

Law Enforcement Agency Action Items:

EARLY WARNING & INTERVENTION PROTOCOLS

Identify, evaluate, and routinely audit mental health providers that offer services to at-risk officers

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

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

Peer Support Personnel

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

Employee Assistance Programs (EAP)

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

Mental Health Professionals

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

culture and acclimated to the daily rigors of police work. This exposure is critical for a qualified evaluator who may be screening potential recruits or interacting with at-risk officers during or following a critical incident.

Consortiums, Cooperative Wellness Groups, and Regional Support Teams

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

Technology

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

Other

Other prevention and intervention sources include agency chaplains, officers’ own chaplains or religious leaders, or medical professionals. Family members are another invaluable resource in identifying and mitigating the effects of mental illness, and in preventing suicidal behavior and death by suicide. Families are a key resource to any successful early warning and intervention program. Programs and information are important for family members in order for them to understand how they can support their significant other as a LEO, including:

- **Training Families:** It is important that family members understand the stressors and indicators in order to support their loved one in seeking department mental health assistance or professional help at crucial times. One participant indicated that her agency meets with academy recruits and their families for a full day after graduation to prepare families for what to expect in a career in law enforcement; to make them aware of warning signs of depression, anxiety, and other mental illness; and, to educate them on available resources. Participants agreed it is crucial to reinforce this family training throughout officers’ careers because family members may have changed due to separation, divorce, death, or simply will not remember what they learned 10 or 15 years earlier should a critical event occur. More important, the resources change over time. One mental health professional indicated that 70 percent of callers to the agency’s internal “help hotline” were concerned spouses, not officers, and that the hotline can provide these family members with valuable prevention and intervention information.
- **Family nights:** Do not underestimate the power of involving family. Hold monthly meetings with officers where family members are invited to discuss issues. If a department cannot manage monthly meetings, it can strive to build in more internal relationships by hosting holiday parties, summer picnics, and other events.
- **Family networks:** Spouse and family networks can organize speakers and training for officers’ families. Children should be involved as well, as they too may recognize changes in their parents and may become the “first responders” to officers with mental illness or suicidal behavior.

Encourage or consider routine mental wellness “check-ins” or exams

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

emotional needs of officers and the ethical responsibility of chiefs is a complex discussion. Other participants encouraged agencies to ensure that medical evaluators undertake suicide risk assessments when they see officers for required annual physicals. One participant indicated that her agency’s psychological services division meets each officer for a voluntary, confidential visit every 18 months for 2 hours. This program is designed **to change the stigma of people going to mental health services** by establishing voluntary but routine, confidential check-ins. For effective oversight, the officers are later surveyed to see if they were satisfied with the therapist “resiliency check” and the service received. Symposium participants agreed that resolution of these topics was beyond the scope of the symposium regarding agency adoption of compulsory versus voluntary mental exams; confidentiality laws addressing any disclosure of mental health issues; and state and local laws and agency policies governing an officer’s status due to mental health illness.

Pay attention to indicators and be prepared to intervene

The following should be considered:

- **Peer responsibility:** Ensure that all officers from recruit to retiree are properly trained to identify indicators of significant emotional problems, mental illness, and suicidal behavior and ideation.
- **Consider a checklist:** Develop a checklist similar to a type of “early warning system” to include in supervisor’s annual evaluations when assessing officers’ performance. The checklist’s goal is to identify whether sufficient warning signs exist to recommend a referral to psychological services. The reality, of course, is that any such checklist may be successfully manipulated, i.e., at-risk officers may know the “trigger” questions, not answer truthfully, and consequently evade detection. Nonetheless, such a checklist may be useful as one type of measurement to establish baseline mental wellness. Implementation of such a tool would necessitate serious discussion over whether this would be part of an employee’s official performance record. An alternative might be that the checklist is given to the officer as a self-assessment tool to evaluate whether they need to seek help. This type of checklist could be used in training as well and may be less threatening than a supervisory assessment tool.
- **Contacts:** If an officer is in a mental health crisis, have a prepared list of contacts that can help. If an agency has already identified and analyzed their mental health providers as recommended above, they will have this list of contacts readily available in both print and online. Publicize this list for new recruits, officers in training, officers in need, and throughout the officers’ careers, both for the individual officer in need and for the officer who recognizes a peer in need.

