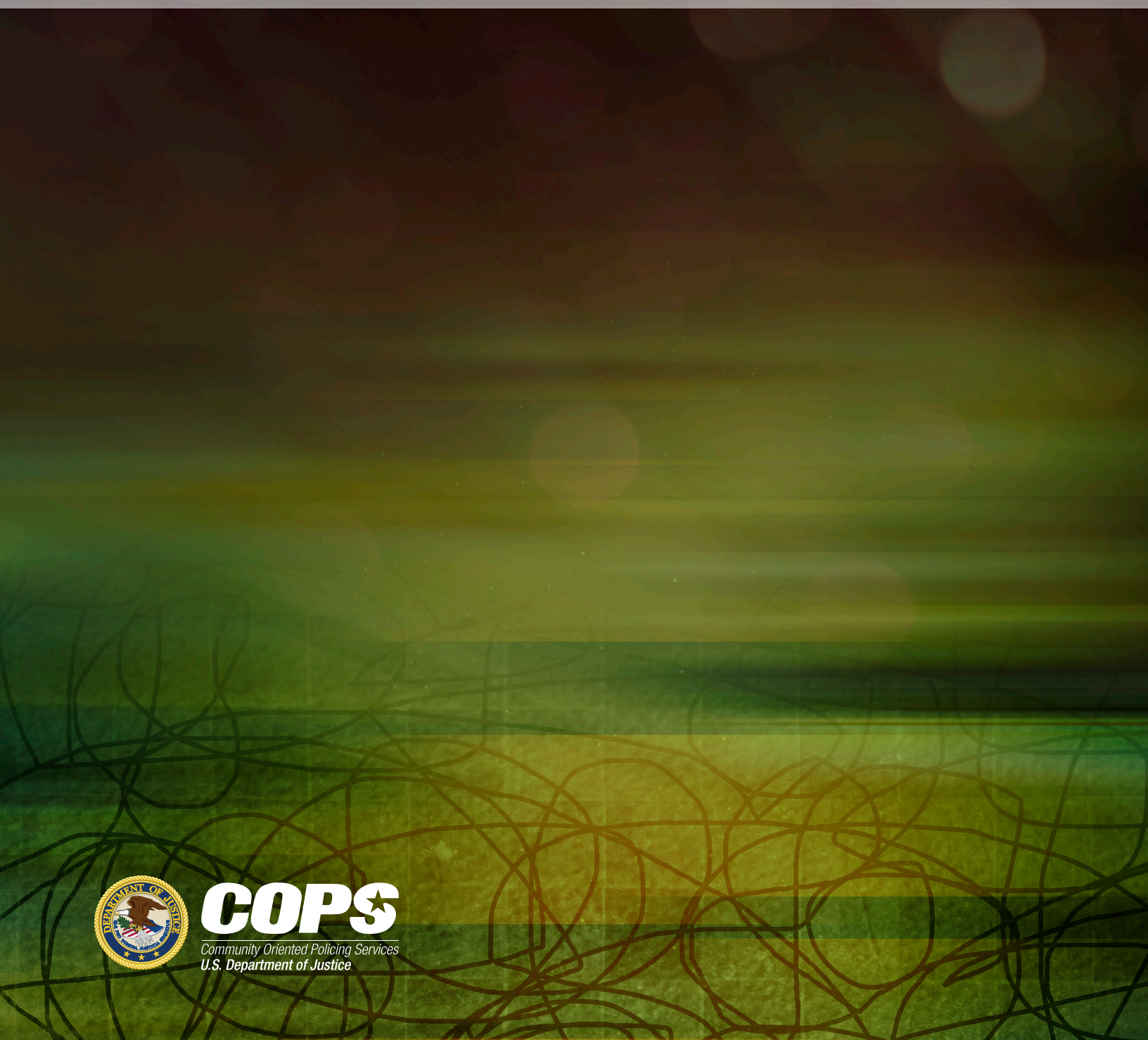
Law Enforcement Mental Health and Wellness Act

Report to Congress



COPS
Community Oriented Policing Services
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Law Enforcement Mental Health and Wellness Act

Report to Congress March 2019

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Introduction

Good mental and psychological health is just as essential as good physical health for law enforcement officers* to be effective in keeping our country and our communities safe from crime and violence. An officer's mental state affects his or her behavior in a variety of situations and can influence decision-making and judgment. However, the current state of support for officer wellness nationally is disjointed and faces both cultural and logistical obstacles.

