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SUICIDE IN LAW ENFORCEMENT: PROTECTING THOSE WHO SERVE

by

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September 2018

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The goal of this thesis was to identify effective suicide prevention protocols currently being used by law enforcement that can help leadership meet their organizations' needs. The research also reviewed suicide prevention protocols used by the military since both occupations are intrinsically connected by the psychological maladies they endure. Specifically, the thesis examined the Air Force Suicide Prevention Program and the Montreal police department's Together for Life suicide prevention program. Both programs used longitudinal studies that combined several suicide prevention protocols into their overall strategies. Metadata from each case study show that combining suicide prevention protocols creates a synergistic effect that results in fewer suicides over a measured period. Although the thesis also examined the effectiveness of individual protocols employed independently—including pre-employment psychological screenings, gatekeeper training, peer support programs, and employee assistance programs—this research was limited by insufficient metadata. Through a critical review of suicide prevention case studies and initiatives, this thesis identified best practices that may be tailored to the needs of law enforcement and the military.

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SUICIDE IN LAW ENFORCEMENT: PROTECTING THOSE WHO SERVE

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ABSTRACT

The goal of this thesis was to identify effective suicide prevention protocols currently being used by law enforcement that can help leadership meet their organizations' needs. The research also reviewed suicide prevention protocols used by the military since both occupations are intrinsically connected by the psychological maladies they endure. Specifically, the thesis examined the Air Force Suicide Prevention Program and the Montreal police department's Together for Life suicide prevention program. Both programs used longitudinal studies that combined several suicide prevention protocols into their overall strategies. Metadata from each case study show that combining suicide prevention protocols creates a synergistic effect that results in fewer suicides over a measured period. Although the thesis also examined the effectiveness of individual protocols employed independently—including pre-employment psychological screenings, gatekeeper training, peer support programs, and employee assistance programs—this research was limited by insufficient metadata. Through a critical review of suicide prevention case studies and initiatives, this thesis identified best practices that may be tailored to the needs of law enforcement and the military.

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LIST OF ACRONYMS AND ABBREVIATIONS

AFSPP	Air Force Suicide Prevention Program
CALEA	Commission on Accreditation for Law Enforcement Agencies
DoD	Department of Defense
DSM-5	*Diagnostic and Statistical Manual of Mental Disorders*, fifth edition
EAP	employee assistance program
IACP	International Association of Chiefs of Police
IDS	Integrated Delivery System
NSOPS	National Study of Police Suicides
PTSD	post-traumatic stress disorder
SOP	standard operating procedure
SPVM	Service de police de la Ville de Montréal (Montreal police department)
TRiM	Trauma Risk Management (Royal Marines program)

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EXECUTIVE SUMMARY

The men and women of law enforcement are the first line of defense for the United States' homeland security. Their mental wellbeing is essential, as they are required to make life-or-death decisions in the course of protecting the citizens they serve. Yet more than 100 law enforcement professionals take their lives through suicide each year.[1] Suicide rates also have increased in the post-9/11 armed forces as the United States continues to participate in conflicts.[2] Although both of these communities—law enforcement and the military—address suicide intervention and prevention through strategies and programs, the problem persists.

The purpose of this research was to analyze various suicide intervention and prevention programs used by military and law enforcement communities to determine whether they are effective in reducing suicides over a measured period of time. Two case studies were compared: the Air Force Suicide Prevention Program, and the Montreal Police Department's Together for Life suicide prevention program. In addition to the case studies, the research analyzed four individual prevention strategies: pre-employment psychological screening, peer counseling programs, gatekeeper programs, and employee assistance programs. Although no empirical data was found to quantify their degree of effectiveness, each protocol showed some utility as part of an intervention or prevention strategy.

The research concluded that, as shown in the case study comparison and backed by preexisting data, when programs combine several individual suicide prevention strategies they create a synergistic effect that significantly reduces suicides.[3]

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[1] Badge of Life, accessed November 13, 2017, http://www.badgeoflife.com/.

[2] *Update on Military Suicide Prevention Programs: Hearing before the Subcommittee on Military Personnel of the Committee on Armed Services*, House of Representatives, 114th Cong., 56 (2015) (statement of Honorable Susan A. Davis, representative from California, ranking member of the Subcommittee on Military Personnel).

[3] For case studies, see Kerry L. Knox et al., "The U.S. Air Force Suicide Prevention Program: Implications for Public Health Policy," *American Journal of Public Health* 100, no. 12 (December 2010): 2458, http://dx.doi.org/10.2105/AJPH.2009.159871; Brian L. Mishara and Martin Normand, "Effects of a Comprehensive Police Suicide Prevention Program," *Crisis: The Journal of Crisis Intervention and Suicide Prevention* 33, no. 3 (2012): 162–168.

Organizations that adopt a holistic approach to suicide prevention are more likely to prevent suicide than those that rely on individual strategies. When leadership, first-line supervisors, employees, family members, and union representatives are included in early intervention efforts, at-risk employees are less likely to be isolated from the care they need. Inclusion of leadership also plays a pivotal role in messaging the importance of suicide prevention, which mitigates the stigma and cultural barriers associated with seeking psychological care.

While these findings are based on the limited research conducted for this thesis, they do provide a starting point for leadership to resolve a significant issue that faces this country's security institutions.

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I. INTRODUCTION

The men and women of law enforcement are the first line of defense for the United States' homeland security. Their mental wellbeing is essential: they are required to make life-or-death decisions in the course of protecting the citizens they serve. According to Badge of Life, an organization dedicated to saving the lives of law enforcement, more than 100 law enforcement professionals take their lives through suicide each year.[1] Suicide rates also have increased in the post-9/11 armed forces as the United States continues to participate in conflicts.[2] Although both of these communities—law enforcement and the military—address suicide intervention and prevention through strategies and programs, the problem persists.

A. RESEARCH QUESTIONS

This thesis addresses the questions: Are current law enforcement suicide prevention and early intervention strategies effective? If so, which ones? Sub-questions include:

- Do cultural barriers specific to the law enforcement community prevent leadership from implementing suicide prevention strategies, or prevent officers from using their agencies' existing programs?
- Are the current screening processes used to identify preexisting psychological maladies in law enforcement candidates effective?

B. LITERATURE REVIEW

This literature review provides a framework for understanding the causes of suicide within U.S. law enforcement. Because military personnel operate in similar high-stress/high-risk environments as law enforcement, the review also examines suicide in the

[1] Badge of Life, accessed November 13, 2017, http://www.badgeoflife.com/.

[2] *Update on Military Suicide Prevention Programs: Hearing before the Subcommittee on Military Personnel of the Committee on Armed Services*, House of Representatives, 114th Cong., 56 (2015) (statement of Honorable Susan A. Davis, representative from California, ranking member of the Subcommittee on Military Personnel).

U.S. armed forces. Additionally, the review provides a broader context for understanding suicide and suicide prevention within the homeland security field.

Identifying the causes of suicide, without a doubt, illuminates the path toward effective suicide mitigation. However, most studies show that suicide is a multifaceted problem and, in many cases, the best way to address it is still being determined. For this thesis to pinpoint effective strategies, it must first examine how the problem is being studied, whether there is a consensus about its causes, and current studies that show positive results in reducing suicide.

Many studies have investigated the causes of suicide among police officers; a significant portion of them discuss mental disorders such as depression and post-traumatic stress disorder (PTSD), which officers frequently develop due to the danger and tragedy they encounter on the job.[3] An article by Dell P. Hackett and John M. Violanti, leading experts in the field of police suicide, suggests that police have "distinctive suicide prevention and intervention needs."[4] They found that, socially and psychologically, law enforcement personnel and their families face unique challenges. According to the article, police officers' work constantly exposes them to "depression, loss, post-traumatic stress or divorce, etc.," making suicide an alluring option to escape the pain. They also argue that, because police officers face dangers without the ability to retreat, they are constantly in discord with the naturally occurring "flight syndrome," which often results in PTSD.[5]

In relation to trauma and combat-related stress, PTSD has understandably received its share of attention. When couple with the amassing stress of daily operations, repeated trauma over time can create an array of physical and psychological manifestations.[6] In the initial *Diagnostic and Statistical Manual of Mental Disorders: Third Edition* (DSM-III)

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[3] Thomas E. Baker, "Dell P. Hackett and John M. Violanti, Police Suicide: Tactics for Prevention," *Journal of Police and Criminal Psychology* 24, no. 1 (April 2009): 66–67, https://doi.org/10.1007/s11896-008-9037-4.

[4] Baker, 66.

[5] Baker, 66.

[6] Mark H. Chae and Douglas J. Boyle, "Police Suicide: Prevalence, Risk, and Protective Factors," *Policing: An International Journal of Police Strategies & Management* 36, no. 1 (2013): 91–118, http://dx.doi.org/10.1108/13639511311302498.

formulation, psychologists considered a traumatic event as something outside the normal range of human experience.[7] To diagnose PTSD, clinicians expect their patients to have experienced events such as war, torture, natural disasters, airplane crashes, or other catastrophic stressors.[8] However, Dr. Judith Herman suggests an alternative diagnostic formulation for PTSD called "complex PTSD," which applies to victims of prolonged repeated interpersonal violence such as sexual abuse, domestic violence, or political torture.[9] A complex PTSD diagnosis considers multiple symptoms, such as "excessive somatization, disassociation, changes in affect, pathological changes in relationships, and pathological changes in identity."[10] Although scientific evidence supporting this subtype is currently inconsistent, it is important to this study because some police officers experience prolonged exposure to interpersonal violence throughout their careers.[11] According to a Badge of Life study, police officers who face the highest risk of suicide are typically on the job for ten to fourteen years before they experience suicidal ideations or take their own lives; this supports Dr. Herman's emphasis on the significance of long-term exposure to violence in PTSD diagnoses.[12] The literature suggests that the challenge is to find effective programs that help mitigate the effects of PTSD immediately following the traumatic exposure, and that offer ongoing protocols designed to provide continuous treatment throughout an officer's career.

Part of the problem with diagnosing PTSD is simply defining the disorder and its parameters. During World War I, the term "shell shock" was used to describe the condition. Then, "Based on earlier work by French psychologist Pierre Janet and German neurologist Sanford Gifford P. J. Mobius, it was ultimately recognized that these post-traumatic

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[7] The *Diagnostic and Statistical Manual of Mental Disorders* is currently in its fifth edition (DSM-5).

[8] Matthew J. Friedman, "PTSD History and Overview," U.S. Department of Veterans Affairs, last updated February 23, 2016, https://www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp.

[9] See Judith Herman, *Trauma and Recovery* (New York: Basic Books, 1992), as cited in Friedman, "PTSD History and Overview."

[10] Friedman, "PTSD History."

[11] Friedman.

[12] Badge of Life.

syndromes were psychological phenomena."[13] These early pioneers developed the base criteria for the causes of PTSD, yet current literature illustrates that experts in the field still disagree about the types of trauma that cause the disorder, and how to classify it.[14] In general, to meet the current standards for PTSD, DSM-5 requires that "a person [must] directly experience a traumatic event, or witness in person a traumatic event that happened to someone else, learn about the violent or unexpected death of a friend or family member, or experience repeated or extreme exposure to aversive details of traumatic events."[15] This definition supports both single-event and prolonged exposure to traumatic events—both of which law enforcement officers are exposed to throughout their careers.

Richard McNally, an advisor to the American Psychological Association's committee for PTSD, has a different view. McNally suggests that PTSD is too loosely defined and recommends sweeping changes to its diagnostic criteria in DSM-5 in order to restore scientific credibility to the field of traumatic studies.[16] He argues that, to be diagnosed with PTSD, a person should be physically present at the traumatic event; patients who suffer indirect trauma, he asserts, should be diagnosed with an alternate anxiety disorder or within a new diagnostic category. In general, McNally suggests that revisions to the diagnostic criteria need to be based on scientific evidence and not "pop culture diagnosis."[17]

Other experts argue that PTSD is not a valid psychiatric diagnostic category at all, and have asserted that its diagnosis is a result of the medicalization of normal human reactions. They suggest that the impetus for diagnosing patients with the disorder is a social construct linked to the "burgeoning health care, insurance, and pharmaceutical industries

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[13] Sanford Gifford, "From the Second World War to Vietnam: Historical, Clinical, and Personal Reflections on Post-traumatic Stress Disorder," *American Imago* 72, no. 1 (Spring 2015): 1–26, http://dx.doi.org/10.1353/aim.2015.0006.

[14] G. M. Rosen and B. C. Frueh, "Challenges to the PTSD Construct and its Database: The Importance of Scientific Debate," *Journal of Anxiety Disorders* 21, no. 2 (2007): 161–163, http://dx.doi.org/10.1016/j.janxdis.2006.09.007.

[15] Friedman, "PTSD History."

[16] Richard J. McNally, "Can We Fix PTSD in DSM-V?" *Depression and Anxiety* 26, no. 7 (July 1, 2009): 597–600, http://dx.doi.org/10.1002/da.20586.

[17] McNally.

which then permits reimbursement for medical diagnosis and treatment."[18] This argument is relevant to this thesis because it questions the veracity of PTSD as a valid stress disorder. Biological scientists and cognitive theorists also offer divergent theories. Biological scientists claim that the DSM-5 diagnostic criteria rely on an ineffective "top-down" reductionist approach that employs a questionnaire and symptom probes without considering the patient's past mental health history, personality traits, environmental factors, and current mental state; "This results in moving the mental health field away from, and not toward, comprehending responses to trauma."[19]

Although PTSD has been largely accepted as a valid stress disorder, there is still debate about how to define it, and gaps in how to address it. And while PTSD receives a lot of attention, other causes of suicide are also highly debated. For instance, the suicide demographics report to the 113th Congress highlighted an increase in the suicide rate among enlisted soldiers, while noting that only a small percentage of military personnel who committed suicide saw combat; half had never left the United States.[20]

Similarly, a study on suicide risk factors in current and former U.S. military personnel, published in the *Journal of American Medical Association* (JAMA), found no nexus between the "number of deployments and combat exposure" and "an increased risk of suicide."[21] This finding contradicts the long-standing assumption that deployments and combat have a direct bearing on military suicide rates. This same study emphasized that "Mental health disorders, depression, and alcohol usage were … found to significantly increase the risk of suicide."[22]

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[18] Rosen and Frueh, "Challenges to the PTSD Construct."