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

Table 2. Suggested Response Protocol for Agency Personnel

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

	needed to assist officers in successfully navigating the emotional impacts of the investigation
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Data Sources: IACP National Symposium on Law Enforcement Officer Suicide and Mental Health: Breaking the Silence on Law Enforcement Suicides

- **Have an established, vetted protocol to address mental wellness policies after critical incidents.**

Incorporate that protocol in agency-wide and career-long training, and routinely audit agency policies and practices to ensure that the protocol is implemented effectively and consistently. Participants disagreed on the effectiveness of mental wellness programs conducted after critical incidents. They noted that often it is not the critical incident that can be the most traumatizing, but rather the chronic stress of the job, or a particular event that may be the impetus for an individual officer’s mental health crisis or suicide attempt.

Some participants indicated that a compulsory mental health exam to discuss the impact of a trauma reduces the “stigma” associated with the help. However, the participants cautioned the effects of trauma are cumulative and that critical incident interventions must be accompanied by subsequent routine resiliency checks. They emphasized if agencies don’t provide officers with the proper resources early on, they may later risk chronic depression and other serious mental health issues. Other participants disagreed and indicated that mandating officers to see a therapist after coming off a horrific incident may impede their ability to heal. One participant indicated that voluntary, confidential counseling is far more effective in treating such instances.

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

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

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

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

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

Some officers who are returning veterans may face transitional challenges. Veterans may seek police employment because of the similar environment that law enforcement provides, yet the profession is subject to similar stressors as the military. If veterans suffer from PTSD or other deployment-related issues, they may require specialized intervention resources. IACP's "Vets2Cops" project (www.theiacp.org/EmployingReturning-Combat-Veterans-as-Law-Enforcement-Officers) includes guidebooks for executives, officers, and families specific to this issue. There is a crucial leadership role in intervention programs and protocols. Symposium participants highlighted that, depending upon the size and nature of the department, executives, command staff, and/or supervisors play an integral role in any intervention program. For example, some participants suggested that executive, command, or supervisory staff "gets back on the street once in a while," and to the extent feasible, get to know their officers' professional and personal lives.

Training

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

- Symposium participants emphasized that agencies must conduct mental wellness and suicide prevention training throughout an officer's career, including the following types of training:
 - Academy
 - In-service
 - Routine resiliency and critical incident
 - Formal (e.g., Power Points) and "informal" (e.g., roll call)
 - Line officer and supervisory/executive, with a particular emphasis on first-line supervisors, as they are the direct link to the officers and in many cases more likely to detect warning signs and need to learn what to say and do if they detect problems
 - Retirement
 - Family training
- Leaders must be front and center at this training to achieve buy-in from officers.
- While symposium participants recommended that IACP, in conjunction with other authorities, develop a national standardized model training on mental wellness and suicide prevention, participants also emphasized that training must be flexible and include the capability to tailor it to each agency's policies and practices.
- There are already resources available on model suicide prevention training, for example, the above-mentioned IACP CD. These prepackaged training presentations, videos, and brochures used by law enforcement agencies provide ready-made and cost-effective materials for an agency. Training should include early warning signs and indicators of mental illness and suicidal behavior; stress-management skills; and the definitions of clinical depression, anxiety, PTSD, and other mental illness. Provide training tailored for supervisors on how they can effectively intervene with at-risk officers (e.g., what words supervisors can use to tell an employee they are concerned about his or her mental wellness).
- The trainer must be a law enforcement officer or someone trained in the law enforcement culture. As with mental health professionals treating officers, if the trainer is not an officer, then the trainer must be acclimated with the daily rigors of police work. This can occur through things such as ride-alongs on all shifts and participating in academy training.