The daily realities of the job can affect officers' health and wellness. They face a constant need to be vigilant, long hours and shift work, exposure to the daily tragedies of life, and regular interaction with people who are in crisis or hostile toward them. Patrol officers face a national undercurrent of heightened public scrutiny of the profession that overshadows the legitimacy of their individual efforts. Corrections officers can expect to encounter verbal abuse and physical assaults from prisoners and exposure to hazardous materials and blood-borne pathogens.[1] All of these things added to the ordinary hassles of the workplace and their personal lives can lead to cumulative stress and burnout.

Officers anticipate and accept the unique dangers and pressures of their chosen profession. However, people under stress find it harder than people not experiencing stress to connect with others and regulate their own emotions. They experience narrowed perception, increased anxiety and fearfulness, and degraded cognitive abilities.[2] This can be part of a healthy fight-or-flight response, but it can also lead to significantly greater probabilities of errors in judgment, compromised performance, and injuries.[3] Failing to address the mental health and wellness of officers can ultimately undermine community support for law enforcement and result in officers being less safe on the job.

Psychological stress may also have serious consequences for the individual officer's health.[4] In particular, traumatic law enforcement work has been shown to increase officers' risk of developing post-traumatic stress disorder (PTSD) symptoms.[5] PTSD is associated with major depression, panic attacks, phobias, mania, substance abuse, and increased risk of suicide.[6] PTSD can increase the risk of cardiovascular disease, hypertension, heart disease, and possibly stroke as well.[7]

With a professional suicide rate estimated at 28.2/100,000 for men and 12.2/100,000 for women, officer mental health and wellness needs to be discussed openly and honestly by the law enforcement field.[8] In releasing his foundation's report on first responder suicide in April 2018, Jay Ruderman said, "We need to end the silence that surrounds the issue of first responder mental health."[9] This echoes what we have been hearing from growing numbers of leaders in the field. With the Law Enforcement Mental Health and Wellness Act, we believe Congress has taken an important step in making the end of that silence a reality. Supporting the expansion of and access to mental health and wellness services will help our nation's more than 800,000 federal, state, local, and tribal law enforcement officers identify issues early and get the help they need. And, most importantly, it will save lives.

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* Throughout this report we refer to law enforcement officers, or "officers," to be inclusive of sheriffs' deputies, marshals, special agents, and all the other individuals who are granted responsibilities for enforcing federal, state, local, or tribal laws and generally engage in the broad range of activities classified as policing even if the word "officer" does not appear in their job title.

Overview of the Law Enforcement Mental Health and Wellness Act

The Law Enforcement Mental Health and Wellness Act (LEMHWA) was passed in Congress in 2017 and signed into law in January 2018. The fact that it passed both chambers unanimously and without amendment shows that its purpose and intended effects are uncontroversial among policymakers: Law enforcement agencies need and deserve support in their ongoing efforts to protect the mental health and well-being of their employees. But the timing of the act and this opportunity to respond to its provisions is important. A damaging national narrative has emerged in which law enforcement officers—whether federal, state, local, or tribal—are seen not as protectors of communities but as oppressors. Even though there are approximately 800,000 individuals who wear badges in this country, and they engage in millions of honorable, positive, and uncontroversial interactions with the community every day, officers today can find that their actions are constantly questioned and viewed suspiciously. The public trust in law enforcement inherent to successful crime prevention, suppression, and prosecution can be damaged by assumptions and misunderstandings as much as by deliberate challenges and provocations. In this environment, where an inherently stressful job is made more so by a constant undercurrent of distrust and negative public opinion, the risks to officer wellness are exacerbated.

To aid in addressing these risks, LEMHWA called for the U.S. Department of Justice (DOJ) to submit (1) a report to Congress on mental health practices and services in the U.S. Departments of Defense (DoD) and Veterans Affairs (VA) that could be adopted by federal, state, local, or tribal law enforcement agencies as well as (2) a report containing recommendations to Congress on

- effectiveness of crisis lines for law enforcement officers;
- efficacy of annual mental health checks for law enforcement officers;
- expansion of peer mentoring programs;
- ensuring privacy considerations for these types of programs.

LEMHWA specified that this work should include identifying and reviewing research as well as consulting with state, local, and tribal law enforcement agencies; the U.S. Department of Homeland Security (DHS); and other federal agencies that employ law enforcement officers.

The DOJ is pleased to respond to the act as officer safety, health, and wellness is a longstanding priority of the agency. This report addresses these specific requests of the act in a single document.

The act also specified that the Director of the Office of Community Oriented Policing Services (COPS Office) would submit a report to Congress that "focuses on case studies of programs designed primarily to address officer psychological health and well-being." That report, entitled *Law Enforcement Mental Health and Wellness Programs: Eleven Case Studies*, is periodically referenced throughout this report, as the case studies provide examples for many of the points and recommendations discussed here.