[19] Paul R. McHugh and Glenn Treisman, "PTSD: A Problematic Diagnostic Category," *Journal of Anxiety Disorders* 21, no. 2 (January 2007): 211–22, http://dx.doi.org/10.1016/j.janxdis.2006.09.003.

[20] *Update on Military Suicide Prevention Programs: Hearings before the Subcommittee on Military Personnel of the Committee on Armed Services*, House of Representatives, 113th Cong., 23 (March 6, 2013) (statement of LTG Howard B. Bromberg, Deputy Chief of Staff, G-1, U.S. Army).

[21] Cynthia A. LeardMann et al., "Risk Factors Associated with Suicide in Current and Former U.S. Military Personnel," *JAMA* 310, no. 5 (August 7, 2013): 496–506, https://doi.org/10.1001/jama.2013.65164.

[22] LeardMann et al., 498.

A RAND study identified seven "intrapersonal correlates" as risk factors for suicide.[23] They include prior suicide attempts, mental and substance-use disorders—and associated anxiety disorders, including PTSD—psychiatric comorbidity ("having more than one psychiatric disorder"), and head trauma.[24] The study also pointed to important "psychological correlates" such as "hopelessness, aggression and impulsivity, problem-solving deficits, genetics and neurobiology."[25] According to the data, 90 percent of successful suicides can be linked to pre-existing mental or substance use disorders through "psychological autopsies."[26] In other words, various issues must be measured when considering the causes of military suicides. Other studies of patients who attempted suicide support the RAND findings. For instance, a study of suicide attempt survivors showed that 27 percent had existing mental disorders. According to the authors of this report, however, "some experts disagree and consider suicide a separate phenomenon from mental illness."[27] Their main argument is that the effectiveness of current suicide prevention protocols is not "well supported by evidence."[28]

Laurence Miller's article, titled "Police Officer Suicide: Causes, Prevention, and Practical Intervention Strategies," suggests that officers develop a simple all-or-nothing, black-and-white thought process over the course of their careers that severely limits their ability to think beyond an immediate personal crisis, making suicide seem like the only option.[29] Officers see little "gray area" in their worlds, and this outlook eventually manifests in every aspect of an officer's life.[30] Miller goes on to explain "that suicide[s] in police officers are more prevalent in officers that have prior histories of depression, or

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[23] Rajeev Ramchand et al., *The War Within: Preventing Suicide in the U.S. Military* (Santa Monica, CA: RAND, 2011), 68–72, https://ebookcentral.proquest.com/lib/ebook-nps/detail.action?docID=684637#.

[24] Ramchand et al., 69–72.

[25] Ramchand et al., 72–73.

[26] Ramchand et al., 69.

[27] Ramchand et al., 69.

[28] Ramchand et al., 85.

[29] Laurence Miller, "Police Officer Suicide: Causes, Prevention, and Practical Intervention Strategies," *International Journal of Emergency Mental Health* 7, no. 2 (2005): 101.

[30] Miller, 102.

in those who have recently faced a combination of debilitating stressors, leading to feelings of hopelessness and helplessness."[31] Although officers' suicidal crises generally do not last long, they typically focus around personal relationships and work difficulties that have accumulated over time.[32]

C. RESEARCH DESIGN

The purpose of this research was to analyze various suicide intervention and prevention programs used by military and law enforcement communities to determine whether they are effective in reducing suicides over a measured period of time. Two case studies were compared: the Air Force Suicide Prevention Program (AFSPP), and the Montreal Police Department's Together for Life suicide prevention program. In addition to the case studies, the research analyzed four individual prevention strategies: pre-employment psychological screening, peer counseling programs, gatekeeper programs, and employee assistance programs (EAPs).

1. Limits

PTSD and other mental disorders that create an elevated risk of suicide was discussed as a backdrop to various suicide intervention and prevention methods; however, this research does not detail the personal reasons "why" police officers are committing suicide. Doing so requires deep cognitive evaluation by trained psychological clinicians and is therefore well beyond the scope of this work.

Other limits include the availability of accurate baseline numbers for law enforcement suicides over a measured period of time. Without accurate baseline numbers, it was difficult to precisely determine which prevention methods were effective over a specific time period. In the case of military suicides, data was plentiful but did not definitively show which prevention programs are working and which are not. Additionally, military suicides have been steadily increasing—with little fluctuation—since the United States' involvement in post-9/11 conflicts; this made it challenging to determine which

[31] Miller, 104.

[32] Miller, 102.

prevention programs are effective. Underreporting through misclassification of suicide as accidental death or undetermined death also contributes to inaccurate suicide reporting.

2. Data Sources

Data sources included but were not limited to: the National Institute of Mental Health, the Department of Veterans Affairs (VA), the International Association of Chiefs of Police (IACP), the Department of Defense Casualty Analysis System, the National Violent Death Reporting System, the American Community Survey, the Federal Bureau of Investigations (FBI), and academic studies and professional journals.

3. Types and Modes of Analysis

Most of the research data were derived from meta-analysis of known data and studies of suicide intervention and prevention protocols, suicide prevention training, critical incident debriefs, peer counseling programs, gatekeeper training, and suicide prevention awareness campaigns. The research studied both individual suicide prevention protocols that have been successful independently, and those that have been successfully integrated into more expansive, multifaceted programs. Protocols that have successfully reduced suicide rates can reasonably be recommended for integration into future suicide prevention program design strategies.

4. Outputs

The research concluded that, as shown in the case study comparison and backed by preexisting data, when military and law enforcement programs combine several individual suicide prevention strategies they create a synergistic effect that significantly reduces suicides. Which protocols are more effective can be a topic for further studies; however, there is no doubt that the protocols studied do address the issues behind trauma. The recommendations offered in Chapter V provide program administrators with the information they need to make informed decisions about the best suicide prevention practices for their organizations. These programs can then be codified into organizational policies and training seminars. Further, leadership may leverage this information to enhance or modify existing suicide prevention programs.

II. BARRIERS TO EFFECTIVE SUICIDE INTERVENTION AND PREVENTION PROGRAMS

Before specific suicide prevention methodologies are examined, it is important to explain the challenges in evaluating their effectiveness over a measured period of time. Impediments that prevent police officers and soldiers from using prevention and intervention resources are also reviewed in this chapter.

Suicide prevention programs are only effective if employees feel there are no repercussions for taking advantage of them. Moreover, employees must feel that their self-acknowledgement and subsequent self-referral will not threaten their employment, hamper future advancement opportunities, or mark them with the stigma that comes with seeking psychological care. This chapter presents challenges that police departments and the military face when trying to evaluate or improve their suicide intervention and prevention programs.

A. SUICIDE RATES: IMPRECISE REPORTING

There is no official, nation-wide suicide reporting system for law enforcement in the United States. Without a consistent system, reporting of annual suicide numbers varies. Additionally, few organizations conduct a comprehensive statistical collection or analysis of police suicides on an annual basis. This creates a statistical disparity that can make it difficult to evaluate the true scope of suicides, or to determine effective mitigation strategies.

Fortunately for this research, Badge of Life is a nonprofit organization that is committed to providing police suicide statistics and profile information for the United States.[33] Established in 2007, the organization's mission is to reduce the impacts of stress and trauma on police officers through information provided on their website. Because Badge of Life is the only organization that readily reports law enforcement suicides for all fifty states on a somewhat regular basis, its data was used for this thesis.

[33] Badge of Life, accessed November 13, 2017, http://www.badgeoflife.com/.

Badge of life established its proprietary National Study of Police Suicides (NSOPS) data collection system in 2009. NSOPS uses a myriad of social media systems to help the organization build annual reports, which comprise news reports of police suicides from all fifty states. Although Badge of Life staff acknowledges that law enforcement suicides are underreported, they remain confident that their data reliably show general increases or decreases in law enforcement suicides at the national level. To compensate for underreporting, Badge of Life adds 37 percent of the annually reported police suicides to their final figures.[34] Ron Clark, the chairman of the board for Badge of Life, asserts that 12 percent of this number was derived from the work of Dr. John Violanti, a leading expert in the field of law enforcement suicide, who, through his analysis of coroner reports, found that some deaths labeled as non-suicides, are actually suicides.[35] An additional 25 percent of the annually reported police suicides is added to the final figure, Clark explains, due to their understanding and analysis of the under-reporting issues. Since Badge of Life is one of the few organizations that collects law enforcement suicide data on a full-time basis, their adjustments to their annual suicide figures highlight the issues surrounding precise data collection of law enforcement suicide within the United States. This is not to suggest, however, that Badge of Life data is not valuable to the field; on the contrary, their efforts do provide a general trend supported by empirical data.

Badge of Life reported data on officer suicides for the years 2008, 2009, 2012, 2016 and 2017. There is no data, however, for 2010, 2011, 2013, 2014, and 2015; this could be due to lack of resources or time needed to compile the data.[36] Since 2009, NSOPS data show a gradual decrease in the number of law enforcement officer suicides, suggesting that agencies' suicide prevention efforts were successful. An unexplained spike in suicides in 2017, however, sends a chilling message about the elusive nature of the problem; more research is needed to determine which strategies are truly effective. In 2016, the NSOPS data show that the rate of law enforcement suicide (12 out of 100,000) was somewhat

[34] "A Study of Police Suicide 2008–2016," Badge of Life, accessed June 14, 2018, http://www.policesuicidestudy.com/index.html.

[35] Ron Clark, email message to author, 2018.

[36] Badge of Life, "Study of Police Suicide."

similar to the national rate as a whole (13 out of 100,000).[37] In 2017, the rate of police suicides rose to 16 out of 100,000, while the national rate rose only to 13.5 out of 100,000.[38] Also in 2017, more officers—about twelve each month—took their own lives than were killed in the line of duty; this is an increase of about three suicides per month, or thirty-two per year, from the 2016 total (140 annual police suicides in 2017, compared to 108 in 2016), showing the increasing prevalence of this problem.[39]

While Badge of Life numbers show that police suicides are above the national average, the organization does not necessarily understand why the increase is occurring. In general, Badge of Life asserts that the numbers should be lower because potential law enforcement officers undergo stringent vetting processes, background investigations, and psychological reviews before they are hired.[40] In other words, law enforcement officers are generally deemed free of mental disorders when they are hired, and should therefore be at a lower risk for suicide.

In contrast to the Badge of Life's conservative reporting, the International Association of Chiefs of Police (IACP) estimates that, annually, there are twice as many police suicide deaths than deaths caused by traffic accidents or felonious acts; however, the IACP concedes that, due to underreporting and "unknown data," there are no conclusive annual figures to support this estimate.[41] Unsubstantiated, anecdotal statements such as the IACP's attempt to shine the light on this problem for the public, but fail to provide useful data to help the public understand the full scope of police suicide. The IACP's inability to provide comparative data exemplifies how challenging it is to determine accurate officer suicide data on an annual basis.

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[37] Badge of Life.

[38] Badge of Life.

[39] Badge of Life.

[40] Badge of Life.

[41] "IACP Releases New Resource: Breaking the Silence: A National Symposium on Law Enforcement Officer Suicide and Mental Health," *IACP Blog*, June 5, 2014, https://theiacpblog.org/2014/06/05/iacp-releases-new-resource-breaking-the-silence-a-national-symposium-on-law-enforcement-officer-suicide-and-mental-health/.

Although military suicide rates are better recorded than police rates, they face similar reporting issues. Reports from the military tend to be more extensive and better organized, but the Department of Defense (DoD) still deals with underreporting. An interesting study that questioned the accuracy of suicide rates reported by the military was published in the fall of 2004 in an article titled "Suicide Surveillance in the U.S. Military—Reporting and Classification Biases in Rate Calculations."[42] It specifically focused on active-duty military deaths that were classified as "accident or undetermined manner of death."[43] Each individual's case was evaluated for a history of psychiatric problems, including evidence of suicidal ideations or intent. The report used two years of data (1998 and 1999) derived from "official death reports and the *DoD Medical Mortality Registry*."[44] The report found sufficient evidence to suggest that the suicide numbers reported were 21 percent lower than they should have been, primarily due to reporting bias and misclassification errors.[45] Without accurate year-to-year data, it is difficult to analyze the effectiveness of military intervention and prevention programs at the national level. Governmental efforts to manage underreporting also highlight the need for systematic records sampling and improved joint-service medical surveillance.[46]

In 2013, the 113th Congress held a hearing before the Subcommittee on Military Personnel to update Congress on the military's suicide prevention programs. During the hearing, Subcommittee Chairman Hon. Joe Wilson reported that "350 service members took their lives in the act of suicide" in 2012.[47] Jacqueline Garrick, the acting director of the Defense Suicide Prevention Office, also stated that the DoD suicide rate rose from

[42] Joel R. Carr et al., "Suicide Surveillance in the U.S. Military—Reporting and Classification Biases in Rate Calculations," *Suicide & Life-Threatening Behavior* 34, no. 3 (Fall 2004): 233–241, https://onlinelibrary.wiley.com/doi/full/10.1521/suli.34.3.233.42785.

[43] Carr et al., 233.

[44] Carr et al.

[45] Carr et al.

[46] Carr et al.

[47] Bromberg, testimony on *Update on Military Suicide Prevention Programs*, 1.

"10.3 to 18.3 per 100,000" in the past ten years.[48] In a follow-up hearing by the 114th Congress two years later, Subcommittee Chairman Dr. Joseph J. Heck reported that "442 active and reserve service members took their own lives" in 2014, showing an increase of 92 suicides since the previous hearing.[49]

However, during that same reporting period, information released by the DoD showed that suicides had decreased among "active duty, Reservist and National Guard in the 2nd quarter of 2014."[50] According to the report, suicides for all three service components combined dropped from 120 in the first quarter to 104 in the second quarter.[51] Garrick provided several DoD initiatives as possible reasons for the decline, yet acknowledged that there may be significant cultural barriers that prevent military personnel from self-reporting their psychological maladies, casting doubt on the accuracy of the reported decline.[52] Her statement once again illustrates the challenges the DoD faces to identify the causes of suicide within the military, or to develop the programs needed to prevent them.

Clearly, the nation needs more comprehensive and reliable accounting to understand the scope of suicides within law enforcement and the military. Relying on approximate suicide numbers—which are adjusted to compensate for underreporting—could cause the data to show a downward trend in suicide when, in actuality, suicide numbers have remained the same. Likewise, the inaccurate data may show an increase in suicides when prevention and intervention protocols are, in fact, effectively mitigating the problem. That having been said, it is only important to obtain national annual suicide data

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48 *Update on Military Suicide Prevention Programs: Hearings before the Subcommittee on Military Personnel of the Committee on Armed Services*, House of Representatives, 113th Cong., 23 (March 6, 2013) (statement of Jacqueline Garrick, LCSW-C, Acting Director of the Defense Suicide Prevention Office), 3.

