RR) read through each of the interview guides and pile-sorted by agency, using an inductive process combining agencies offering similar services together. As described in the results, four broad categories of agencies emerged from this process based on the intensity of services they provided in addressing officer wellness, and defining features were applied to each (Table 2). These broad categories were then validated by the original interviewers, who also discussed and resolved any categorization discrepancies with RR. Interviews that RR led were reviewed by an independent researcher (JS).

Results

Agencies were categorized into four categories representing a continuum of support services that varied by intensity or the level of direct service provided. The categories were agencies offering minimal services, basic services, proactive services, and integrated services, described in Table 2. In Table 3, we present the distribution of agencies within each category by agency size and operating budget. Most agencies did not have services specifically for preventing suicide, but spoke more broadly of the services they provided for promoting employee mental health.

Agencies with Minimal Services

Only a few ($N = 11$) organizations we interviewed were considered to have 'minimal' services, where mental health services were provided through an Employee Assistance Program (EAP) or health insurance available to all municipal or state employees, and thus not specific to law enforcement personnel or first responders. In general, these were smaller, municipal agencies (i.e., fewer than 50 officers with full arrest powers), though four agencies representing state police departments also were considered to offer minimal services. For the municipal agencies, most interviewees told us that

Table 1 Selected characteristics of final sample vs. 2013 Law Enforcement Management and Administrative Statistics (LEMAS)

	Local Police Department Our sample: $n = 57$ 2013 LEMAS: $n = 1540$*	Sherriff Office Our sample: $n = 31$ 2013 LEMAS: $n = 602$*	Primary State Department Our sample: $n = 22$ 2013 LEMAS: $n = 50$*
Operating budget			
Our sample range	$298,919–$1.3 Billion	$700,000–$729.3 Million	$23 Million–$180 Million
LEMAS range	$650,000–$4.6 Billion	$575,500–$2.8 Billion	$14.2 Million–$1.9 Billion
Our Sample Median	$70,100,000	$128,158,629	$18,819,295
LEMAS median	$8,000,000	$10,778,600	$139,536,200
FT Sworn Officers**			
Our sample range	3–36,000	10–9400	200–7200
LEMAS range	11–34,500	11–9300	143–7200
Our sample median	610	524	1235
LEMAS median	57	72	707
FT Civilians**			
Our sample range	0–13,903	2–7100	35–4600
LEMAS range	0–14,600	0–7700	35–5000
Our sample median	176	867	674
LEMAS median	13	47	441

*We limited the sample to departments with more than 10 full time sworn officers

**Rounded to nearest hundred

suicide gets discussed within their agency when they hear about a law enforcement suicide in another area, but that for the most part "there aren't any formal policies because it doesn't seem to be that big of an issue for us." Instead, they often mentioned an informal culture of support: "we're all friends, we go out after work or go to each other's houses, we talk off duty. It's a small town." If there is a personnel issue with an officer within the agency, informal procedures are preferred. A few interviewees expressed interest in developing a more formal program. Some of these agencies may also rely on community-based organizations, but support for such programs varies.

The four state agencies offering minimal services varied in size, employing between 200 and 2000 full-time sworn officers.

Table 2 Summary of wellness services by category

Category	Defining features	*n*
Minimal services	No specialized program beyond the presence of a municipal Employee Assistance Program and/or health insurance provided through their employer-sponsored health insurance.	11
Basic services	Minimal services *plus any of the following*: • Mental health services specific to law enforcement (outside of the EAP) • Process for responding to staff exposed to critical incidents • Training on stress/wellness	37
Proactive Services	Minimal and basic services *plus* at least one additional proactive approach to either identify people at risk for suicide or mental health problems and/or facilitate them into care. This included: • Process for proactively identifying people at risk • In-house mental health care • Embedded chaplains within workforce • Substance abuse services specific to law enforcement personnel • Peer support program • Official health/wellness program	55
Integrated services	Minimal, basic, and proactive services *plus* suicide prevention/mental health promotion integrated into day-to-day operations. This includes units focused on mental health or suicide prevention, or adopting policies to improve officer mental health (i.e., restorative sleep policies).	7