Methods

Recognizing the potential linkages between recommendations for improving officer mental health and wellness and the case studies of promising practices in that area, the DOJ tasked the COPS Office with preparing this report. In addition to working closely with the authors of the case studies report to make the best use of their site visit experiences, the COPS Office team also reviewed the available literature on mental health in police officers, crisis lines, peer support and mentoring, and mental health checks. Publicly available program information was reviewed from the DoD, the VA, and a variety of law enforcement agencies to identify examples and understand operational context. Contacts within other federal agencies, national law enforcement stakeholder organizations, and recognized experts in different aspects of mental health in law enforcement agreed to consultation interviews providing their perspectives and examples. Recommendations and examples were then presented and discussed with subject matter experts and knowledgeable practitioners to ensure their reasonableness and feasibility.

The end result is that this report first summarizes some of the existing efforts supported by the DOJ aimed at promoting mental health and wellness in law enforcement. It then reviews some of the programs and efforts of the DoD and the VA that appear to have the most appeal and applicability to law enforcement. This is followed by discussions of crisis lines, mental health checks, and peer mentoring programs. Recommendations concerning all these areas are presented throughout the report as well as summarized in appendix A to this report.

This report concludes with additional recommendations that are more global to the mental health and wellness issue than the specifically named approaches but that we believe are important to the design and delivery of effective services for the men and women who serve in our nation's law enforcement agencies whether at the federal, state, local, or tribal level.

There are differences to be found in some of the existing services available to members of different types of departments, and some of the stressors can be different for federal agents as compared to tribal officers, city-based officers, sheriffs' deputies, or state patrol and investigative officers. But overwhelmingly we found that the similarities far outweighed the differences. People we spoke to in agencies with peer support programs felt there was always room for expansion and improvement and worried about other agencies where programs did not exist. The challenges of trust, system navigation, insurance limitations, and confidentiality were also cross-cutting. The lack of geographically proximate behavioral health professionals is equally significant for employees of rural sheriffs' offices and tribal departments as it is for federal agents assigned in remote field offices. Suicide threatens officers at all types of agencies. Consequently, initial plans to specify recommendations by the type of agency (i.e., federal, state, local, or tribal) eventually were set aside in favor of recommendations that speak to all of law enforcement. The levels and mechanisms of support needed to implement these recommendations may vary depending on the size and type and location of an agency, but the mental health and wellness needs of law enforcement officers—and the types of programs most likely to meet those needs—do not.

U.S. Department of Justice Support for Law Enforcement Mental Health and Wellness

The health and safety of all law enforcement officers, including their mental health and wellness, is an important priority of the DOJ. Law enforcement officers do difficult work in unforgiving conditions; even if most days in the working life of most patrol officers do not involve high-speed car chases, ambush by armed vigilantes, struggles with people made belligerent by drug use, or other risks to their lives, the fact remains that any day could involve any of those dangers or one of many others—and even less sensational aspects of the job can nevertheless be stressful and have long-term negative effects on officers' mental well-being.

The DOJ recognizes that law enforcement officers perform uniquely dangerous tasks. It has long undertaken efforts to promote officer safety, officer morale, and public respect for their work and has several programs that translate this support into action. In 2011, the COPS Office and the Bureau of Justice Assistance (BJA) formed the national Officer Safety and Wellness (OSW) Group to bring attention to the safety and wellness needs of law enforcement officers following a number of high-profile ambushes on police. The OSW Group convenes regularly and brings together law enforcement practitioners, researchers, and subject matter experts to help amplify new and existing efforts to improve officer safety and wellness in the field. The third of four main themes into which the OSW Group's priority areas are organized is mental and physical health and wellness; the priority areas under that theme are physical health (e.g., fatigue, alcohol, weight, and nutrition), maintaining good health, former military in law enforcement, and—importantly—psychological health. The OSW Group meetings in October 2016, October 2017, and April 2018 all dealt with aspects of officers' mental health, with the October 2016 meeting focusing on resilience (specifically in response to mass casualty events and other major crises) and the October 2017 and April 2018 meetings including in-depth discussion of emotional health and officer suicide. The reports on all three of those meetings provide recommendations of ways agencies can support their officers' mental health.[10]

In addition to cosponsoring the OSW Group, the COPS Office publishes reports written by its award recipients whose work involves law enforcement mental health and wellness. This library of resources includes reviews of the 2016 Pulse nightclub shooting in Orlando, Florida, and the ambush of two officers in Las Vegas, Nevada, in 2014 as well as other events in which the demands of the job have had the potential to cause long-standing mental effects on officers.[11] After the massacre at Sandy Hook Elementary School in 2012, the COPS Office partnered with the National Alliance on Mental Illness to produce a guide for law enforcement leadership to help equip their departments for the long-term emotional effects of such critical incidents.[12]