49 *Update on Military Suicide Prevention Programs: Hearing before the Subcommittee on Military Personnel of the Committee on Armed Services*, House of Representatives, 114th Cong., 56 (2015), 1.

50 Amaani Lyle, "Troop Suicide Rates Decline in Second Quarter," Targeted News Service, December 11, 2014, https://search.proquest.com/docview/1635138131?OpenUrlRefId=info:xri/sid:primo&accountid=12702.

51 Lyle.

52 Lyle.

among police officers if suicide prevention programs efforts are being managed at the national level. Further research may discover that it is more effective to track efforts at the local level for both military and law enforcement populations.

B. CULTURAL BARRIERS TO SELF-REFERRAL: THE HIDDEN PROBLEM

Law enforcement and military occupations develop their personnel to be strong and self-reliant. Police officers and military personnel may feel that revealing their need for help will make them look "weak." Additionally, the rigorous mental and physical screening tests that officers undergo prior to employment may be sending a message that such problems can lead to unemployment or underemployment, which could deter reporting. Other concerns about the stigma of seeking professional counseling or psychiatric treatment might prevent them from using available resources.

Rookies start adapting to the police culture early in their careers. Officers are taught early on to be self-reliant and are trained to control the varied and dangerous situations they might face in the course of their duties. Techniques for safely controlling violent offenders, suspect interviews, crime scenes, vehicles during high-speed pursuits, and virtually every aspect within the working environment are emphasized repeatedly. New officers are taught not to view the world the way the rest of society does; they are taught to trust no one, and that no call for service is considered routine—danger is lurking around every corner. This thinking process transforms officers from new recruits who think and act like the citizens they are sworn to protect, into the law enforcement officers who provide that protection. Officers then see themselves as the authorities who respond to other people's problems, not as the *source* of problems. Consequently, they may not recognize that they need help, even when others do.[53]

Typically, new officers are naive; they do not fully understand the tragedy, trauma, and stress they will experience in their new occupation. Once they do, these experiences create deepening emotional scars—ever-widening caverns of mistrust toward the people

[53] Ronald A. Rufo, *Police Suicide: Is Police Culture Killing Our Officers?* (Boca Raton, FL: CRC Press, 2016), 2–3.

they contact, both on and off duty. These experiences only further their need to control every aspect of their personal and professional lives. When they realize they cannot gain complete control, they get frustrated, which often creates problems within their personal lives. John Violanti asserts that the substantial culture change from civilian to police officer during the police academy stays with officers for the rest of their careers—that the police culture instills within officers a feeling of "superhuman emotional strength."[54] The reality is that police officers face the same emotions as the citizens they serve, but police culture imbues them with a personal dichotomy: mental toughness and control against the real emotional injury they experience while performing their duties. It is police culture, not the lack of officer self-awareness that often inhibits officers from seeking treatment through available programs. In time, officers begin to believe they have a superior ability to control their emotions and do not need the support of family and friends.

Cultural barriers are not limited to law enforcement occupations. As mentioned previously, Jacqueline Garrick, the acting director of the Defense Suicide Prevention Office, suggested that underreporting of psychological problems is a problem within the military.[55] This is in large part due to military culture which, like police culture, is a barrier to self-referral. William P. Nash notes that military warriors consider war to be a test of their strength, courage, and ability to do what they were trained to do.[56] For a warrior, Nash explains, demonstrating weakness of any kind is synonymous to admitting cowardice or failure. Though combat stress is a valid, diagnosable condition with treatment options, soldiers perceive it as something they should be able to overcome or endure by themselves; subsequently, they are ashamed to admit they are experiencing stress, and remain silent.[57]

It is important to understand and address the cultural aspects of each environment that may be causing barriers to self-referral. Both military and law enforcement leadership

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[54] Rufo, 3.

[55] Lyle, "Troop Suicide Rates Decline in Second Quarter."

[56] William P. Nash, "The Stressors of War," in *Combat Stress Injury*, ed. Charles R. Figley and William P. Nash, 11–31 (New York: Routledge, 2007).

[57] Nash.

must establish command climates that encourage early intervention by all leadership, while inculcating within their employees the virtues of early self-referral and reporting.

C. ISOLATION PREVENTING EARLY INTERVENTION

Isolation is another police culture–related barrier that inhibits early intervention and self-referral. As new recruits experience harsh environments, they quickly lose their naiveté and begin to see the world as a dangerous and unpredictable place. They build a knowledge base that is essential to survival in this on-duty world, where they are constantly exposed to criminal elements and violence, even from the most unlikely people. This causes internal changes in the way they perceive the world. As their experience grows in the criminal world, so does their suspicion about everyone around them. They become cynical. Eventually, this leads them to develop emotional barriers that isolate them from all those who are outside of the law enforcement world—a world they know and trust. These barrier may further isolate them from agency resources that could help them through their emotional difficulties.[58]

In a three-part series about social isolation among police, *Law Officer* suggests that "social isolation begins early in an officer's career stemming from two different but often interconnected sources."[59] The first source is the officer's unpredictable schedule, which gives the officer little time to maintain relationships with family and friends. Rotating shift assignments, staffing requirements for weekends and holidays, and being pulled to duty on days off further isolates officers from the people and activities they ordinarily engage with. The second source stems from the first one: In time, this isolation is habituated; the officer accepts this as the way things "just are." Events such as birthdays, church services, family dinners, and anniversary celebrations are often missed. Shift parties and organizational functions take priority, isolating the officer further from his or her main support system—family.[60]

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58 "Police Isolation, Part I," *Law Officer* (blog), February 8, 2010, http://lawofficer.com/archive/police-isolation-part-i/.

59 "Police Isolation, Part I."

60 "Police Isolation, Part I."

D. OTHER FACTORS

Immediately following a suicide, those most affected by the loss—such as family members and community leaders—often bring increased attention to suicide prevention.[61] Unfortunately, these windows of increased interest are fleeting. They are more the result of emotional impact than a real desire to address practical, long-term solutions to the problem of suicide. This poor follow-through can, again, possibly be connected to the culture of the institution. Due to the tragic and often personal circumstances surrounding suicide, community leaders and citizens in general are reluctant to address the problem immediately following an incident, thus missing an opportunity to establish programs while the momentum is still going.[62]

Another factor that limits the establishment of aggressive prevention programs is competing demands within the public health sector. Although the suicide rate for the United States as a whole makes the problem clearer from a national perspective (refer to Chapter I, Section A), individual communities typically experience a very low number of suicides each year; some communities may see no suicides for several years. Compared to other world-wide health concerns, suicide is therefore a low-frequency event in most communities.[63] Also, like in military and law enforcement populations, many suicides remain unreported by communities due to the sensitive nature of the death and the stigma of suicide.[64]

Inaccurate reporting, culture barriers to self-reporting, and isolation all reduce the effectiveness of suicide intervention and prevention strategies. This thesis attempts to identify both individual protocols and multifaceted programs that mitigate these barriers, thus increasing their effectiveness in the overall suicide prevention effort.

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[61] Morton M. Silverman and Robert D. Felner, "Suicide Prevention Programs: Issues of Design, Implementation, Feasibility, and Developmental Appropriateness," *Suicide & Life-Threatening Behavior* 25, no. 1 (Spring 1995): 92–104, https://doi.org/10.1111/j.1943-278X.1995.tb00395.x.

[62] Silverman and Felner, 93.

[63] Silverman and Felner, 93.

[64] Silverman and Felner, 93.

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III. SUICIDE INTERVENTION AND PREVENTION CASE STUDIES

Central to this thesis are the questions: Are current law enforcement suicide prevention and intervention strategies effective? If so, what are some of the effective strategies? This chapter examines military and law enforcement suicide prevention strategies that reduced suicides over a measured period of time and addressed the suicide prevention barriers outlined in Chapter II. Both cases studied apply a combination of suicide prevention strategies to smaller, closed populations, eliminating inaccurate suicide data prevalent in large national studies. Furthermore, pre-existing metadata provided by each case study is used as the basis for analysis for determining the effectiveness of each case strategy in reducing suicide.

A. MILITARY CASE STUDY: AIR FORCE SUICIDE PREVENTION PROGRAM (AFSPP)

The Air Force Suicide Prevention Program (AFSPP), conducted by the U.S. Air Force from 1990 to 2002 and comprising five million active-duty personnel, resulted in a 33-percent decline in suicides (13.5 out of 100,000 down to 9.2 out of 100,000) during the period assessed.[65] The focus of the program was to reduce risk factors and the stigma associated with airmen being identified as "mentally unhealthy."[66] It was a multifaceted program that involved training for leaders, training for all airmen, and the availability of information on mental health referral services. During training, airmen were given information about suicide risks and referral procedures. Significantly, the Air Force also provided additional staffing to enhance treatment throughout the entire community. Intervention efforts included on-call response teams to assist in prevention activities during suicide attempts and other critical events. The program also established patient privileges for treatment, surveys to determine potential mental health risks, and a system to monitor

65 Paul G. Shekelle, Steven Bagley, and Brett Munjas, *Strategies for Suicide Prevention in Veterans* (Washington, DC: Department of Veterans Affairs, Health Services Research & Development Service, 2009), 16.

66 Shekelle, Bagley, and Munjas, 16.

and track risk factors.[67] Although psychologists could not isolate the effectiveness of the individual components within the program, there was clear evidence that the program efforts reduced suicides.[68]

The following initiatives are the basis for the AFSPP:

(1) Leadership Commitment

A great deal of emphasis was placed on getting a commitment from the Air Force chain of command to support each AFSPP component—from the Air Force Chief of Staff down to first line supervisors. Commitment at every level of leadership was needed for the program to reach its full potential.[69]

(2) Military Education

Suicide prevention training involved educating personnel about the signs and symptoms of suicidal ideation, the importance of peer intervention, and resources available to assist at-risk airmen.[70]

(3) Leadership Protocols on Mental Health Services

Leadership were expected to know and understand the services that were available to their airman while promoting self-efficacy for airmen who needed or requested mental health services.[71]

(4) Community Services

To create a greater impact for the larger population, a community approach to providing mental health services was established. To track the use of prevention services,

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[67] Shekelle, Bagley, and Munjas, 16.

[68] Shekelle, Bagley, and Munjas, 16.

[69] Kerry L. Knox et al., "The U.S. Air Force Suicide Prevention Program: Implications for Public Health Policy," *American Journal of Public Health* 100, no. 12 (December 2010): 2458, http://dx.doi.org/10.2105/AJPH.2009.159871.

[70] Knox et al., 2458.

[71] Knox et al., 2458.

the Air Force updated its Medical Expense and Performance Reporting System. It was a dual-purpose system: it tracked which preventive services airmen used and also served to promote prevention activities through community awareness.[72]

(5) Community Education and Training

Suicide prevention training was not limited to military personnel. The Air Force included the civilian workforce in its annual suicide prevention training, adopting a holistic, community-based approach to suicide prevention.[73]

(6) Investigative Interview Policy

Airmen who were arrested for a crime or legal violation were required to undergo an investigative interview. This often placed them under severe duress, which put them at increased risk to experience suicidal ideations or to self-harm. The Air Force established a policy that required investigators to release airman to their chain of command following their interviews. This ensured the chain of command as able to directly observe these at-risk airmen for signs of suicidal ideations or any potentiality of self-harm. Airmen who exhibited indicators were escorted as soon as possible to the nearest counseling service or treatment provider.[74]

(7) Trauma Stress Response

The Air Force also established trauma stress response teams (formerly referred to as critical incident stress management teams) across its operating theaters, both within the United States and overseas. The teams were designed to help airmen work through psychological problems resulting from traumatic events such as terrorist attacks or the deaths of fellow service members.[75]

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[72] Knox et al., 2458.

[73] Knox et al., 2458.

[74] Knox et al., 2458.

[75] Knox et al., 2458.

(8) Integrated Delivery System (IDS) and Community Action Integration Board (CAIB)

Both the Integrated Delivery System (IDS) and Community Action Integration Board were major command and base-level functions. Their purpose was to review individual cases and identify family and organizational challenges that affect unit readiness or airmen quality of life. Both initiatives helped agencies achieve a more "synergistic impact in solving community problems and reducing suicide."[76]

(9) Limited Privilege Suicide Prevention Program

This program ensured confidentiality for mental health patients receiving treatment for suicidality by limiting the release of their information to requesting authorities concerning their treatments and medical conditions.[77]

(10) IDS Consultation Assessment Tool

Unit leaders used the IDS Consultation Assessment Tool (formerly called the Behavior Health Survey) to determine the condition of their unit's strengths and potential behavioral health weaknesses. IDS consultants were available to assist commanders as needed once problems were identified.[78]

(11) Suicide Event Surveillance System

The Suicide Event Surveillance System has a central database that captured all Air Force personnel suicides in order to discern potential risk factors. Close monitoring provided exact numbers of suicides over a measured evaluation period to determine if suicide prevention efforts were effective.[79]

[76] Knox et al., 2458.

[77] Knox et al., 2458.

[78] Knox et al., 2458.

[79] Knox et al., 2458.