Table 3 Characteristics of final sample (taken from CSLLEA, 2008) by category of service offerings

	Minimal services ($N = 11$)	Basic services ($N = 37$)	Proactive services ($N = 55$)	Integrated services ($N = 7$)
Full-time sworn officers				
1000 or more	2	5	34	6
500–999	0	7	8	0
250–499	2	3	6	1
100–249	0	5	2	0
50–99	1	5	1	0
20–49	4	3	2	0
Less than 20	2	9	2	0
Operating budget				
Less than $1.0 M	0	4	0	0
$1M–$49,999,999	9	18	8	0
$50M–$99,999,999	0	5	4	1
$100M–$499,999,999	2	9	23	5
$500M–$999,999,999	0	0	11	0
More than $1.0 B	0	0	2	0
Missing	0	1	7	1

These officers are dispersed throughout the geographically large states that they serve, with some serving in remote areas that are hard to access. Representatives from two of these agencies indicated that officer stress, mental health, and suicide are high priorities but that limited resources which need to be delegated throughout the state often constrain the preventive services they can offer. In other cases, programs existed but were abandoned. In one case, the agency had a peer support program but it lost its funding. Another agency abandoned the EAP service that was previously included as a health benefit in exchange for another benefit.

Agencies with Basic Services

Agencies with basic services ($N = 37$) generally had some mental health services available to staff, and almost all had some process for responding to critical incidents. Many also offered some type of training to staff on topics such as stress reduction, wellness, or available resources. The agencies within this category varied in size: 12 had under 50 sworn personnel and 5 had over 1000 sworn officers. Some of the agencies in this group were in the process of developing new programs or expanding their services.

Mental Health Services

Similar to agencies offering minimal services, the most common mental health service was an EAP, which was typically offered to all municipal or county employees including law enforcement. Some smaller agencies contracted directly with one or more community-based mental health care providers as a resource available to staff. In some (but not all) instances, the contracted community-based mental health care provider was also responsible for making return-to-duty determinations. EAP providers, on the other hand, generally did not assume this role. In addition to these services, many law enforcement agencies also relied on chaplains in the community who volunteered to provide services to members of the law enforcement community. However, agencies embedding chaplains or mental health care professionals within them are considered as offering a proactive approach, described in the next category.

Critical Incident Policies and Procedures

All the agencies in this category had policies, procedures, or teams that were mobilized after a critical incident—many of whom referred specifically to an officer-involved shooting or fatal car crash involving a child as the most common incidents for which they provide support. Generally, for organizations with fewer than 100 sworn officers, the critical incident protocol was led by an external body which ranged from a mental health care provider who served all first responders in the community, the community fire department, private organizations, or in one case a statewide network that organized and served all the public safety offices within the state. Larger agencies generally had critical incident response teams comprised of law enforcement personnel from their own agencies who volunteered or were selected to be part of the team. These volunteers received some type of training which varied from trainings provided by external organizations to those conducted internally. Sometimes, interviewees told us that the volunteer officers who were part of critical incident response teams

continued to have informal relationships with the officers they interacted with for days, weeks, and even years after the incident—thus offering 'peer support' akin to more formalized peer support programs common in agencies with proactive services (described below). Critical response protocols were often led by a contracted mental health professional, EAP provider, or chaplain; however, in some instances the response was led by senior-ranking officers who served on the team.

Training

Trainings were common in this group and were reported by 20 of the 37 agencies. Most commonly mentioned were in-service trainings that the agency offered on stress reduction. However, agencies also mentioned trainings to cadets/recruits either on stress-reduction techniques, the resources that were available in the agency, warning signs of distress, or a combination of the above. Two offered training on mental health (one to recruits, one in-service) that were designed primarily to help officers address mental health-related issues in the community but also included training on officer mental health and well-being. Two mentioned trainings in their agencies' critical incident procedures, and one smaller agency of 65 officers brought in a life coach two days per year for an agency-wide session. Finally, one agency told us specifically of training they offered to families on warning signs of distress and resources for officers.