Similarly, the BJA's efforts extend beyond the OSW Group. The Officer Robert Wilson III Preventing Violence Against Law Enforcement Officers and Ensuring Officer Resilience and Survivability (VALOR) Initiative is a collection of programs providing training, research, partnerships, and other resources to benefit law enforcement officers' short- and long-term safety, wellness, and resilience. The suite of programs in the VALOR Initiative includes training and technical assistance programs on de-escalation strategies and tactics, crisis intervention training, and other physical safety concepts, as well as research and programs on resilience and other

mental health and wellness concepts.[13] In 2018, BJA also launched the National Officer Safety Initiative in support of the President's February 9, 2017, officer safety–focused executive order. This BJA National Officer Safety Initiatives program is funding innovative approaches to augment law enforcement safety in three key areas: (1) law enforcement suicide, (2) traffic safety, and (3) a national public awareness and education campaign.

For many years the BJA has administered two programs important to officer safety and wellness: (1) the Public Safety Officers' Benefits (PSOB) program and (2) the Bulletproof Vest Partnership (BVP). The PSOB program provides a death benefit to the eligible survivors of federal, state, or local public safety officers. It also provides a disability benefit to eligible public safety officers who have been permanently and totally disabled as the direct result of a catastrophic personal injury sustained in the line of duty.[14] Since its inception in 1976, the PSOB program has provided more than $1.8 billion in these death and disability benefits to law enforcement officers, first responders, and their families. The BVP has assisted state and local agencies in purchasing more than one million vests since it was created in 1998.[15]

Other components provide mental health support and services to law enforcement officers as well. The Office for Victims of Crime's online resource, the Vicarious Trauma Toolkit, "was developed on the premise that exposure to the traumatic experiences of other people"—survivors of terrorism and mass violence, as well as their families; people who have been physically or sexually abused or subject to human trafficking; even first responders—"is an inevitable occupational challenge for the fields of victim services, emergency medical services, fire services, law enforcement, and other allied professionals."[16] The toolkit offers guidance in assessing agencies' readiness to cope with vicarious trauma; prioritizing needs, making plans, and identifying resources to help agencies become trauma-informed; and developing policies, procedures, and programs to strengthen agencies' response to vicarious trauma.

The National Institute of Justice funds dozens of projects on officer safety—as of September 5, 2018, there are 23 open awards accounting for close to $12 million, of which about one-third of the awards (and more than half the funds—eight awards worth more than $6 million) specifically focus on officer stress, resilience, or mental well-being and a ninth almost million-dollar award is a multilevel study on officer safety and wellness in general.[17]

But even with these programs and projects in place, gaps still remain—which is why Congress has charged the DOJ with investigating other ways to make stronger government support for law enforcement mental health and wellness a reality.

Mental Health and Wellness Programs for Military Professionals and Veterans

Section 1(a) of LEMHWA requires that this report examine DoD and VA mental health practices and services that could be adopted by federal, state, local, or tribal law enforcement agencies. The precedent for looking to the armed services for examples of programs to serve the law enforcement professions is well established; there are similarities in the structure of organizations, in the round-the-clock functions, in the exposure to life and death situations, and in the cultural intertwining of personal and professional identity. Both military and law enforcement professionals hold ranks, carry weapons, and are trained to use deadly force. We expect them all to run toward danger, not away from it, to face some of the most horrific circumstances imaginable while remaining calm and rational, and to work to restore order from chaos. Courage, valor, honor—these are important words in both professional worlds, telling us as much about the values they hold for themselves as about those we hold them to.

But while the paramilitary nature of law enforcement agencies and the hypervigilant environment in which they work are no doubt some of the primary reasons why parallels are often drawn between the two professions, the composition of the respective workforces is also an important consideration when looking for ways to promote and preserve the mental wellness of the law enforcement organization.

According to the Bureau of Labor Statistics, the overall labor force in the United States is approximately 53 percent male with an average age of 42. Law Enforcement Management and Statistics data from the Bureau of Justice Statistics show that the composition differs in local law enforcement, where about 87 percent of those employed in the industry are men, and the average age is 39. DoD statistics show that the active duty and reserve workforce is more similar to that of law enforcement than the general population, with men accounting for approximately 83 percent of the workforce and an overall average age of 34.