Program Results

When analyzing the AFSPP data, the project's staff applied detailed scientific analysis, using an intervention regression model and the Statistical Analysis System (SAS) software. Data from 1990 through 1996 were collected for the control group, while treatment group data came from 1997 through 2002. The staff used a longitudinal study approach (1981 to 2007) to determine the Air Force's quarterly suicide rates for a twenty-six-year period. This provided sixteen years of data from before program implementation and eleven years of data following implementation. The measurement used was the number of suicides per 100,000 among the active-duty Air Force population (see Figure 1).[80]

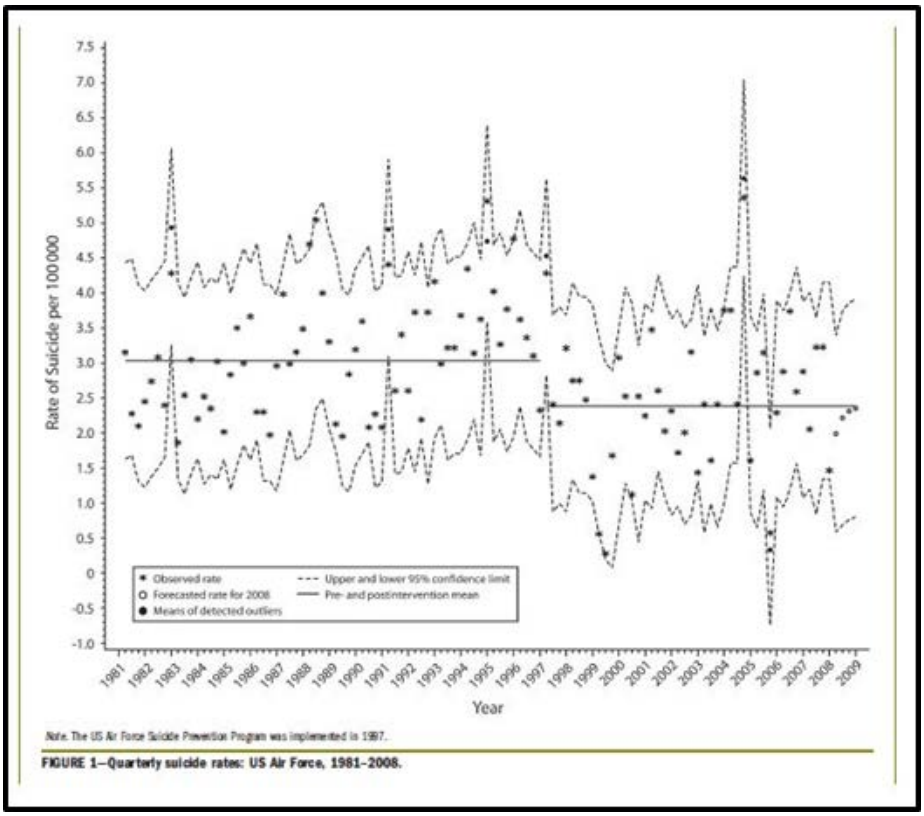

Figure 1. AFSPP Quarterly Suicide Rates, 1981–2008[81]

80 J. John Mann et al., "Suicide Prevention Strategies: A Systematic Review," *JAMA* 294, no. 16 (October 26, 2005): 2064, https://doi.org/10.1001/jama.294.16.2064.

81 Source: Knox et al., "The U.S. Air Force Suicide Prevention Program," 12.

As Figure 1 shows, suicides began to decrease in 1997 and continued to decrease through 2009. The horizontal lines indicate the pre- and post-intervention means, with the asterisks indicating the observed rate. Of particular importance is the increase in suicides in 2004. Although this increase occurred outside of the test period, the AFSPP components were measured for 2004 in an effort to determine its cause. Program evaluators speculated that the increase in suicides was caused by multiple combat deployments, continued conflicts in two different operating theaters, diminished Air Force population numbers, and reduced efforts in program continuity for several years prior to 2004 (though empirical data did not show exactly when program implementation efforts subsided).[82] This initiated an Air Force community–wide effort to reestablish the AFSPP program, after which suicide rates decreased to the typical post-AFSPP implementation levels.[83]

Eleven AFSPP core initiatives were deemed effective; to create a measuring tool, Air Force program managers grouped the eleven initiatives into seven prevention categories:

1. Ongoing professional training,
2. Guidelines for commanders,
3. Development of the IDS and public information boards,
4. Upgrade of community mental health services,
5. Establishing policies,
6. Leadership involvement, and
7. Ongoing community education.[84]

Each prevention category was assigned a score to measure its implementation at the Air Force installation level. Surveys were administered in 2004 and in 2006, which were used to gather data on the level of implementation for each intervention category. These data

[82] These causes were based largely on anecdotal evidence; there was no definitive proof to conclusively attribute these factors to the increased suicides in 2004.

[83] Knox et al., "The U.S. Air Force Suicide Prevention Program," 2460.

[84] Knox et al., 2458–2459.

were then converted to a maximum percentage of intervention implementation across Air Force installations for those years. Data showed that implementation for all domains in 2004 fell well below 90 percent, with the lowest domain measuring 56 percent.[85]

The 2006 data showed increased implementation across all seven AFSPP domains. Most significant were the employment values for ongoing professional training and upgrades of community mental health services, which showed 100 implementation percent for 95 percent of all bases in the study.[86] "For prevention activities in the 5 other prevention domains in 2006, at least half of the bases were found to have high levels of implementation."[87] These domains included leadership involvement, guidelines for commanders, ongoing community education, and the development of IDS and public information boards.[88] Though each component of the AFSPP was not individually evaluated for its effectiveness, together, the eleven preventive initiatives reduced suicides during the test period.

The program's success was due, in large part, to the Air Force's holistic, community approach. For example, the barriers to self-referral created by military culture were largely overcome by leadership involvement across the chain of command. Problems with data accuracy and underreporting were avoided by the program's use of the Suicide Event Surveillance System and a single database to capture data. Ongoing military and community suicide prevention training provided airmen and their families with the knowledge they needed to understand the warning signs and symptoms of depression, PTSD, and other psychological maladies that might lead to suicide. Included in this training were the resources available to assist them, as well as information about where to obtain services within a confidential, supportive environment. Just as important to early identification and treatment was the development of commander guidelines and institutional policies that set the program's goals and path forward. Having the means to

85 Knox et al. 2459.

86 Knox et al., 2459.

87 Knox et al., 2459.

88 Knox et al., 2459.

capture, store, and retrieve program data to codify AFSPP processes was also crucial to evaluate the program's overall effectiveness within the test period and beyond. Finally, the study demonstrated that the program's effectiveness relied heavily on continual command emphasis.

B. LAW ENFORCEMENT CASE STUDY: CANADA'S "TOGETHER FOR LIFE" SUICIDE PREVENTION PROGRAM

Importantly, this case study examines a closed law enforcement population and provides quality metadata to prove the program's ability to reduce suicide over a measured period of time. As with the Air Force study, this case study also addressed the barriers to suicide prevention outlined in Chapter II.

Canada's "Together for Life" program was conducted by the Montreal police department (the Service de police de la Ville de Montréal, or SPVM) from 1998 to 2010 and included all 4,178 members of the SPVM police force.[89] "Prior to this study, the Montreal police suicide rate was 30.5/100,000 versus 26.0/100,000 for other Quebec police forces."[90] After the program had run for twelve years, the department saw a 79-percent decrease in suicides (down to 6.4/100,000). The program involved a publicity campaign, all-hands training on suicide risk factors, and telephone helplines.[91]

The Together for Life study provides detailed information about the surveys, interviews, and meetings that were used to rate each program component's effectiveness.[92] Program psychologists concluded that the involvement of the entire police force—including union representatives—was essential to its success, though they were unable to determine which individual component had the greatest effect. The psychologists also believed that educating both leadership and employees caused a change in thinking, which

89 Brian L. Mishara and Martin Normand, "Effects of a Comprehensive Police Suicide Prevention Program," *Crisis: The Journal of Crisis Intervention and Suicide Prevention* 33, no. 3 (2012): 162–168.

90 Mishara and Normand, 162.

91 Mishara and Normand, 163.

92 Mishara and Normand, 167.

prevented employees from engaging in risky behaviors, which in turn helped reduce suicides within the department.[93]

The following initiatives were established as the basic components for the Together for Life suicide prevention program:

(1) Training for All Units

All officers, regardless of position within the agency, were provided an overview of the causes of suicide. They were taught the signs and symptoms of suicidal ideation, and the importance of looking after each other. Training also reviewed the intervention and prevention resources available to them and the process for obtaining the resources.[94]

(2) Police Resource Line

A police helpline was established; upon calling, helpline callers could choose from four menu options: gay and lesbian concerns, traumatic work events, family/personal problems, and alcohol and other addiction problems. The calls were managed by an answering service, and the calling officer was asked to leave his or her name, contact information, and nature of his or her problem. This information was then referred to a police volunteer trained in suicide prevention who contacted the officer.[95]

(3) Training of Supervisors and Union Representatives

The Together for Life training curriculum consisted of a full day of training for union representatives and supervisors, led by trained psychologists. They were trained to identify early signs of at-risk behavior, and in techniques they could use to help employees while minimizing the stigma associated with psychological maladies in the workplace.[96]

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[93] Mishara and Normand, 167.

[94] Mishara and Normand, 163.

[95] Mishara and Normand, 163.

[96] Mishara and Normand, 163.

(4) Publicity Campaign

As part of the program, Together for Life hosted an ongoing publicity campaign. Articles highlighting the program were placed in local law enforcement publications, and program brochures and large posters were placed throughout the SPVM in each police duty station and precinct.[97]

Program Results

The program's long-term goal was to reduce suicides within the Montreal police force. The administration's immediate goals were to provide officers with the ability to take care of each other, identify when they needed help, improve self-efficacy to overcome psychological challenges, and to create an awareness of the available intervention and prevention resources.[98] Each component of the program was evaluated following the post-intervention period, and all four initiatives saw positive feedback.

The unit training follow-up feedback component comprised 350 meetings involving 2,620 officers—87.4 percent of the officers on the force. In questionnaires, over 95 percent of the officers reported the training was helpful and the format suitable for its intended audience. Over 99 percent said they would recommend the training to fellow officers. The officers also made an important distinction in the surveys: that the people who trained them from the police counseling service were well-respected because they could "speak their language."[99] The study suggests that service providers who understand police culture and tailor their services accordingly are likely to be better received.

Surprisingly, the telephone helpline was used infrequently. A two-year sample taken between 1991 and 2002 indicated the helpline was used approximately 46 times. Interviews showed that most line-level officers on the force knew about the service, with 84 percent of supervisors aware of the call line. Despite its infrequent use, most officers felt comfort knowing that resources were a phone call away. Call takers felt strongly about

97 Mishara and Normand, 163.

98 Mishara and Normand, 163.

99 Mishara and Normand, 165.

the importance of the resource; most were convinced they helped the officers who used the service.[100]

A great deal of emphasis was placed on obtaining feedback from supervisors and union representatives about the usefulness of the training from psychologists. Table 1 shows the pre- and post-training survey results from 1998. The table shows that leadership who received the initial training felt more comfortable intervening when necessary, and that they felt the same way three years after their training.[101] Further, supervisor intervention data collected after program implementation (1997–2008) showed significant ongoing intervention on the part of supervisors. Of the 119 supervisors, "43 percent … responded that they had intervened with an officer in crisis, and over half (51 percent) reported having intervened on several occasions…. Almost all of the interventions (96 percent) were rated as having positive effects."[102] A total of eighty-nine interventions took place within the test period, which included eleven incidents when the officer's weapon was taken away as a precautionary measure. It is important to note that most of the interventions did not require the officer to forfeit his or her weapon. In the eleven cases when an officer's weapon was taken away, the officer was usually placed on a modified duty status or administrative leave until a trained psychologist had administered a fitness for duty evaluation. During this time, officers also cannot perform extra duty jobs, which they may rely on to supplement income. The fear of unwarranted removal of an officer's weapon may therefore serve as a barrier to self-referral.[103]

[100] Mishara and Normand, 165.

[101] Mishara and Normand, 165–166.

[102] Mishara and Normand, 166.

[103] Rufo, *Police Suicide*, xxix.

Table 1. Responses Pre- and Post-training by SPVM Supervisors and Union Representatives in 1998 and 2001[104]

	1998 pre	1998 post
"If you have to intervene with a police officer in difficulty, to what extent are you comfortable with":		
Evaluating his suicidal intentions*		
Not at all	1%	0%
A little comfortable	53%	3%
Comfortable	42%	86%
Very comfortable	4%	11%
Removing his service revolver**		
Not at all	2%	0%
A little comfortable	45%	7%
Comfortable	38%	57%
Very comfortable	15%	36%
Informing his family of your concerns**		
Not at all	6%	0%
A little comfortable	47%	13%
Comfortable	41%	64%
Very comfortable	6%	23%
Working in collaboration**		
Not at all	0%	0%
A little comfortable	18%	2%
Comfortable	58%	53%
Very comfortable	24%	45%

Notes. *Pre-post differences significant 1998 (χ^2) $p < .001$; 2001 pre-post significant (χ^2) $p < .05$. **Pre-post differences significant 1998 and 2001 (χ^2) $p < .001$.

1998: $N = 197$
2001: $N = 72$

According to this case study, most officers who took advantage of the program were having problems with relationships or family. Because they reported these problems to their supervisors, the supervisors could adjust the officers' schedules, and 82 percent of the supervisors referred their officers to the police counseling service. When program administrators asked how they could improve supervisor training, supervisors suggested annual refresher training.[105]

[104] Source: Mishara and Normand, "Effects of a Comprehensive Police Suicide Prevention Program," 165–166.

[105] Mishara and Normand, 166.

The publicity campaign seemed to be the least effective component. When questioned about the effectiveness of the campaign, the majority of officers understood that specific measures for suicide prevention had been established, yet did not know they were subcomponents comprising the Together for Life program.[106]

In reviewing Montreal police's pre- and post-program suicide figures (see Table 2), the drop of ten suicides within the implementation period supports Together for Life's effectiveness. When compared to other police agencies in Canada, Montreal's department achieved a 78.9-percent reduction in suicide while adding over 1,000 additional employees to its workforce. Other Canadian agencies experienced three additional suicides from 1998 to 2008 while losing slightly over 900 employees.[107]

Table 2. Montreal Police Suicide Rates Compared to Quebec Rates before and after Together for Life Implementation[108]

		Montreal police	Police rest of Quebec	Comparison Montreal to rest of Quebec
Before program 1986–1996	Suicides	14	29	
	Population	4178	10131	
	Rate per 100 000	30.46	26.02	$p = 0.63$ (*ns*)
	95% confidence interval	18.04–51.44	18.08–37.45	
After program 1997–2008	Suicides	4	32	
	Population	5189	9197	
	Rate per 100 000	6.42	28.99	**p = .007**
	95% confidence interval	2.31–17.88	20.19–41.64	
Change from 1986–1996 to 1997–2008		–78.9%	+ 11.4%	
95% confidence interval		–93.3% to –33.4%	–33.3% to 86.2%	
Comparison before-after		**p = .008**	$p = .68$ (*ns*)	

Significant differences are in **bold**.