Agencies with Proactive Services

In addition to the 'basic services' described above (available mental health care, critical incident response, and training), most ($N = 55$) of the agencies we interviewed had adopted some type of additional proactive approach to either identify people at risk for suicide or mental health problems and/or facilitate them into care. These initiatives were in addition to psychological evaluations done prior to employment or as part of return-to-duty assessments. Although some interviewees mentioned physical health-based initiatives and told us these initiatives were intended to improve mental or emotional health, we did not include these as proactive approaches because they were not direct services aimed at mental health or wellness.

In general, agencies offered one or a combination of six types of proactive approaches: having in-house mental health care available for officers, having embedded chaplains (and in one case a mental health care provider) within the agency, creating special programs to address substance misuse, establishing a peer support program, screening procedures for identifying high risk personnel, or having an official health and wellness program. Agencies in this group that offered in-house mental health care may not have had additional EAP services, or may have de-emphasized EAP services during our conversations. As described below, agencies with peer support programs often used those peers to assist or run critical incident responses.

In-House Mental Health Care

Sixteen of the agencies assigned to this category offered in-house, free mental health counseling by licensed mental health care providers in addition to EAP services that were also often available. Fourteen of these agencies had over 1000 sworn officers. In some agencies, the service provided is an internal EAP in which mental health professionals (typically licensed social workers or psychologists) are employed to offer short-term counseling and referrals. At other agencies, mental health professionals are available to offer long-term mental health treatment and "therapy." Two agencies we spoke with (one with fewer than 15 sworn officers and one with nearly 1500 sworn officers) had arrangements with community psychologists who specialize in services for law enforcement personnel, who frequently visit the agency and "knows us [the officers] by name."

In addition to offering short- or long-term counseling, mental health professionals working within law enforcement agencies often engage in other activities including responding to critical incidents (and often overseeing such responses), collaborating with police officers during hostage negotiations, conducting academy and other trainings in emotional wellness, administering psychological evaluations for all new officers or return to duty evaluations, and overseeing peer support programs.

Embedded Chaplains and Mental Health Care Professionals

Eleven agencies relied on chaplains that were affiliated with the agency and often embedded within it. Six of these organizations had fewer than 1000 sworn officers, and three had fewer than 100. Most organizations had one or more volunteer chaplains: in one organization, the volunteer chaplain was also a police officer and in another the head of the volunteer chaplain program was a veteran leader at the police agency. In only 4 organizations were the chaplains paid employees. Agency representatives told us that these chaplains often conducted ride-alongs with officers to be "proactive," keep their "fingers on the pulse" of the agency and its officers, and to get to know the officers "one-on-one." Organizations that relied on chaplains also used them to help respond to critical incidents and to conduct death notifications to members of the community. One organization had a similar arrangement with a licensed clinical social worker: originally hired to conduct "coping mechanism trainings" with special units within the agency (e.g., homicide, crimes against children), now the social worker "comes in and hangs

out with them, shadow[s] them on calls, to be around and be familiar with them."

Substance Use Services

Two agencies we spoke with mentioned specific programs they had created to address substance misuse among officers. Both agencies told us that they offered direct linkages to regional outpatient and inpatient substance use services covered by the agencies' health insurance plans, and one agency offered closed Alcoholics Anonymous meetings for the region's police officers and firefighters.