Why might these demographics matter? Consider suicide rates: Men are 3.5 times more likely to commit suicide than women, and one of the highest suicide rates is for middle-aged men.[18] Policing and the military professions are both reported to experience suicide at rates higher than the general population. Whether the higher suicide rate is due to the fact that these professions employ significantly higher percentages of men or whether middle-aged men are at higher risk of suicide because they are more likely to work in these types of high stress and high risk professions is not for this report to determine. But the commonality of male-majority workforces is significant because to the extent they are interested in promoting wellness and help-seeking behaviors among employees, they will face some gender-related challenges. A number of studies over the years have found that men pursue preventive screenings, maintain a regular source of care, and get timely medical interventions much less often than women.[19]

This tendency is not because men are somehow programmed to avoid seeking help. But some research has suggested that "men who score higher on measures assessing dimensions of masculinity norms generally have less favorable

help-seeking attitude, seek help for psychological problems less often, and in some cases fail to obtain routine health examinations."[20] While the reasons behind this gender difference are not fully understood, research indicates that men who more strongly identify with masculine norms tend to show poorer mental health and less psychological help seeking.[21] In addition, studies have found that a prominent socially accepted role for men includes the notion that need for help and perceived weakness are not congruent with masculinity.[22] Put another way, cultural expectations of male behavior, often valued by both the military and law enforcement professions, can be among the main barriers to ensuring not only that there are programs and services to address the unique health and wellness needs of a largely male workforce but also that those programs and services are accessed and used by that workforce. An additional concern, unique to this population, is that seeking assistance can jeopardize an officer's career—that they may be taken off the street or forced to turn in their weapon—which is another important challenge to help-seeking behavior in law enforcement.

While both professions are predominantly male, there are growing numbers of women serving both in the military and in law enforcement. Research supports the need for greater awareness of sex-specific mental health needs as well as more definitive studies to further address these needs in the context of sex-specific treatment approaches.[†]

Is the military a model for law enforcement?

There are reasons why so many people in the law enforcement arena may look to the military for ideas, models, and programs to improve officer mental health and wellness. To the extent that the DoD and the VA have identified ways to encourage help-seeking behavior and provide services that recognize the unique challenges facing the workforce, the law enforcement community should absolutely look to learn from those efforts. But it should do so recognizing that the DoD and the VA working across the nation with their public and private partners still have room to improve their own efforts to support service member and veteran mental health and wellness—as evidenced by a suicide rate higher than the general population's—and that not every program they have implemented has been proven effective. Every death by suicide is a tragedy, and as long as there are deaths by suicide, efforts to prevent suicide must continue.

There are also ways in which the two professions are not so neatly comparable, particularly when it comes to their ability to implement wellness programs. The military ultimately has a single employer. All health services both for active duty and retired service members are centralized. While the individual experience of ease of access and quality can vary, the development and implementation of wellness programs can be rolled out on a national scale to all employees and retirees. The Defense Health Agency (DHA) is the joint, integrated Combat Support Agency that "supports the delivery of integrated, affordable, and high quality health services to Military Health System (MHS) beneficiaries and is responsible for driving greater integration of clinical and business processes across the MHS."[23] DHA directs the execution of multiple shared services across the service branches including pharmacy, health information technology, education and training, and public health. DHA also administers the TRICARE Health Plan, which provides medical, dental, and pharmacy programs to more than 9.4 million uniformed service members, retirees, and their families.

In policing, there are more than 17,000 agencies in the United States with a wide variety of benefits plans and providers, a variety of affinity groups and labor organizations, and no agency exists to

[†] More research is needed regarding the impact of increasing workforce diversity and gender balance on wellness, help-seeking behaviors, and treatment and intervention effects in law enforcement work environments.

serve the unique health and wellness needs of law enforcement retirees. Furthermore, nearly half of those law enforcement agencies employ fewer than 10 full-time sworn officers.[24] Although most of the approximately 800,000 officers in this country work for larger agencies—63 percent of officers work for one of the 5 percent of agencies that employ more than 100 sworn[25]—even a large police department in this country is small when thinking of them as organizations providing a complex series of training and services to their employees. Only 43 local police departments in the Unites States have more than 1,000 sworn employees. The total number of military personnel (active duty and reserve) is nearly 3.5 million. The DoD and the VA have the ability to support and deploy large-scale, multifaceted, health and wellness programs in a way that most law enforcement agencies do not.

With this basic understanding of why DoD programs may hold promise as models for addressing the unique needs of law enforcement personnel but nevertheless not be plug-and-play replicable, we can look at some DoD and VA resources and programs. The focus in this report is not to comprehensively catalog everything they have to offer in terms of mental health and wellness, but to focus on approaches that seem to offer not just the most applicability to the law enforcement context, but also the potential for replicability in a highly decentralized professional environment.