106 Mishara and Normand, 166.

107 Mishara and Normand, 166–167.

108 Mishara and Normand, 166.

The program clearly achieved the desired goal of reducing suicides, but program administrators could not determine which program components were most effective. Evaluators surmised that, when combined, the components created a synergistic effect that each individual component might not have achieved on its own.[109] While the overall program was a success, there were also several weaknesses in the execution and data collection, which are addressed in Chapter V. It is clear, however, that the publicity campaign needed improvement. Few officers could recall the program's title, despite the printed program materials provided to each precinct. Logic suggests that the training for every officer within the force overcame this shortfall, since officers questioned about the publicity campaign could articulate the program's primary components. It is impossible to know if a more aggressive publicity campaign might have made more officers aware of prevention resources, and therefore have prevented more deaths.

A key factor in the program's success was its holistic approach, which allowed every SPVM member to take part in the program and therefore share a common understanding of its components. Another key factor was that leadership at every level was trained, which empowered them to intervene—and they did so on well over 119 occasions. This sent the line-level officers the message that they were important, simultaneously removing any cultural barriers that may have prevented them from seeking help. Because the program incorporated both active and passive intervention components, officers had access to help from fellow officers and leadership while on duty, but also had helplines available after duty hours to assist them as needed. Another element that likely enhanced program success was obtaining "buy-in" from union representatives. With union support of the program, it is likely that officers were more willing to support the program knowing their rights as union-represented employees were closely guarded. Finally, the police counseling service that managed the program and provided much of the counseling to the officers was well-respected throughout the department. They understood the stress, trauma, and problems associated with police work so they were readily resourced without the stigma associated with mental health programs.

[109] Mishara and Normand, 167.

C. CASE SUMMARIES

Both the U.S. Air Force and Montreal police suicide prevention programs effectively reduced suicides over a measured period of time. Similarly, both studies incorporated individual prevention initiatives into a multifaceted program to achieve their overall suicide prevention strategy. Both case studies show that combining individual protocols—with a focus on education and training—influences each member within the organization to take an active part in suicide prevention. Organizational leadership at every level played an important role in maintaining each program's momentum while reducing the cultural barriers that often deter employee self-referral.

1. Successes

Though the Air Force case study had a much larger population than the Montreal case study, four key components in the programs' successes closely paralleled each other: leadership involvement and training, employee involvement and training, a holistic approach, and an established method for evaluating program success.

(1) Leadership Involvement and Training

As mentioned previously, both organizations trained leadership to help identify, and intervene in, their subordinates' problems. Leadership involvement also helped break down cultural barriers and mental health stigmas that prevent employees from seeking help. The importance of continued leadership involvement is further illustrated by the Air Force study, which showed an increase in suicides during a year of reduced leadership involvement in the program.

(2) Employee Involvement and Training

All employees were trained to identify early signs of depression and suicidal ideation, and were familiarized with the intervention resources available. This education added an additional layer of prevention for employees who were hesitant to seek help directly through their chain of command. These employees were more likely to reach out to a peer for assistance, or self-refer themselves for available resources.

(3) Holistic Approach to Suicide Prevention

Program administrators deliberately involved every segment of the organization, such as union representatives, military family members, and the civilian workforce. In both cases, all employees, including immediate supervisors and upper-echelon command staff, played an integral role in each program's execution and success. This approach ensured that every layer within the organization worked as a support system and was active in suicide prevention.

(4) Established Systems to Evaluate Program Success

The Air Force's use of their Suicide Event Surveillance System and establishment of a single database to consolidate data helped them manage the dataset for a large population. The SPVM had a much smaller population, used a single database, and took advantage of interviews and questionnaires to evaluate program effectiveness. Both systems successfully measured the suicide rates over the study periods.

2. Weaknesses

The primary weakness with both programs was their inability to determine which components were the most influential in reducing suicide. Some individual components had more success than others yet were not tested to determine if their absence caused a change in suicide outcome over time. Although the program administrators for the Montreal study could not determine conclusively which component reduced suicides, they surmised that the components' combined effects likely could not have been achieved by any one component alone.[110] The Air Force study did not state emphatically that the synthesis of the program's components reduced suicides; the study does, however, conclude that "suicides can be reduced through a multilayered, overlapping approach that encompasses key prevention domains and tracks implementation of program activities."[111]

[110] Mishara and Normand, 167.

[111] Knox et al., "The U.S. Air Force Suicide Prevention Program," 2457.

IV. SUICIDE PREVENTION: INDIVIDUAL PROTOCOLS

The previous chapter described military and law enforcement programs that successfully used a combination of initiatives to reduce suicide and address the prevention barriers outlined in Chapter II. Not all police agencies, however, have large employee populations or the resources needed to support such programs. Military organizations typically do have these resources, but may need to tailor their programs to meet specialized operational considerations—such as Special Forces units operating autonomously outside of the United States. In this type of situation, a measure of psychological care might be limited due to austere operating conditions.

This chapter provides an overview of initiatives that may be adapted by either law enforcement or military organizations to create customized suicide prevention programs. Pre-existing metadata is used to evaluate the initiatives' ability to effectively reduce suicides and to address prevention barriers. The first initiative is pre-employment psychological screening, which is designed to prevent candidates who have psychological problems from being hired. This protocol is important to this study because its intent is to provide the military and law enforcement with populations that are deemed psychologically fit for service. The chapter then evaluates peer support programs and gatekeeper training programs. Both of these initiatives incorporate the proven leadership and employee training components identified in the case studies from Chapter III. The final initiative examined in this chapter is employee assistance programs (EAPs). EAPs are a baseline counseling service for employees experiencing trouble with personal, family, or work-related matters, and they are widely used throughout industries. This chapter provides an overview of these initiatives and discusses their current applications in law enforcement and the military.

A. PRE-EMPLOYMENT PSYCHOLOGICAL SCREENING

In law enforcement hiring, robust screening processes are commonly used to eliminate candidates who have pre-existing mental health conditions. The importance of these tests cannot be understated. Candidates with pre-existing conditions are predisposed to the negative effects of high-risk, high-stress environments, and may become a danger to

the public they serve, or to themselves. Because pre-existing mental health conditions may be exacerbated by a law enforcement occupation—causing the candidate to suffer depression, suicidal ideations, or in worst case, self-harm—pre-employment screenings serve as a suicide prevention protocol, and help indicate how well candidates will adapt to the stressors of police work.

In the United States, 90 percent of the law enforcement agencies administer a series of psychological tests for candidates, which are typically analyzed by a psychologist and followed by one-on-one interviews or evaluations for each applicant.[112] To ensure candidates are answering test questions candidly, the applicants are given multiple tests; analysts compare the results for signs of deceptive answers. Candidates also often undergo a polygraph (truth verification) exam, during which the analyst may ask about the candidate's responses on the written evaluations. Any sign of deception is considered grounds for a candidate's dismissal from the hiring process.[113] In her article "Pre-employment Psychological Screening for Cops," Ellen Kirschman asserts that about two out of every 100 candidates make it through police testing, background checks, financial checks, interview boards, medical exams, and polygraph tests to arrive at the interview. Of those, only "fifteen to twenty percent of the applicants will successfully pass the psychological exam."[114] If a candidate makes it through this process and is hired, the screening results are generally only valid for a year; different psychological profiles can be expected following more exposure to the work environment. Although this arduous process cannot guarantee that all new hires are free of mental health maladies, it does demonstrate due diligence on the part of law enforcement leadership. According to Badge of Life, officers who attempt or commit suicide serve, on average, about fourteen years before the attempt.[115] This long lead time before officers reach a point of needed intervention

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[112] Timothy Roufa, "Learn about the Psychological Tests and Screening for Police Officers," The Balance Careers, accessed March 2, 2018, https://www.thebalance.com/psychological-exams-and-screening-for-police-officers-974785.

[113] Ellen Kirschman, "Pre-employment Psychological Screening for Cops," *Psychology Today* (blog), September 5, 2017, https://www.psychologytoday.com/blog/cop-doc/201709/pre-employment-psychological-screening-cops.

[114] Kirschman.

[115] Badge of Life, "Study of Police Suicide."

suggests that the screening process does help recruit well-adjusted, highly resilient employees.

A study conducted by the U.S. Army between 2004 and 2009, however, identified needed improvements to the military's psychological pre-employment screenings.[116] The study disclosed 9,650 suicide attempts during the six-year test period and found that soldiers within their first two months of service, who had never deployed to a combat zone, were at a high risk for suicide (see Figure 2). The study also determined that, at the time of a candidate's entry into the service, "the presence of a mental disorder and the number of disorders" substantially increases a soldier's risk of suicide early in his or her enlistment.[117] Unlike law enforcement pre-screening, the military screening process does not include written psychological testing or interviews with a clinical psychologist to evaluate if the applicant has pre-existing mental health maladies. Nor does the military have a process through which to determine if an applicant is withholding information.

[116] Robert J. Ursano et al., "Risk Factors, Methods, and Timing of Suicide Attempts among U.S. Army Soldiers," *JAMA Psychiatry* 73, no. 7 (July 1, 2016): 741–749, https://doi.org/10.1001/jama psychiatry.2016.0600.

[117] Ursano et al., 742.

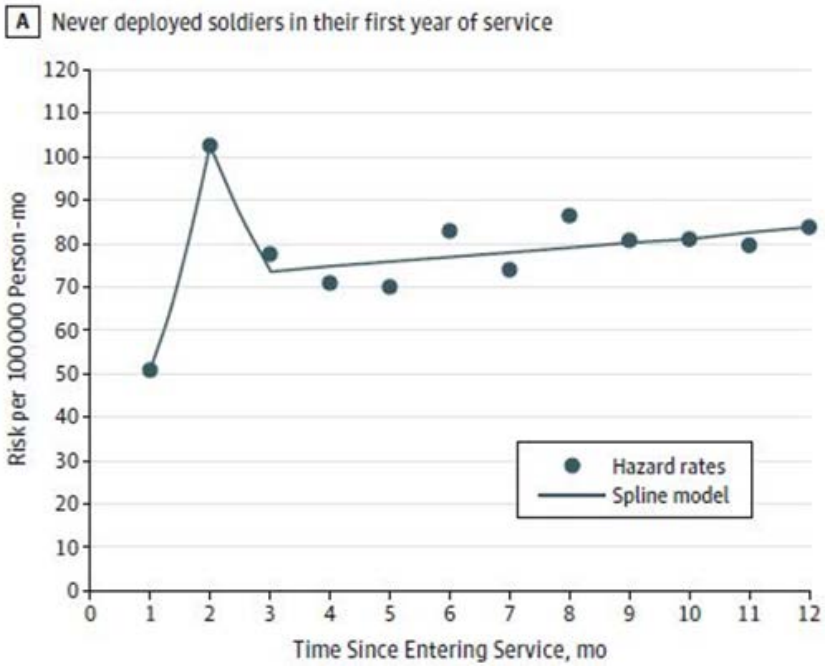

Figure 2. Suicide Attempt Risk by Deployment Status among Regular Army Enlisted Soldiers (Monthly)[118]

According to the DoD's *Report on Preliminary Mental Health Screenings for Individuals Becoming Members of the Armed Forces*, the DoD is looking into methods for obtaining additional information about applicants to better determine their suitability for military service. However, the study mentions several barriers to intensifying current screening practices, such as the lack of validated screening tools, limited research on the utility of clinical assessments, the cost associated with hiring specialized staff to conduct the screenings, and the increased time needed to screen all applicants.[119] In light of this study, the DoD asserts there is a need to "identify effective means to facilitate both prevention and early intervention for mental health conditions during basic military training and throughout service members' careers."[120]

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[118] Source: Robert J. Ursano et al., "Risk Factors, Methods, and Timing of Suicide Attempts Among U.S. Army Soldiers," JAMA Psychiatry 73, no. 7 (July 1, 2016): 741–49, https://doi.org/10.1001/jamapsychiatry.2016.0600.

[119] Department of Defense, *Report on Section 593 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114-92): Report on Preliminary Mental Health Screenings for Individuals Becoming Members of the Armed Forces* (Washington, DC: Department of Defense, 2017), 16.

[120] DoD, 16.

B. PEER SUPPORT PROGRAMS

A peer support program is a suicide intervention and prevention strategy that designates trained volunteer employees to assist their coworkers with problems relating to their occupation or personal lives.[121] In the mid-1960s, Martin Reisner established the first comprehensive law enforcement peer support program in the Los Angeles Police Department, which included both sworn officers and nonsworn employees as peer counselors.[122] Since then, personnel specifically trained to identify early signs of suicidality have been recognized as critical components in holistic suicide prevention programs; agencies across the country incorporate some variation of peer support in their programs.[123]

In law enforcement, peer support officers are police officers who volunteer to provide early intervention for fellow officers exhibiting signs of psychological trouble or at-risk behavior. Peer support officers provide confidential peer counseling and help their coworkers obtain professional counseling services when needed. They help mitigate cultural barriers to suicide prevention by eliminating the fear many officers have of being identified as someone not competent or safe due to the stigma associated with mental health counseling. Programs are typically structured so that peer officers are available throughout the organization and assigned to all shifts. Their distribution throughout the agency makes them available to fellow officers who are generally isolated from professional help during normal business hours due to shift work or outlying assignments. This, in part, addresses the isolation barriers identified in Chapter II.

The officers identified for peer counseling positions are well respected and trusted within the organization. Trust is important, as the volunteer peer counselors will need to keep their coworkers' information confidential. The officers are not clinical psychologists and do not diagnose psychological problems or provide clinical advice. They are, however,

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121 Dell Hackett, "Peer Support in Law Enforcement: A Helping Hand," In Harm's Way, accessed June 15, 2018, http://policesuicide.spcollege.edu/assets/hackettpeersupportle.pdf.

122 Robin Klein, "Police Peer Counseling: Officers Helping Officers," *FBI Law Enforcement Bulletin* 58, no. 10 (October 1989): 2, https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=120501.

123 "IACP Releases New Resource."

trained to identify early signs of stress, depression, and abnormal behavior that could lead to suicidal ideation; they listen to their coworkers' concerns, suggest professional help if needed, and direct their coworkers to professional services.[124]

To better understand why peer-to-peer counseling is effective in law enforcement, it is important to understand the "cop" mentality toward seeking help for personal problems—a cultural barrier identified in this thesis. In an *FBI Law Enforcement Bulletin* article titled "Police Peer Counseling: Officers Helping Officers," Robin Klein asserts that peer counselors are more readily accepted than outside therapists since the peer officer has experienced many of the same challenges and dangers as the officer in need. These shared experiences provide the peer counselor with immediate credibility. In the view of the officer in need, fellow officers are more apt to understand their problems and therefore more apt to empathize with their needs.[125] As retired police Lieutenant Dell Hackett points out, peer support in police agencies is not a new concept; officers often place their confidence with fellow officers, who they trust and respect, creating informal peer support networks.[126] Many of these trusted officers are the agency's natural, emergent leaders, who make themselves available to help fellow officers in their times of need. Understanding the dynamics of these naturally occurring peer relationships and leveraging these relationships to underpin a more formalized peer intervention process maximizes personnel resources and acts as a force multiplier in the suicide prevention effort.