Peer Support

Formalized peer support was the most common form of proactive service offered by law enforcement agencies, offered by 31 agencies, most of which had over 100 sworn officers. Although many agencies offering basic services used peer volunteers to respond to critical incidents, the agencies in this group used peers as para-professionals within the agency to address concerns officers had in using formal mental health/EAP services, and many spoke of laws or policies that assured the peer support personnel could provide confidential services. In most instances, officers apply to be a part of the program, are vetted, and receive formal training; in some cases, officers must be invited to be part of the program. Not all interviewees knew the number of trained peer supporters available, but among those that did the ratio of peer supporters to sworn officers ranged from 1 to 10 to 1 to 50. Once trained, most agencies advertise the officers who are part of the program. Although there are exceptions, officers typically do not have set "office hours" but meet with their fellow officers more informally. Oversight of the program varied: in some cases, it was overseen by an agency psychologist or other mental health professional, in other instances it was overseen by agency leadership.

We spoke with five agencies that approached peer support somewhat differently than the typical model just described. A small agency of 13 sworn officers partnered with a neighboring, larger agency to advertise the larger agency's peer support team. One state-level agency had a peer support program specifically for military veterans. Two agencies had formal partnerships with outside, community-based organizations that run peer support programs and hotlines specifically for members of law enforcement and at one agency, officers who volunteer for the program receive permission to volunteer "on company time." Finally, an agency of 3200 sworn officers recognized that over the years, officers who took their lives were often under investigation and administrative leave, so they established a program run by trained agency retirees who reach out to officers on administrative leave to "give them a confidential sounding board."

Screening

Six agencies, ranging from those with roughly 300 officers to one with close to 4000 officers, had established a procedure to proactively identify officers at potentially heightened risk—not only for suicide, but for other adverse outcomes as well (e.g., excessive use of force). In most cases, monitoring systems were in place to send messages to agency leaders when an officer had reached a threshold of indicators, like being involved in a set number of use-of-force incidents over a certain period of time, or exhibiting one of a pre-specified list of risk factors. Once an officer is identified, agencies' policies varied: one agency treated these on a case-by-case basis and left the decision to the officer's supervisor, but in other agencies, officers received a mandatory referral to a review board made up of representatives throughout the department or to the agencies' mental health care professionals (either in-house or a contracted EAP). At one state-level agency, those with a rank of captain and above had physicals twice per year and if their results were deemed "poor," they "get a letter" and are required to see a physician and are "at risk of losing their benefits." Although this may be related to shortfalls in physical health, the interviewee for this agency told us that the volume of those who received a letter in the prior year was so high that it "sparked getting more coverage for mental health."

Health and Wellness Program

Seven agencies told us about official health and wellness programs that were active within their agency. At one statewide agency with 1100 officers, the program was run by the contracted state EAP and consisted of "assessment and surveys and opportunities to engage and earn points and get $125 credit." A similar program was in place at a large sheriff's department, but was specifically designed for that department and also included fitness pins, meditation classes, and work chair massages; the agency even had stamina-in-motion desk elliptical trainers for officers in central control centers within the county jail. In three other instances, the program mostly organized seminars or promoted messages (e.g., posters, flyers) related to health and wellness. The program at the remaining agency of 60 sworn officers had a clearly defined mission statement and agenda to increase participation of the agency's peer support team, identify specialists within the county's contracted EAP to work with police officers, develop trainings for officers and families and messages and materials for officers (i.e., wallet cards), and organize social activities.

Multiple Programs

Most of the agencies in this group offered one proactive service: of the 55 agencies, 35 offered one proactive service and 21 of those offered only peer support. Next most common was

embedded chaplains, offered by 6 agencies. Sixteen offered two proactive services and the pairings varied widely, though most common was three agencies that offered both a peer support and wellness program. The remaining four agencies offered three proactive services that were each unique: two offered in-house mental health treatment, an embedded chaplain, and a peer support group; one offered an internal EAP, embedded chaplain, and peer support, and the last offered an internal EAP, peer support program, and conducted screening of officers.