We therefore attempt to stay away from programs and services that are the most integrated with the structure of the DoD as a centralized health care provider with enforceable fitness-for-duty standards because the inability to replicate across 50 states and thousands of cities and counties with different health care provider networks and collective bargaining agreements would likely make replication unsuccessful. For example, policy updates to TRICARE ended limits on the number of annual visits covered individuals could use for various mental health services. Insurance limits on mental health services is often reported as a major barrier to accessing services or completing treatment plans by law enforcement officers. For another example, this report will later look at the idea of annual mental health checks in law enforcement—but if we simplistically present the DoD's predeployment readiness screens as potential models for law enforcement, we overlook the importance of the DHA infrastructure in the design and administration of the program as well as overlooking the important differences between daily police work and sustained military deployments to duty stations far removed from home and civilian life.

Public information and wellness promotion campaigns

Spend any time looking at Military OneSource, or the Defense Suicide Prevention Office website, or the MHS site, or Crisis Line pages, or many of defense community news sites for service members and their families, and it becomes apparent just how much public information the DoD promotes to encourage help seeking behavior. Promotional campaigns, resource guides, social media feeds, news stories, all work to destigmatize and demystify mental health services and ensure service members that providers in their communities are familiar with the challenges of military life. Promotional efforts are expanded when they can build on other national-level initiatives, such as during National Mental Health Month or National Suicide Prevention Week, amplifying the broader public health efforts around mental wellness with military specific information.

For example, the MHS runs Operation Live Well. First launched in 2013, it takes a holistic approach to helping military families live their best. It provides information and resources in integrative wellness, mental wellness, nutrition, physical activity, sleep, and tobacco-free living.

Its information is designed to make healthy living an easier option for service members by being informed by the service member experience. At the time the multiyear, multiphase effort was launched, the DoD estimated that in a single year, the military discharged more than 1,200 first-term enlistees before their contracts were up because of weight problems and that TRICARE was spending more than $1 billion per year on obesity-related medical costs.[26] Its whole health, whole family approach recognizes that our physical and mental well-being are interrelated, that our environments can make it easier or harder to be healthy, and that good information on health and fitness needs to be presented to communities in ways that recognize the complexities of their lives—particularly when dealing with the unique aspects of life in the military community.

Comprehensive mental health promotion may be similarly beneficial. One interview subject spoke about work he had read by Dr. Michael Matthews, Professor of Engineering Psychology at the United States Military Academy, that had influenced his thinking in recent years. In his 2014 book, *Head Strong: How Psychology is Revolutionizing War*,[27] Dr. Matthews explores how a change in perspective—going from a reactive, disease-based health care model to a proactive, prevention-based health and wellness model—can make an immediate difference in operational readiness. And that training in prevention is not just for building a stronger and more ready military but also the route to improving the operational readiness of all first responders. The interviewee believed that there should also be a corresponding savings in health care cost related to reducing or eliminating chronic health problems associated with the daily exposure to stress—such as PTSD, anxiety, hypertension, and other metabolic diseases—in the emergency services.

DoD and VA resources include easy-to-find materials on what to expect at a first appointment with a behavioral health provider, how to talk to a medical provider about mental wellness concerns, and how to recognize risks in family members and peers and what to do when you see them. They also provide smartphone apps for self-care like Virtual Hope Box (VHB), which is modeled on a cognitive behavioral therapy technique that uses a physical box containing things that remind patients of positive experiences, reasons for living, people who care about them, or coping resources. A recent study found that the smartphone app was more effective than print materials at improving veterans' ability to cope with unpleasant emotions and thoughts. The authors of the study concluded that the VHB may be an important way to improve patient coping by making an existing cognitive behavioral therapy technique more convenient and accessible.[28]

And they produce resources aimed at helping the civilian clinician community better understand the unique needs of service members and veterans. For example, the VA produced a Community Provider Toolkit on suicide prevention with information on assessment, safety planning, VA resources, education, and other tools a community-based care provider might need to know to help a client at risk who is a veteran.

Recommendation 1. Support the creation of a public service campaign around law enforcement officer mental health and wellness in conjunction with National Mental Health Month.

The law enforcement community is only just beginning to talk about mental health and wellness. Support is needed to develop national campaigns about the risks and opportunities to officer mental health that can be deployed in conjunction with key national public health initiatives. One of the biggest barriers to seeking help is fear of the unknown or a sense that there is no one who can help. Reinforcing the already existing public message that there is help with law enforcement–specific messages that acknowledge the community's unique needs can

help officers and agencies talk about those needs. National campaign material can then be customized by agencies with wellness programs to include resources on programs and services they offer.