Hackett's article mentions another advantage of peer support programs: avoiding the high cost of potentially losing an experienced officer due to job-related psychological maladies or family problems. Although the financial figures in the article are from 1996, and therefore outdated, they prove that early intervention is less costly than losing an experienced officer; the cost for early intervention care was approximately $8,600 dollars,

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[124] International Association of Chiefs of Police, *IACP National Symposium on Law Enforcement Officer Suicide and Mental Health: Breaking the Silence on Law Enforcement Suicides* (Washington, DC: Office of Community Oriented Policing Services, 2014), 12.

[125] Klein, "Police Peer Counseling," 3.

[126] Hackett, "Peer Support in Law Enforcement."

while the cost of replacing a five-year veteran was approximately $100,000.[127] Computed for today's dollar value with an adjusted 2.6-percent rate of inflation, the cost to replace an officer is approximately $160,610, versus $13,812 for early intervention and treatment. While these savings are significant, Hackett emphasizes that they are secondary to providing the best possible resources to officers in need. Hackett's article provides a strong counter-argument for those who believe the training and implementation for effective suicide prevention programs is too costly. Klein closes his article by asserting that, although studies about the efficacy of police peer support programs are limited, the sooner officers are provided the care they need, the sooner officers benefit, the sooner the agency benefits, and the sooner the citizens they are sworn to protect benefit.[128]

On November 6, 2016, the DOD announced a new peer support service called "Be There," a telephone-based outreach center for active-duty, reserve, and National Guard units. The service is manned by military veterans and their families, and appears to be well advertised on the Defense Suicide Prevention Office website, though there is no information about the program's success in reducing suicides within the military.[129] Examining the military's suicide rates from 2016 against data for 2017 indicates that—despite this new program—the aggregate suicide rate for 2017 is higher than the 2016 rate (see Table 3).[130]

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127 Hackett.

128 Klein, "Police Peer Counseling," 4.

129 "New Peer-Support Service Launches," DoD, November 22, 2016, https://www.defense.gov/News/Article/Article/1011425/new-peer-support-service-launches/.

130 "Quarterly Reports," Defense Suicide Prevention Office, accessed March 13, 2018, http://www.dspo.mil/Prevention/Data-Surveillance/Quarterly-Reports/.

Table 3. Military Suicide Rates, 2016 and 2017[131]

DoD Service and Component	CY2016					CY2017				
	Q1	Q2	Q3	Q4	Total 2016	Q1	Q2	Q3	Q4	Total 2017
Active Component	**62**	**56**	**83**	**79**	**280**	**74**	**57**	**71**	**83**	**285**
Air Force	10	15	14	22	**61**	19	12	14	17	**62**
Army	31	20	42	37	**130**	32	23	27	34	**116**
Marine Corps	12	11	8	6	**37**	7	9	15	11	**42**
Navy	9	10	19	14	**52**	16	13	15	21	**65**
Reserve Component	**56**	**51**	**45**	**50**	**202**	**53**	**66**	**65**	**35**	**219**
Reserve	**18**	**24**	**18**	**20**	**80**	**21**	**29**	**27**	**16**	**93**
Air Force Reserve	5	2	1	2	**10**	2	4	5	0	**11**
Army Reserve	6	13	11	11	**41**	12	20	17	14	**63**
Marine Corps Reserve	4	6	5	4	**19**	5	3	2	0	**10**
Navy Reserve	3	3	1	3	**10**	2	2	3	2	**9**
National Guard	**38**	**27**	**27**	**30**	**122**	**32**	**37**	**38**	**19**	**126**
Air National Guard	5	5	1	3	**14**	2	4	3	3	**12**
Army National Guard	33	22	26	27	**108**	30	33	35	16	**114**

Note: All figures above may be subject to change in future publications as updated information becomes available. Suicide counts are current as of 31 December 2017.

Highlighted for comparison
Indicates a change from the previous QSR based on updated information.

An article in *Military Magazine* titled "Soldier Peer Mentoring Care and Support: Bringing Psychological Awareness to the Front" describes a peer support program established by the British Royal Marines called the Trauma Risk Management (TRiM) program. The program's focus is establishing a peer mentoring component within the Royal Marine forces that identifies service members who might benefit from clinical incident stress debriefing.[132] The article mentions the utility of the program for personal and family-related problems, although the program's primary purpose is the early identification of war-related psychological trauma to prevent its effects from developing into more serious conditions. TRiM also employs peers counselors, and the article notes that service members are more willing to share their problems with their peers, which—as in police peer support programs—eliminates the stigma associated with seeking mental health help through the chain of command.[133] Using TRiM as a model, Richard Keller et

131 Source: Defense Suicide Prevention Office, 4.

132 Richard T. Keller et al., "Soldier Peer Mentoring Care and Support: Bringing Psychological Awareness to the Front," *Military Medicine* 170, no. 5 (2005): 356.

133 Keller et al., 356.

al. developed a similar program for the U.S. military called Soldier Peer Mentoring Care, which, to date, has not been adopted by the DoD. Like the law enforcement and British models, Keller et al.'s program has trained peer support soldiers work in concert with formal mental health practitioners as the initial contact point for soldiers in need.[134]

Peer support programs enhance employee self-referral through the use of compassionate, empathetic peers who break down cultural barriers associated with direct command referrals. This protocol enhances suicide prevention programs by populating the work force with employees who are trained, and willing, to help their coworkers. Trained peer counselors are placed where they are needed within the organization, which reduces the possibility of employees being isolated by their work schedules or remote locations.

C. GATEKEEPER TRAINING PROGRAMS

The concept of assigning specially trained people as gatekeepers to fill a suicide prevention role is not new. According to the U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, a gatekeeper is defined as any person who has a great deal of contact with members of a specific community on a continuous basis and is trained to "identify persons at risk of suicide and refer them to treatment or supporting services as appropriate"[135]

Within law enforcement, the training that immediate and midlevel leadership receives in suicide prevention is consistent with the Surgeon General's description of gatekeepers, though they are generally not formally titled as such. A report published by the International Association of Chiefs of Police (IACP), titled *Breaking the Silence on Law Enforcement Suicides*, recommended continuous mental wellness training for law enforcement officers, with supervisors taking a leading role in training their subordinates.[136] A portion of leadership's training, according to the report, should focus

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[134] Keller et al., 356.

[135] Crystal Burnette, Rajeev Ramchand, and Lynsay Ayer, "Gatekeeper Training for Suicide Prevention," *RAND Health Quarterly* 5, no. 1 (July 15, 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158249/.2.

[136] IACP, *Breaking the Silence on Law Enforcement Suicides*, 1.

on identifying job-related experiences that lead to stress, PTSD, or other mental health maladies. This knowledge will empower supervisors and leaders to teach their subordinates how to cope with problems and how to take advantage of available resources. The IACP also recommends that family members receive similar training, as they may readily identify changes in personality, behavior, or early signs of trouble. Accordingly, a case study conducted by the Montreal police department determine that leadership throughout the department benefitted from this type of intervention training.[137] The study showed that leadership felt more comfortable approaching their subordinates in a collaborative manner to help them arrive at solutions to their problems. Follow-up interviews revealed that the supervisors felt the same way three years after their initial training.[138]

In the military realm, Army Regulation (AR) 600-63 states that "Commanders will coordinate training events for all noncommissioned officers (NCOs), officers, and Army Civilian supervisors on recognizing symptoms of BH [behavioral health] disorders and potential triggers or causes of suicide and other harmful, dysfunctional behavior."[139] Importantly, this statement specifies that all leadership is trained to perform the functions of a gatekeeper, though it does not identify them formally as gatekeepers. Table 4 identifies the official positions the Army designates as primary and secondary gatekeepers. Gatekeeper training requirements are similar to Army leadership requirements; they include a segment on identifying behavioral patterns that place soldiers at risk for suicide.

137 Brian L. Mishara and Martin Normand, "Effects of a Comprehensive Police Suicide Prevention Program," *Crisis: The Journal of Crisis Intervention and Suicide Prevention* 33, no. 3 (2012): 162–168.

138 Mishara and Normand.

139 Department of the Army, *Army Health Promotion*, AR 600-63 (Washington, DC: Department of the Army, 2015), 25, https://www.army.mil/e2/downloads/rv7/r2/policydocs/r600_63.pdf.

Table 4. Army-Designated Gatekeepers[140]

Primary Gatekeepers	Secondary Gatekeepers
Chaplains & Chaplain Assistants	Military Police
ASAP Counselors	Trial Defense and Legal Assistance Attorneys
Family Advocacy Program Workers	Inspectors General
Army Emergency Relief Counselors	DOD School Counselors
Emergency Room Medical Technicians	Red Cross Workers
Medical/Dental Health Professionals	

Air Force Instruction (AFI) 90-505, *Suicide Prevention Program*, does not use the term "gatekeeper," but states that "leaders will understand what policies and practices promote or discourage help-seeking, and develop skills to detect at-risk individuals and intervene early with Airmen under stress."[141] The Air Force regulation further outlines various suicide prevention training components that are mandatory for leaders, as well as the associated time requirements for program completion. AFI 90-505 was developed largely in response to the successful Air Force suicide prevention case study covered in this thesis, which emphasized robust leadership involvement, training, and enforcement of suicide prevention initiatives.[142] During the study, Air Force leadership essentially acted as Surgeon General–defined gatekeepers; although this formal naming convention was not used, the gatekeeper protocols were effective.

OPNAVINST 1720.4A outlines the Department of the Navy's suicide prevention program. The Navy directs commanding officers to ensure suicide prevention training takes place annually. The instruction does not designate enlisted personnel as gatekeepers, but it does state that all members of the Navy are responsible for reporting their fellow service members' suicidal threats or behaviors.[143] Additionally, on the Navy's Personnel Command website, the suicide prevention portal contains a link to a gatekeeper training

140 Source: Department of the Army, 19.

141 Secretary of the Air Force, *Suicide Prevention Program*, AFI 90-505 (Washington, DC: Department of the Air Force, 2016), 18, http://static.e-publishing.af.mil/production/1/afmc/publication/afi90-505_afmcsup/afi90-505_afmcsup.pdf.

142 Knox et al., "U.S. Air Force Suicide Prevention Program."

143 Chief of Naval Operations, *Suicide Prevention Program*, OPNAVINST 1720.4A (Washington, DC; Department of the Navy, 2009), http://www.med.navy.mil/sites/nmcphc/Documents/health-promotion-wellness/psychological-emotional-wellbeing/opnav-inst-1720-4a-navy-suicide-prevention-policy.pdf.

site. On the site, the Navy names "Corpsmen, families and ombudsmen, Sailors working as staff in Transitional Personnel Units (TPUs) or other barracks, instructors and staff in school houses, and attorneys and other members of the legal staff who interact most frequently with Sailors at high risk for suicide" as Navy gatekeepers.[144] Navy gatekeepers are trained in suicide prevention but also undergo additional training on how to assess behaviors of at-risk personnel.

The Marine Corps' suicide prevention program, found in Marine Corps Order (MCO) 1702.2, is identical to the Navy's program, placing the responsibility of Marine suicide prevention on every service member within the Corp.[145] The Marine Corp offers suicide prevention services through the Marine Corp Community Services website, but makes no reference to gatekeeper training.[146]

The term "gatekeeper" is more than a mere naming convention to identify a specialist or leader within an organization who is trained in suicide prevention. Gatekeeper protocols permeate leadership at all levels, attempting to break down cultural barriers to employee self-referral. Leaders accomplish this by demonstrating their support for suicide prevention initiatives and taking an active role in addressing suicide, which is a continuously pervasive problem in both the military and law enforcement. Both case studies presented in this thesis provided evidence that leadership training and involvement is crucial to the overall success of a suicide prevention program.

D. EMPLOYEE ASSISTANCE PROGRAMS

Employee assistance programs (EAPs) are "job-based programs operating within a work organization for the purpose of identifying 'troubled employees,' motivating them to resolve their troubles, while providing access to counseling or treatment for those

144 "Gatekeeper Training," Navy Personnel Command, last modified December 12, 2017, http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/suicide_prevention/command/Pages/GatekeeperTraining.aspx.

145 Commandant of the Marine Corps, *Marine Corps Suicide Prevention Program (MCSPP)*, MCO 1720.2 (Washington, DC: Department of the Navy, 2012), http://www.marines.mil/Portals/59/Publications/MCO%201720.2.pdf.

146 Marine Corps Community Services, accessed March 23, 2018, http://usmc-mccs.org/.

employees who need these services."[147] EAPs usually offer assessments, referrals, and counseling services that cover a wide range of employee issues, such as substance abuse, mental health disorders, family problems, anger control, loss, and grief.[148] EAPs are based on early industrial alcoholism programs of the 1940s; the National Institute on Alcoholism and Alcohol Abuse realized that other problems—such as drug use and family or marital problems—as well as mental health problems all affect worker performance.[149] In 1974, the institute expanded its programs, and formally named them Employee Assistance Programs.[150] Since then, EAPs have been available to employees through private contractors, as well as through federal, state, and county human resource services.[151] In 2006, "71 percent of all employers in the United States offered some form of EAP," pointing to their widespread utility throughout industry.[152] Conceptually, EAPs operate under the premise that early detection and treatment will reduce absenteeism and other consequences associated with poor mental health.[153] Although the focus of this thesis is suicide intervention and prevention for the military and law enforcement, EAPs are designed to provide early detection and treatment for any organization.

There are several surveys used for evaluating the effectiveness of EAPs, including needs assessments, process evaluations, impact evaluations, and outcome evaluations.[154] Needs assessment surveys gauge the number of people within an organization that require services, and the types of services they need, while process evaluations determine if the

147 Tyler D. Hartwell et al., "Aiding Troubled Employees: The Prevalence, Cost, and Characteristics of Employee Assistance Programs in the United States," *American Journal of Public Health* 86, no. 6 (June 1996): 804.