Agencies with Integrated Services

Seven of the agencies we spoke with stood out for offering services in which suicide prevention and mental health promotion services were integrated into day-to-day operations. Five agencies described to us entire units devoted to health and wellness within their agencies. In four instances, we were told of units specifically for officers, their families, and veteran officers run by command staff with responsibilities for coordinating suites of activities, which mostly include the activities defined above. However, these units may take on additional responsibilities as well, often similar to those of a military casualty assistance officer (i.e., providing support for making funeral arrangements for both line-of-duty and veteran officer deaths). One agency of nearly 3000 officers has a 6-member mental health unit that is primarily responsible for responding to mental-health related calls, but because unit members are specifically trained in mental health, they are also called upon to support officers in need. This unit exists in addition to the agency's own in-house mental health services, as well as their volunteer-run peer support and family assistance programs. Finally, one very large department had multiple units and policies devoted to officer health and wellness, including a counseling service unit, psychological evaluation section, peer support and chaplain program, an employee relations unit, a relationship with a non-profit organization dedicated solely to providing a potentially less stigmatized resource for referral for the agency's officers, and policies to ensure anonymity for an officer who comes forward with personal issues.

In addition to having the services described above, one agency told us about official policies they had adopted to promote health and wellness. In response to an increase in mandatory overtime expected among its officers, a metropolitan agency with just over 300 officers instituted a "restorative sleep policy" that created sleep rooms within the office and encouraged officers to take naps while on their lunch breaks.

Discussion

Workplaces have been called upon to help address increasing suicide rates in the U.S., and law enforcement agencies are heeding this call in a variety of ways. While there are exceptions, the results of these interviews indicate that many law enforcement agencies are engaged in some type of effort to promote the mental health of and prevent suicide in their workforce. This is increasingly important given the demographic profile of law enforcement officers and the potential increased risk of suicide among those in the profession. It is also important given the socio-political landscape of law enforcement and the stressors associated with increased scrutiny and accountability placed on police officers (Saunders JB, Kotzias V, Ramchand R. The evolving nature of police stress: the impact of the socio-political environment (under review)).

Assessing Services Against Recommended Practices

In an evaluation of efforts by the Department of Defense to prevent suicide, the RAND Corporation recommended agencies seeking to prevent suicide have a multi-pronged strategy with programs that: (1) raises awareness and promote self-care; (2) identifies those at high risk; (3) facilitates access to quality care; (4) provides quality care; and (5) restricts access to lethal means (Ramchand et al. 2011). We structure our discussion around these elements.

Raise Awareness and Promote Self-Care

Law enforcement agencies in our sample relied primarily on in-service or new hire trainings, or trainings that were part of more formalized health and wellness programming, for raising awareness and promoting self-care. We are limited in our ability to discuss the trainings because our interviews did not generally elicit enough detail on the content and delivery of trainings. However, guidance exists on conditions for which such trainings may be most successful (Kelly and Hoban 2017). We heard less about proactive policies to reduce work-related organizational stressors. In particular, temporal issues (e.g., shift work, mandatory overtime) are known to impact sleep (Fekedulegn et al. 2016), and sleep disturbances (insomnia, sleep disturbances, and nightmares) increase risk for suicidal behaviors (Bernert et al. 2015). While we did not ask specifically about such policies, only one agency discussed with us their restorative sleep policy as relevant to their mental health promotion efforts. Institutional policies and practices that promote self-care should not be overlooked as critical elements of ensuring a healthy workforce. Other areas that may be worth focusing on are responsible drinking and promoting family relationships.

Identifying Those at High-Risk

Perhaps most controversial for law enforcement agencies, and workplaces in general, are procedures and policies for identifying those at high risk – a strategy recommended at the National Symposium on Law Enforcement Suicide and Mental Health (IACP (International Association of Chiefs of Police) 2014)). Informally, this may be done using peers or embedded chaplains. One way this is being done more formally is with screening programs that use administrative data to identify officers at risk. Such a strategy is similar to a recent effort used by the Veterans Health Administration to identify patients at high risk of suicide (McCarthy et al. 2015). The controversy about such approaches in workplaces, however, is whether the intervention for those identified as being at high risk is, or is perceived as, being punitive, and the statistical accuracy of such predictions (particularly the proportion of false positives) (Ramchand and Kelly 2016). In our interviews, we learned that suicide risk is one of many behaviors law enforcement agencies are targeting using these methods; the other common behavior targeted is excessive use of force. However, we are not aware of any published literature examining the validity of prediction models for either outcome in law enforcement agencies. While researchers should continue help inform agencies interested or already engaged in such practices, agency leaders along with representatives from law enforcement unions, and law enforcement officers themselves, should be engaged in discussions about the routine use of such tools in agencies.