Recommendation 2. Support the development of resources for community-based clinicians who interact with law enforcement and their families to help them better understand some of the unique risks facing their clients and what resources may be available to them as members of the first responder community.

Encouraging officers to seek help is only half the equation. No public campaign will succeed if they cannot access quality clinical support that understands the profession. Evidence-based web and electronic toolkits of resources and safety plan quick guides that introduce clinicians to some of the unique realities of law enforcement should be developed. Congress already recognized this need in part in section 3 of LEMHWA when it directed the Attorney General and the Secretary of Health and Human Services to partner in producing law enforcement–specific resources for clinicians and behavioral health providers. But the development of clinician training and toolkits of provider resources—including the identification of referral networks, family support options, and locality-specific information in connection with support for growing the network of embedded professionals—would help further extend the reach of informed clinicians, particularly in more rural or isolated parts of the country where there may not be an extensive clinical network of providers. Existing comprehensive wellness programs in law enforcement agencies, like those profiled in the wellness case studies report, as well as clinicians who have direct law enforcement experience and the community of police psychologists could all be tapped to build a national-level evidence-based toolkit in cooperation with the DOJ.

Embedded mental health professionals

It can be difficult to convince anyone in need of help to make the effort to seek it. Finding mental health professionals who can be trusted and are perceived as beneficial can be tough for anyone, not just service members or law enforcement officers. So finding ways to make access easy and convenient is important. The DoD runs a variety of efforts to expand access and use, including producing extensive resources on how to find a provider that will work for you and what to expect when calling a crisis line or meeting with a behavioral health professional through the TRICARE network.

One of the ways the DoD is attempting to improve access is by embedding services and providers with the service members. Madigan Army Medical Center, which is located on Joint Base Lewis-McChord just outside Lakewood, Washington, offers all behavioral health service line programs in-house. Outpatient and inpatient care, substance abuse treatment, family advocacy, child and family care, support for traumatic brain injuries—all are available through what they are calling embedded behavioral health (EBH) teams.

EBH teams are in the unit areas. Service members therefore spend less time travelling to appointments; also, the teams' being embedded in operational units helps remove some of the stigma around their use. The teams also work to build a working relationship with unit commanders so that they can be informed on generalized trends across units, like with sleep or leadership stressors. In an article published early in 2018, the lieutenant colonel who serves as the chief of behavioral health at Madigan observed that with the EBH teams in place, soldiers "are willing to come in and get care . . . they realize they can go get care and not be treated as broken."[29]

The integration of clinicians with the unit also helps in explaining to soldiers that seeking care is highly unlikely to impact their careers. There are very few diagnoses that are career limiting, and command is seldom aware of who is receiving care.

Recommendation 3. Support programs to embed mental health professionals in law enforcement agencies.

It is clear from a variety of DoD programs that it is important to military personnel that programs and services be culturally competent to the military experience. This is the experience in first responder communities as well—law enforcement officers want the people they talk to to understand the job and the unique stresses it can place on them. While some people will enter a career in behavioral health after spending time as a sworn law enforcement officer, there will never be enough to provide care to all the law enforcement officers in the country. Also, ease of access is important to encouraging use.

But a program that embeds behavioral health practitioners into law enforcement agencies even part time could not only reduce barriers to use but could also help expand the understanding of mental health professionals in terms of the unique risks and experiences of law enforcement. Examples of this already exist in a number of police departments with physicians who act as medical directors, often attached to specialty units like special weapons and tactics (SWAT). In some agencies licensed physicians are also sworn reserve officers, bringing them into the culture and climate of the department where they get to know the officers alongside whom they serve. Even if primary medical care is not their job purpose in the department, they can be a resource for officers with questions, help demystify the system of medical care locally, and assist departments in vetting the services of other medical specialists for the ability to work with the unique population and in a unique environment.

Mental health professionals could also be integrated into agencies through reserve officer programs or through memoranda of understanding, retainers, or other flexible arrangements. While not every agency can support its own exclusive police physician, there may be ways to support the expansion of police physician programs on a regional sharing basis and similarly encourage the building of programs to embed police behavioral health providers into departments as well.

Family readiness and mental health and wellness

For anyone, either the home can be the place where they find the strength to manage the stress of their job or it can be the source of stress that makes the job more challenging. This is particularly true for service members and law enforcement officers. In many respects, military families also serve—not just the uniformed individual. There are unique stresses to being the family of a service member, and the DoD has built extensive programs over the years to assist families. Helping the family be healthy and well is part of making sure the service member is also. Family readiness programs are built on the premise that knowing that a spouse will have the support they need while the service member is deployed will help the service member stay mission-focused.