- Symposium participants recommended that mental wellness and suicide prevention training should occur at least once a year for two to four hours. Online training can supplement but not replace live training. With frequent, mandatory training, it normalizes and institutionalizes these concepts.
- Train everyone in the agency to be responsible for everyone in the agency, from the chief to the administrative assistant and dispatcher.
- Find a spokesperson to be the face of the campaign and appoint a person at the training academy level as point of contact for the coordination of all this information.
- Monitor and routinely evaluate the training for effectiveness and consistency.
- States vary in how they institutionalize new training. For example, some states require police training to be set by legislature and agencies have to get buy-in from state legislators. In other states, police academies are decentralized and are able to establish new training as needed. The symposium participants indicated that due to the differences in establishing new training, it is difficult to achieve consistency in training curriculum.

Event Response Protocols

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

Funeral protocols: Symposium participants overwhelmingly agreed that police departments should honor how officers lived and not how they died. The symposium discussions focused on the general theme that the funeral and post-event protocols should celebrate the officers' life regardless of cause of death. There was some debate, however, about the precise protocols that should govern funerals of officers who die by suicide. For the most part, however, participants recommended that these officers should receive the same funeral protocols as all active-duty officer deaths that have passed away from a heart attack or natural causes. Participants also recommended that department leadership must do the following: 1) be physically present at the funeral; 2) establish the agency's funeral protocols; and 3) ensure that the entire department is well-informed of and routinely updated on these protocols.

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

- **Officer's Family:** In any officer death by suicide, there may be difficult dynamics between protecting the agency and comforting the officer's bereaving family. Litigation or possible litigation can complicate any officer death by suicide. Some agencies have faced pressure, both internal and external, on the specific descriptive language to be used when documenting a death by suicide that will be sensitive to the officer's family as well as how it may impact the family's ability to receive death benefits. Regardless of these dynamics and the legal classification of death following a suicide, agency leaders should personally visit with the family who has suffered the loss. If the suicide occurred at work, the agency leaders should also notify the family first before informing the department. The agency leaders should appoint an officer and an alternate to keep in continued, close contact with the family. Some participants recommended that a close friend of the officer and the officer's family should be appointed;

others suggested that person might be too bereaved to fill this role. In any event, an alternate should be appointed as a backup.

- **Officer's Agency:** After family notification, agency leaders should personally and in a timely manner address the entire department about the facts of the officer's death by suicide. Leaders should also take this time to advocate strongly for the value of officers utilizing mental health resources; to offer specific and available mental health education opportunities and resources; and to provide post-event counseling to affected officers, including those officers who may have responded to the suicide scene. There was continued debate among symposium participants about whether counseling should be compulsory or voluntary, but there was universal support that counseling is available by providing the following:
 - Contact information for psychological services
 - Time for officers to visit mental health resources and to heal
 - Post-suicide counseling services to affected officers, as officers who are already at-risk for mental illness and suicidal behavior or ideation may find this time a particular stressor
- **Information Dissemination:** Symposium participants offered several strategic guidelines addressing dissemination of information about an officer death by suicide. Most important, an agency should have established and well-publicized protocols governing notification of the family, officers, and the media, including the following:
 - The family must be notified first. As discussed, all active officers should be on record indicating who is to be notified in case of death to ensure timely notification consistent with the officers' wishes.
 - When notifying the family designee of an officer's death by suicide, the agency should find out the family's wishes with respect to notification of the agency and the media.
 - Request that officers refrain from discussing the death until the family has first been notified. Officers are more willing to comply if the chief personally tells officers what happened.
 - When addressing the public, the agency must speak clearly and consistently about the officer's death by suicide:
 - The agency must have precise protocols for dealing with the media in these situations. If an agency develops a trusting relationship with members of the media, these matters can be reported far more efficiently and respectfully.
 - Protocols must include guidelines on officers' use of social media. If agencies reduce the anxiety and anger that may result from the officer's death, they will avoid misuse of social media as an outlet.
 - Ensure that the role of the agency's public information officer is transparent and well-defined.

Read full report [here](#) from the IACP National Symposium on Law Enforcement Officer Suicide and Mental Health: Breaking the Silence on Law Enforcement Suicides