The other common strategy used by law enforcement agencies in our sample to identify people at risk focuses on personnel exposed to critical incidents. Because of their job duties, police may encounter a variety of frequent and severe traumas in their careers (Weiss et al. 2010). The relationship between adult traumatic exposures and suicide is tenuous (Knox 2008); however, trauma exposure may result in post-traumatic stress disorder (PTSD) and there is increasing evidence of an association between PTSD and suicide (Ilgen et al. 2012). Reviews of the research literature and strategies about what to do after a critical incident are discussed elsewhere (Brucia et al. 2017). Debriefing is one term that is used by law enforcement agencies, as it is with researchers, to encompass a variety of approaches for supporting officers after critical incidents (Brucia et al. 2017). While we did not probe to gather enough details about the practices currently in place across agencies, we did hear about both voluntary and mandatory debriefings, the use of mental health practitioners as well as peers to run such programs, and both group and individual sessions: at times, even within the same agency based on the nature of the traumatic event. It is likely that while some practices may align with the evidence base, such as offering cognitive behavioral therapy (CBT) to symptomatic persons (Roberts et al. 2010; Wei et al. 2016), other agencies are still using single-session group-based procedures that are no longer recommended (Brucia et al. 2017; Rose et al. 2002), but were mentioned to us during interviews in good favor.

Facilitate Access to and Provide Quality Care

The third and fourth component of the RAND framework can be considered together. The use of peers as paraprofessionals is one strategy used to facilitate access to care: theoretically, peer supporters are supposed to address mental health care stigma by helping introduce peers in need to available mental health counselors (Bohl-Pernod and Clark 2017). Unfortunately, the evidence that such programs achieve these goals is limited. A recent meta-analysis of such programs found promising evidence that peer counselors can yield beneficial outcomes with respect to promoting behavior change (e.g., reduced substance use, adherence to a diet) but not necessarily changes in health conditions (e.g., depression) or health care utilization (Ramchand et al. 2017).

There are likely economic considerations law enforcement agencies need to consider when deciding how to provide mental health care available to its employees. While it may be partially designed to make officers more familiar and comfortable with mental health care providers, officer receptivity and utilization of in-house vs. contracted vs. external mental health care providers (like external EAPs) remains an unanswered question. There are important legal and ethical considerations as well, particularly as they relate to the confidentiality provided by in-house mental health care providers and with negotiating the multiple relationships these providers may have with officers in the agency (McCutcheon 2017). Some agencies distinguish between mental health care providers who offer counseling from those that conduct return-to-duty investigations, but many organizations do not establish such boundaries. A provider who assumes both duties may be, and/or be perceived of as being, a conflict of interest and thus further prevent officers in need from accessing mental health services. As important as policies are to ensure confidentiality and minimize potential conflicts of interest, so too is ensuring officer-clients have accurate understandings of these issues. A perceived lack of confidential care is a well-established barrier to mental health care in military populations, for whom in-house mental health care is also available (Acosta et al. 2014). Similarly, officers may not provide accurate assessments of their own mental health symptoms if they perceive that such information is not confidential or could be used for matters related to their employability or return to duty (Fear et al. 2012).

The availability of in-house mental health care also suggests that law enforcement agencies have a role in ensuring providers deliver quality care. Recent publications advocate for mental health professionals with specialized competency in working with law enforcement personnel (Axelrod 2017;

McCutcheon 2017). However, the authors have failed to stress that mental health care provided to police officers should also be evidence-based. High quality care requires both the delivery of evidence-based and culturally competent care (Tanielian et al. 2014). There is no overall assessment of the quality of care in-house mental health care providers offer to police officers, though recent studies indicate relatively low quality of care delivered in civilian and military settings suggesting there may be deficits in law enforcement agencies as well (Hepner et al. 2017; McGlynn et al. 2003).