148 Mitchell L. Cary and Dorian H. Edrick, *Police Psychology and its Growing Impact on Modern Law Enforcement* (Hershey, PA: IGI Global, 2016).

149 Hartwell et al., "Aiding Troubled Employees."

150 Hartwell et al.

151 Hartwell et al.

152 Cary and Edrick, *Police Psychology*, 201–206.

153 James T. Decker, Richard Starrett, and John Redhorse, "Evaluating the Cost-Effectiveness of Employee Assistance Programs," *Social Work* 31, no. 5 (October 1986): 391–393.

154 Lynne Bennett, "Employee Assistance Programs: Philosophy, Theory and Practice," (discussion paper 5, Royal Canadian Mounted Police External Review Committee, 2015), 18, http://www.erc-cee.gc.ca/cnt/rsrcs/pblctns/dscssn/pdf/dp5-eng.pdf.

program is working as planned and identifies weak links. An impact evaluation measures changes to the organization as a result of the program's implementation. Outcome evaluations, however, are most significant to this research: they attempt to determine employee satisfaction and positive life changes, and if employees' problems have been mitigated or resolved as a result of the program.[155]

A significant problem associated with evaluating the effectiveness of EAPs is that few program administrators are properly trained to conduct assessments. Complicating assessments further is the vast differences between the various EAP models in use. There are no standardized measuring tools, and the employee populations that use the programs are typically small, limiting data. Finally, because maintaining employee confidentiality is an important aspect of the program, most EAPs do not release employee data.[156] Despite the difficulties in evaluating their effectiveness, EAPs grew tremendously between 1993 and 2002, showing a 194-percent increase in enrollment with "71 percent of employers in the United states using some form of EAP."[157]

EAPs have been effective at reducing mental health problems while enhancing employees' quality of life, especially if the program is designed to address workplace challenges specific to the organizational culture.[158] A study mentioned in *Police Psychology and its Growing Impact on Modern Law Enforcement* showed that 57 percent of employees that used an EAP increased their work productivity; another study showed a 50-percent increase in employees' quantity of work and a 50-percent reduction in employee absenteeism.[159] The report also showed that 64 percent of workers who used an EAP for work-related issues, and 46 percent who used an EAP for personal issues, saw an improvement in their conditions. Employees who are satisfied with their professional and personal lives tend to develop fewer psychological issues that may lead to more serious conditions, or suicidal ideation.

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[155] Bennett, 18.

[156] Bennett.

[157] Cary and Edrick, *Police Psychology*, 201.

[158] Cary and Edrick, 201.

[159] Cary and Edrick, 204.

During the 2013 National Symposium on Law Enforcement Officer Suicide and Mental Health, the IACP recommended that all law enforcement agencies evaluate the effectiveness of their EAPs to determine if they are meeting officers' needs.[160] This suggests that most, or at least many, police agencies within the United States have EAPs. The Commission on Accreditation for Law Enforcement Agencies (CALEA) requires law enforcement agencies seeking accreditation to provide their employees with an EAP, suggesting the programs' further prevalence in this community; CALEA's 2016 annual report lists 1,014 accredited agencies.[161]

The military takes a different EAP approach in order to cater to its vast, widespread population. The DoD offers EAP services to each of the four branches of service through a program called Military OneSource. This program makes a clear distinction between medical and non-medical treatments, is completely confidential, and is free of charge to all active duty, Reserve, National Guard, and their family members.[162] Personnel who need more extensive clinical care are referred to military clinicians or Department of Veterans Affairs (VA) treatment facilities. In general, Military OneSource counselors address grief, loss, combat deployments, marital problems, parenting, and reintegration back into family or civilian life. Military personnel experiencing PTSD, suicidality, depression, and drug and alcohol addiction are cared for by active-duty doctors or referred to nonmilitary specialists for care.[163]

In summary, some studies have found that EAPs effectively reduce absenteeism, increase employee productivity, and generally improve employee quality of life.[164] The widespread growth of EAPs since their establishment in the 1940s adds credibility to their utility. Law enforcement and military cultural barriers withstanding, EAPs appear to be the

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160 IACP, *Breaking the Silence on Law Enforcement Suicides*, 6.

161 "Accreditation for Small Law Enforcement Agencies," CALEA, accessed February 20, 2018, http://www.calea.org/calea-up date-magazine/issue-101/accreditation-small-law-enforcement-agencies; "2016 Annual Report," CALEA, April 26, 2017, http://www.calea.org/content/2016-annual-report.

162 "About Us," Military OneSource, accessed February 17, 2018, http://www.militaryonesource.mil/web/mos/about-us.

163 Military OneSource.

164 Cary and Edrick, *Police Psychology*, 204.

basic standard of care for industries nationwide, suggesting they might provide a good foundation to build upon when creating a tiered suicide prevention program.

E. INDIVIDUAL PROTOCOLS SUMMARY

For this thesis, a suicide prevention protocol's effectiveness is measured by its ability to reduce the number of suicides within an organization over a measured period of time. Although few studies have been conducted to determine the efficacy of individual suicide prevention protocols, the protocols do provide organizations with tools that can help them mitigate potential employee mental health disorders.

EAPs appear to be the most prevalent suicide prevention service offered to employees. In order for EAPs to meet an organization's specific needs, however, their services must be evaluated and the EAP staffs must be qualified to address problems specific to the unique work environment. Clinicians who have worked in similar environments or who have faced similar challenges as their patients are more likely to be readily accepted by employees, and the EAPs are therefore more likely to be used, and the employees are more likely to be receptive to their care.

The value of peer counseling programs lies in their ability to identify problems early, which allows timely, preventative referral to professional services. The cornerstone of effective peer counseling programs—as with the best EAPs—is that peer counselors identify with their coworkers' problems, which earns them immediate credibility and acceptance as a resource.

Gatekeeper programs also aim for early intervention, but from leadership rather than peers. Supervisors, by virtue of their jobs, are gatekeepers who have the authority to accommodate employee work schedules, which may be of value to employees experiencing mental health issues. Their direct involvement in caring for their subordinates helps break down cultural barriers and mitigates the stigma associated with employees seeking treatment for psychological problems.

V. CONCLUSIONS AND RECOMMENDATIONS

A. CONCLUSIONS

The goal of this thesis was to provide law enforcement leadership with effective suicide prevention protocols that meet their organizations' needs. Military suicide prevention methods were included in this research since both occupations are intrinsically connected by their occupational challenges.

The case studies reviewed in Chapter III strongly suggest that combining multiple prevention protocols creates a synergistic effect that results in lower suicide rates for both the military and law enforcement. The Air Force Suicide Prevention Program and the Montreal police department's Together for Life program reduced suicide within their organizations significantly by adopting such an approach.

Additionally, organizations that adapt a holistic approach to suicide prevention are more likely to prevent suicides. Including leadership, first line supervisors, employees, family members, and union representatives in early intervention efforts can prevent at-risk employees from being isolated from the care they need. Leadership can play a pivotal role in communicating the importance of suicide prevention, which helps dissolve the stigma and cultural barriers associated with seeking psychological care.

Another key finding was that the use of national suicide data to evaluate local suicide trends is largely ineffective. National data provides an approximate number of annual suicide deaths for law enforcement, but provides no analysis on the factors that caused suicides to increase or decrease in a given year. Both national and organizational suicide data are affected by the misclassification of suicide deaths as "accidental," or "cause of death unknown," which contributes to the underreporting of suicide deaths for both the military and law enforcement.

Finally, pre-employment psychological screening protocols are most effective as a proactive suicide prevention tools if they contain clinical psychological assessments designed specifically for the occupation they are assessing.

B. RECOMMENDATIONS

In April 2018, *USA Today* published an article titled "'Silence can be deadly': 46 officers were fatally shot last year. More than triple that—140—committed suicide."[165] This article illustrates the insidious manner in which psychological maladies are killing law enforcement officers. The article strongly suggests that "Departments must break the silence on law enforcement suicides by building up effective and continuing suicide-prevention programs."[166]

The *USA Today* article corroborates the core findings of this thesis: organizations must view suicide prevention strategies from a holistic perspective and not from a narrow, "one size fits all" perspective. Agencies should tailor suicide prevention programs to their specific needs while monitoring their programs' effectiveness and adopting new strategies when necessary. The recommendations in this section support these conclusions.

The suicide prevention triangle shown in Figure 3 encompasses the primary prevention protocols analyzed in this thesis. It is not an all-inclusive model; its intent is to provide a general program design that may be tailored to the needs of both law enforcement and military organizations. The model's hierarchical pyramid design suggests a logical order in which to establish each element of the program; however, the only process that must necessarily remain in this order is the pre-employment screening evaluation, which must be the first step. The model also suggests that a well-designed, multifaceted program—as demonstrated by the case studies—will reduce the number of people in an organization who are at risk for suicide. To the right of each tier, starting at the base of the pyramid, are the terms *mitigate*, *educate*, *collaborate*, and *cultivate*. These descriptors connect the specific prevention protocols to the results expected from their proper application.

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165 Christal Hayes, "'Silence Can Be Deadly': 46 Officers Were Fatally Shot Last Year. More Than Triple That—140—Committed Suicide," *USA Today*, April 11, 2018, https://www.usatoday.com/story/news/2018/04/11/officers-firefighters-suicides-study/503735002/.

166 Hayes.

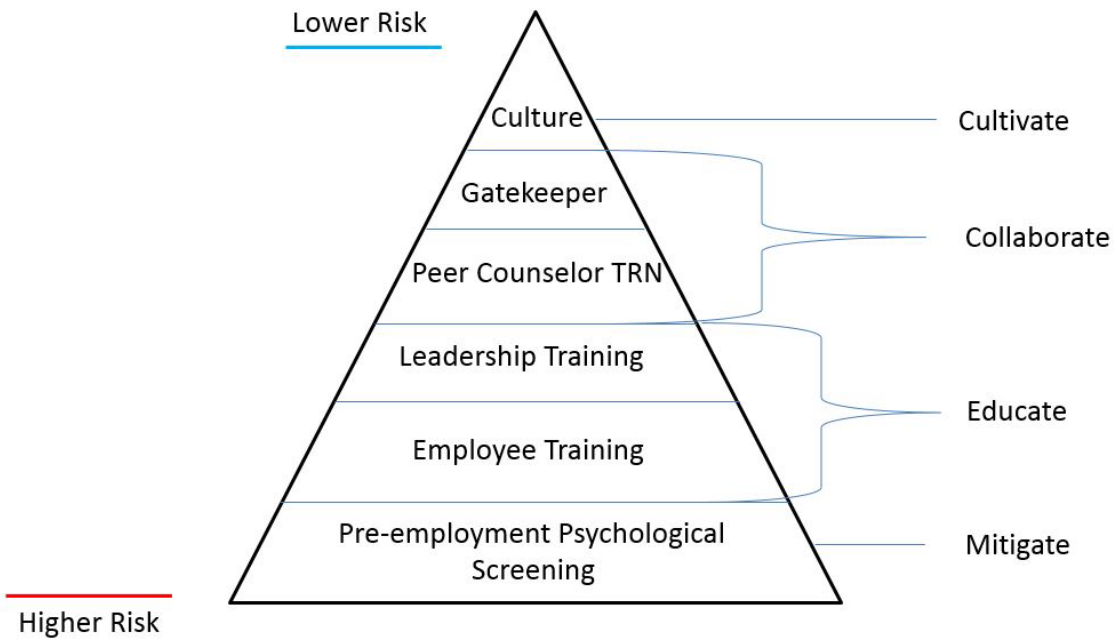

Figure 3. Suicide Prevention Triangle

1. Pre-employment Psychological Screening

Pre-screening through psychological testing and clinical evaluations ***mitigates*** employees with pre-existing psychological conditions from entering military or law enforcement service. Approximately 90 percent of law enforcement agencies within the United States conduct pre-employment screening during their hiring processes.[167] Although the military does conduct pre-employment screening, the screening does not include a clinical testing and interview components necessary for effective screening.

Recommendations

- Law enforcement agencies not conducting pre-employment psychological screening should incorporate pre-employment screening as part of their hiring processes, to include psychological testing and interviews with a trained clinical psychologist.

[167] Roufa, "Psychological Tests and Screening."

- The military should establish pre-employment screening processes similar to law enforcement processes, which incorporate clinical psychological tools.

- Ongoing psychological interviews should be conducted by both law enforcement and the military to monitor employees for psychological problems throughout their careers.

2. Employee and Leadership Suicide Prevention Training

The goal of suicide prevention training is to ***educate*** employees about methods for managing the stress and trauma of their jobs, as well as the immediate and long-term effects of that trauma and stress. Prevention training should provide employees with contact information for resources available to them within the organization as well as outside professional services (EAPs, staff psychologists, chaplains, etc.)

Recommendations

- All employees should be trained on suicide prevention and resiliency techniques, and should be informed about the counseling resources available to them.

- Leadership should be an integral part of the training—both as trainers and as students. Leadership involvement sends the message to employees that suicide prevention is an important concern at the organization's highest levels. This messaging helps reduce the stigma associated with psychological problems that often prevents employees from seeking professional care.

- Organizations should develop policies and standard operating procedures (SOPs) that address every aspect of the organization's suicide prevention program. SOPs should include a section that addresses the barriers that prevent employees from seeking help for their psychological maladies.

3. Peer Support Training and Gatekeeper Training

The purpose of gatekeeper and peer support training is to establish both formal and informal leadership within the organization who are trained to identify the signs and symptoms of suicidal ideation. First line supervisors and select peers are trained to intervene with at-risk coworkers before their conditions worsen. These protocols are meant to be ***collaborative***; peers, first line supervisors, and at-risk employees work together toward the common goal of suicide prevention. By establishing peer and gatekeeper initiatives, leadership sends a strong message throughout the organization that suicide prevention and the health of the organization is a top priority.

Recommendations

- Organizations should provide training to first line supervisors (gatekeepers) to help them recognize the signs and symptoms of suicide. Training should include techniques for approaching at-risk employees in a caring and professional manner so as not to undermine their dignity or self-respect.

- Peer counselor intervention training is similar to gatekeeper training in that it equips peer counselors with the strategies needed to maintain their peers' dignity while guiding them to professional counseling services. Peer counselors do not perform clinical counseling. Their counseling approach is based on their shared understanding of the stress and trauma their coworkers are experiencing, and their ability to connect with them on a personal level. Peer counselors should be volunteers who are well respected throughout the organization.