Restrict Access to Lethal Means

Firearms are the most common method Americans use to take their lives, and we asked directly about firearm training, storage, and access in the agencies in our sample. Across almost all agencies, we were told that officers receive training on proper use and storage annually and that they generally take their work-issued firearms home with them. While there is evidence supporting means reduction for reducing suicide (Azrael and Miller 2016), doing so in U.S. law enforcement agencies may be a challenge. However, there are illustrative examples from similar agencies. The Israeli Defense Force (IDF), which, after noticing a significant number of suicides over the weekends among young soldiers, required them to leave their firearms on base when they returned home on weekends and witnessed a 40% reduction in the suicide rate among young Israeli men (Lubin et al. 2010). While such a policy may have worked for the IDF, U.S. law enforcement agencies wanting to adopt such an approach will need to consider one that best suits their law enforcement communities. Any effort should be considered alongside potential adverse consequences, like the worsening of mental health symptoms caused by removing a person's firearm.

Limitations

Our study was not designed to be generalizable to all law enforcement agencies in the U.S., but rather to maximize variability across agencies in the services they offered. There may be law enforcement agencies offering services not included in our study. In addition, we purposely excluded nearly half of all law enforcement agencies: those with fewer than 10 full-time sworn officers. However, agencies with more than 10 full-time officers employ most police officers working in the U.S. today. Finally, with respect to our protocol, our interviews were designed to capture the breadth of services available and we were often not able to gain explicit and precise detail about variation across different approaches (for example, procedures for responding to critical incidents).

Conclusions

Of the law enforcement agencies we spoke with, the majority expressed interest in expanding their mental health and wellness services, but noted that budget realities and constant operational challenges prevent this from becoming a priority. As one interviewee noted:

> *Honestly, putting out fires has prevented them from formulating and implementing a policy or program. Until something really bad happens, it's not on the forefront of our minds. We have so many fires in our department – staffing, budget, day-to-day statewide events that need attention…. We had 5 in-line deaths, so during that period, everyone was hot on addressing [mental health] as an issue, but once things quiet down, it's easy to get pushed to the backburner.*

The results of these interviews have implications for research. Services varied by intensity ranging from minimal to more proactive, and future research should evaluate whether intensity of services is associated with improved mental health outcomes and reduced rate of suicide. Research should also evaluate individual services offered, including the most prominent: procedures after critical incident stress debriefings, peer support programs, access to and receptivity of in-house versus external mental health care services, and the quality of care offered by in-house mental health care providers. Such research is necessary to help law enforcement agencies use empirical data when designing or selecting programs to adopt to prevent suicide or support officer mental health, as well as justify the costs associated with different approaches. In addition, translational research is needed to encourage agencies to abandon unsupported and potentially dangerous procedures in favor of those approaches that are garnering empirical support.

The results have immediate practical implications as well, particularly for agencies looking to adopt suicide prevention or mental health promotion activities. Those agencies with minimal services were either smaller agencies or state agencies in large states with geographically dispersed field offices. How other smaller and state agencies approached mental health promotion and suicide prevention may provide examples for similar agencies seeking to efficiently expand the services they offer. Some smaller agencies formed strategic partnerships with their other local first responder agencies to offer joint services or with neighboring law enforcement agencies with a peer support program to ensure their own officers had access to this type of support. State agencies often relied on an external EAP that had contracts with community providers throughout the state.

In conclusion, many U.S. law enforcement agencies are offering services, and the services they offer generally can be categorized into the types of policies and procedures that

are recommended. However, few agencies—particularly smaller ones—are offering a comprehensive suite of programs, and there is a weak evidence base for many of the specific approaches being used.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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