4. Organizational Culture

Organizations should ***cultivate*** environments that support suicide prevention programs.

Recommendations

- Leadership at every level should cultivate an atmosphere that eliminates the stigma associated with psychological counseling. Policies and SOPs should clearly outline referral processes.

- Leadership should apprise union representatives of all suicide prevention policies and SOPs. Union representatives should also take part in suicide prevention training.

- Employees' families should be made aware of suicide prevention polices and protocols, and be offered training that helps them identify the signs and symptoms of suicide. This is important since military and law enforcement families are most familiar with the normal behavior patterns of employed family members and are more likely to notice any significant changes in their behavior.

5. Suicide Data Collection

Accurate suicide data is needed to determine the prevalence of suicide within an organization. Organizations also need this data in order to evaluate the effectiveness of their suicide prevention programs, to determine the scope of the suicide problem, to identify factors that may have contributed to an employee's death, and to address any gaps in the current prevention program.

Recommendation: Law enforcement agencies and the military should establish systems to collect and maintain accurate suicide data that are compliant with county, state, and federal laws.

6. Underreporting of Suicide Deaths

In an article titled "Suicide Surveillance in the U.S. Military: Reporting and Classification Biases in Rate Calculations," Joel Carr et al. assert that the classification of suicides as undetermined or accidental deaths contributes to suicide deaths being underreported by the military.[168] Consistent with Carr et al.'s findings is Badge of Life's assertion that suicide deaths are also underreported through misclassification by law enforcement.[169]

Recommendation: The DoD and law enforcement agencies should conduct postmortem analysis on all deaths classified as "undetermined manner" or "accidental death" to ensure they are not deaths caused by suicide.

While these recommendations are based on the limited research conducted for this thesis, they do provide a starting point to resolve a significant issue that faces this country's security institutions. The recommendations, combined with the research presented here, seek to fill a gap and initiate new work in this field.

[168] Carr et al., "Suicide Surveillance in the U.S. Military."

[169] Badge of Life, "Study of Police Suicide."

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LIST OF REFERENCES

Badge of Life. Accessed November 13, 2017. http://www.badgeoflife.com/.

———. "A Study of Police Suicide 2008–2016." Accessed June 14, 2018. http://www.policesuicidestudy.com/index.html.

Baker, Thomas E. "Dell P. Hackett and John M. Violanti, Police Suicide: Tactics for Prevention." *Journal of Police and Criminal Psychology* 24, no. 1 (April 2009): 66–67, https://doi.org/10.1007/s11896-008-9037-4.

Bennett, Lynne. "Employee Assistance Programs: Philosophy, Theory and Practice." Discussion paper 5, Royal Canadian Mounted Police External Review Committee, 2015. http://www.erc-cee.gc.ca/cnt/rsrcs/pblctns/dscssn/pdf/dp5-eng.pdf.

Burnette, Crystal, Rajeev Ramchand, and Lynsay Ayer. "Gatekeeper Training for Suicide Prevention." *RAND Health Quarterly* 5, no. 1 (July 15, 2015). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158249/.2.

CALEA. "2016 Annual Report." April 26, 2017. http://www.calea.org/content/2016-annual-report.

———. "Accreditation for Small Law Enforcement Agencies." Accessed February 20, 2018. http://www.calea.org/calea-up date-magazine/issue-101/accreditation-small-law-enforcement-agencies.

Carr, Joel R., Charles W. Hoge, John Gardner, and Robert Potter. "Suicide Surveillance in the U.S. Military—Reporting and Classification Biases in Rate Calculations." *Suicide & Life Threatening Behavior* 34, no. 3 (Fall 2004): 233–241. https://onlinelibrary.wiley.com/doi/full/10.1521/suli.34.3.233.42785.

Cary, Mitchell L., and Dorian H. Edrick. *Police Psychology and its Growing Impact on Modern Law Enforcement*. Hershey, PA: IGI Global, 2016.

Chae, Mark H., and Douglas J. Boyle. "Police Suicide: Prevalence, Risk, and Protective Factors." *Policing: An International Journal of Police Strategies & Management* 36, no. 1 (2013): 91–118. http://dx.doi.org/10.1108/13639511311302498.

Chief of Naval Operations. *Suicide Prevention Program*. OPNAVINST 1720.4A. Washington, DC; Department of the Navy, 2009. http://www.med.navy.mil/sites/nmcphc/Documents/health-promotion-wellness/psychological-emotional-wellbeing/opnav-inst-1720-4a-navy-suicide-prevention-policy.pdf.

Commandant of the Marine Corps. *Marine Corps Suicide Prevention Program (MCSPP)*. MCO 1720.2. Washington, DC: Department of the Navy, 2012. http://www.marines.mil/Portals/59/Publications/MCO%201720.2.pdf.

Decker, James T., Richard Starrett, and John Redhorse. "Evaluating the Cost-Effectiveness of Employee Assistance Programs." *Social Work* 31, no. 5 (October 1986): 391–393.

Defense Suicide Prevention Office. "Quarterly Reports." Accessed March 13, 2018. http://www.dspo.mil/Prevention/Data-Surveillance/Quarterly-Reports/.

Department of the Army. *Army Health Promotion*. AR 600-63. Washington, DC: Department of the Army, 2015. https://www.army.mil/e2/downloads/rv7/r2/policydocs/r600_63.pdf.

Department of Defense (DoD). "New Peer-Support Service Launches." November 22, 2016. https://www.defense.gov/News/Article/Article/1011425/new-peer-support-service-launches/.

———. *Report on Section 593 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114-92): Report on Preliminary Mental Health Screenings for Individuals Becoming Members of the Armed Forces*. Washington, DC: Department of Defense, 2017.

Friedman, Matthew J. "PTSD History and Overview." U.S. Department of Veterans Affairs. Last updated February 23, 2016. https://www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp.

Gifford, Sanford. "From the Second World War to Vietnam: Historical, Clinical, and Personal Reflections on Post-traumatic Stress Disorder." *American Imago* 72, no. 1 (Spring 2015): 1–26. http://dx.doi.org/10.1353/aim.2015.0006.

Hackett, Dell. "Peer Support in Law Enforcement: A Helping Hand." In Harm's Way. Accessed June 15, 2018. http://policesuicide.spcollege.edu/assets/hackettpeersupportle.pdf.

Hartwell, Tyler D., Paul Steele, Michael T. French, Frank J. Potter, Nathaniel F. Rodman, and Gary A. Zarkin. "Aiding Troubled Employees: The Prevalence, Cost, and Characteristics of Employee Assistance Programs in the United States." *American Journal of Public Health* 86, no. 6 (June 1996): 804–808.

Hayes, Christal. "'Silence Can Be Deadly': 46 Officers Were Fatally Shot Last Year. More Than Triple That—140—Committed Suicide." *USA Today*, April 11, 2018. https://www.usatoday.com/story/news/2018/04/11/officers-firefighters-suicides-study/503735002/.

"IACP Releases New Resource: Breaking the Silence: A National Symposium on Law Enforcement Officer Suicide and Mental Health." *IACP Blog*, June 5, 2014. https://theiacpblog.org/2014/06/05/iacp-releases-new-resource-breaking-the-silence-a-national-symposium-on-law-enforcement-officer-suicide-and-mental-health/.

International Association of Chiefs of Police (IACP). *IACP National Symposium on Law Enforcement Officer Suicide and Mental Health: Breaking the Silence on Law Enforcement Suicides*. Washington, DC: Office of Community Oriented Policing Services, 2014.

Keller, Richard T., Neil Greenberg, William V. Bobo, Peter Roberts, Norma Jones, and David T. Orman. "Soldier Peer Mentoring Care and Support: Bringing Psychological Awareness to the Front." *Military Medicine* 170, no. 5 (2005): 355–361.

Kirschman, Ellen. "Pre-employment Psychological Screening for Cops." *Psychology Today* (blog), September 5, 2017. https://www.psychologytoday.com/blog/cop-doc/201709/pre-employment-psychological-screening-cops.

Klein, Robin. "Police Peer Counseling: Officers Helping Officers." *FBI Law Enforcement Bulletin* 58, no. 10 (October 1989): 1–4. https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=120501.

Knox, Kerry L., Steven Pflanz, Gerald W. Talcott, Rick L. Campise, Jill E. Lavigne, Alina Bajorska, Xin Tu, and Eric D. Caine. "The U.S. Air Force Suicide Prevention Program: Implications for Public Health Policy." *American Journal of Public Health* 100, no. 12 (December 2010): 2457–2463. http://dx.doi.org/10.2105/AJPH.2009.159871.

LeardMann, Cynthia A., Teresa M. Powell, Tyler C. Smith, Micharl R. Bell, Besa Smith, Edward J. Boyko, Tomoko I. Hooper, Gary D. Gackstetter, Mark Ghamsary, and Charles W. Hoge. "Risk Factors Associated with Suicide in Current and Former U.S. Military Personnel." *JAMA* 310, no. 5 (August 7, 2013): 496–506. https://doi.org/10.1001/jama.2013.65164.

Lyle, Amaani. "Troop Suicide Rates Decline in Second Quarter." Targeted News Service, December 11, 2014. https://search.proquest.com/docview/1635138131?OpenUrlRefId=info:xri/sid:primo&accountid=12702.

Mann, J. John, Alan Apter, Jose Bertolote, Annette Beautrais, Dianne Currier, Ann Haas, Ulrich Hegerl, Jouko Lonnqvist, Kevin Malone, Andrej Marusic, Lars Mehlum, George Patton, Michael Phillips, Wolfgang Rutz, Zoltan Rihmer, Armin Schmidtke, David Shaffer, Morton Silverman, Yoshitomo Takahashi, Airi Varnik, Danuta Wasserman, Paul Yip, and Herbert Hendin. "Suicide Prevention Strategies: A Systematic Review." *JAMA* 294, no. 16 (October 26, 2005): 2064–2074. https://doi.org/10.1001/jama.294.16.2064.

McHugh, Paul R., and Glenn Treisman. “PTSD: A Problematic Diagnostic Category.” *Journal of Anxiety Disorders* 21, no. 2 (January 2007): 211–22. http://dx.doi.org/10.1016/j.janxdis.2006.09.003.

McNally, Richard J. “Can We Fix PTSD in DSM-V?” *Depression and Anxiety* 26, no. 7 (July 1, 2009): 597–600. http://dx.doi.org/10.1002/da.20586.

Military OneSource. “About Us.” Accessed February 17, 2018. http://www.militaryonesource.mil/web/mos/about-us.

Miller, Laurence. “Police Officer Suicide: Causes, Prevention, and Practical Intervention Strategies.” *International Journal of Emergency Mental Health* 7, no. 2 (2005): 101–114.

Mishara, Brian L., and Martin Normand. “Effects of a Comprehensive Police Suicide Prevention Program.” *Crisis: The Journal of Crisis Intervention and Suicide Prevention* 33, no. 3 (2012): 162–168.

Nash, William P. “The Stressors of War.” In *Combat Stress Injury*, edited Charles R. Figley and William P. Nash, 11–31. New York: Routledge, 2007.

Navy Personnel Command. “Gatekeeper Training.” Last modified December 12, 2017. http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/suicide_prevention/command/Pages/GatekeeperTraining.aspx.

“Police Isolation, Part I.” *Law Officer* (blog), February 8, 2010. http://lawofficer.com/archive/police-isolation-part-i/.

Ramchand, Rajeev, Joie Acosta, Rachel M. Burns, and Lisa H. Jaycox. *The War Within: Preventing Suicide in the U.S. Military*. Santa Monica, CA: RAND, 2011. https://ebookcentral.proquest.com/lib/ebook-nps/detail.action?docID=684637#.

Rosen, G. M., and B. C. Frueh. “Challenges to the PTSD Construct and its Database: The Importance of Scientific Debate.” *Journal of Anxiety Disorders* 21, no. 2 (2007): 161–163. http://dx.doi.org/10.1016/j.janxdis.2006.09.007.

Roufa, Timothy. “Learn about the Psychological Tests and Screening for Police Officers.” The Balance Careers. Accessed March 2, 2018. https://www.thebalance.com/psychological-exams-and-screening-for-police-officers-974785.

Rufo, Ronald A. *Police Suicide: Is Police Culture Killing Our Officers?* Boca Raton, FL: CRC Press, 2016.

Secretary of the Air Force. *Suicide Prevention Program*. AFI 90-505. Washington, DC: Department of the Air Force, 2016. http://static.e-publishing.af.mil/production/1/afmc/publication/afi90-505_afmcsup/afi90-505_afmcsup.pdf.

Shekelle, Paul G., Steven Bagley, and Brett Munjas. *Strategies for Suicide Prevention in Veterans*. Washington, DC: Department of Veterans Affairs, Health Services Research & Development Service, 2009.

Silverman, Morton M., and Robert D. Felner. "Suicide Prevention Programs: Issues of Design, Implementation, Feasibility, and Developmental Appropriateness." *Suicide & Life-Threatening Behavior* 25, no. 1 (Spring 1995): 92–104. https://doi.org/10.1111/j.1943-278X.1995.tb00395.x.

Ursano, Robert J., R. C. Kessler, M. B. Stein, J. A. Naifeh, P. A. Aliaga, C. S. Fullerton, G. H. Wynn, P. L. Vegella, T. H. Ng, B. G. Zhang, C. L. Sryter, N. A. Sampson, T.C. Kao, L. J. Colpe, M. Schoenbaum, J. E. McCarroll,, K. L. Cox, S. G. heeringa, and Army STARRS Collaborators. "Risk Factors, Methods, and Timing of Suicide Attempts among U.S. Army Soldiers." *JAMA Psychiatry* 73, no. 7 (July 1, 2016): 741–749. https://doi.org/10.1001/jamapsychiatry.2016.0600.

U.S. Congress. House of Representatives. *Update on Military Suicide Prevention Programs: Hearing before the Subcommittee on Military Personnel of the Committee on Armed Services, House of Representatives*. 113th Cong., 23. Statement of LTG Howard B. Bromberg, Deputy Chief of Staff, G-1, U.S. Army. March 6, 2013.

———. Statement of Jacqueline Garrick, LCSW-C, Acting Director of the Defense Suicide Prevention Office. March 6, 2013.

———.114th Cong. Statement of Honorable Susan A. Davis, representative from California, ranking member of the Subcommittee on Military Personnel. 2015.

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