Family readiness groups (FRG) are the long-standing focal point of family readiness in the U.S. Army and Navy. In the Air Force, it is known as the Key Spouse program; the Marine Corps has the Family Readiness Program; and the Coast Guard has the Work-Life Program. But what all these programs do is keep spouses and families informed and supported during a service member's time with a unit, especially during that unit's deployment. The FRGs all operate slightly differently by branch of service, but they are key sources of information to unit families and strive to make family members feel as resilient and connected to the broader support community as possible.

The DoD also supports broader programs aimed at spouse and family member resiliency, not just during deployments but also when they return and are managing the day-to-day realities of military life like periodic moves, which can make it challenging for spouses to maintain careers and lead to children struggling with changing schools. Research has shown that military spouses and children experience higher levels of depression and anxiety than the general population.[30] Extensive resources for parents are available through Military OneSource.

Recommendation 4. Support programs for law enforcement family readiness at the federal, state, and local level.

When law enforcement officers are asked about the major stressors in their lives, family worries are always near the top of the list. They know their families fear for them on the job, and that can make it hard for them to fully share their experiences with their families in ways that might benefit their own mental wellness. The 24/7 nature of the job, shift work, exposure to traumas that they wish to protect their own loved ones from—all of these things can make it hard for law enforcement families to understand and support their officers. Furthermore, unlike service members on deployment, law enforcement officers are "deployed" in their own communities. In natural disasters or civic emergencies, the stress of ensuring their own families' safety can be an additional emotional burden that affects their ability to stay mission-focused. In short, law enforcement families also serve, just as military families do, and it is important to provide them with both education and counseling services to help the whole family.

Some agencies and organizations have begun to spend more time on supporting the whole officer family, but the effort is nascent. Most family support programs, whether local or national, primarily focus on the survivors of fallen officers. The COPS Office is taking a first step toward better informing future expansion efforts with a project it funded in FY 2018 for the International Association of Chiefs of Police to develop resources on supporting officer families, including a guidebook on integrating family-friendly policies into a department, blog posts, a podcast series, and a brochure on starting family support groups. To shed more light on this important resiliency factor, support is needed in three key areas: (1) to more fully explore the stressors that law enforcement families experience; (2) to create educational programs that help families recognize and acknowledge when they may need professional assistance and where and how to get that assistance; and (3) to build more comprehensive family readiness programs, whether through national organizations or at the individual agency level.

Expanding support in transition

The coordination of DHA and VA programs and services is one of the ways the DoD is able to provide care to many transitioning service members and retirees in a way that would be beyond the capability of law enforcement agencies. But even then the system is not a complete guarantee. In January 2018, President Trump signed an executive order, "Supporting Our Veterans During their Transition From Uniformed Service to Civilian Life," which directed the DoD, the VA, and the DHS to develop a joint action plan ensuring that the new veterans who did not qualify for VA healthcare would receive treatment and access to services for mental health care for one year following their separation from service.

At the time the executive order was signed, it was noted by the U.S. Secretary of Veterans Affairs that service members in transition to veteran status face higher risks of suicide and mental health issues than active-duty members. In addition to working to expand mental health programs to new veterans and eliminating prior time limits, the

three departments also announced plans to extend Military OneSource to veterans in the first year following separation.

Military OneSource offers a wide range of individualized consultations, coaching, and counseling for many aspects of military life. Its programs are available at no cost to service members whether active duty, reserve, or National Guard; their families and survivors; and the recently separated. The services are all encompassing, from nonmedical counseling to assistance with elder care, adoption, education, spousal employment, relocation tools, and even tax preparation services. It also gives users confidence that all the information it provides through its web portal and call center have been vetted by the DoD.

Recommendation 5. Encourage departments to allow retired law enforcement officers to make use of departmental peer support programs for a select period of time post-retirement or separation.

The memories of traumatic incidents and the impacts of a career composed of high-level stress do not automatically dissipate when officers leave the job.

Taking a page out of the recent executive order expanding the use of Military OneSource to recent separations, law enforcement agencies with peer support programs could make those services available to recently retired officers for a period of time. The transition to retirement can be a critical time for law enforcement, particularly considering that they often retire many years ahead of their non–law enforcement peers. A sudden separation from the peer networks that help make the job manageable puts retirees at risk for depression, and given research that shows officers on average live significantly shorter lives than non-officers,[31] more needs to be done to support the transition to retirement.

In fact, many peer support programs in law enforcement agencies are run and staffed by retirees. In the wellness case studies report, the authors found that those staff and volunteers value the chance to give back to the profession and to continue to serve other officers. But for those new retirees who are not looking for volunteer service, being able to access their agency's wellness networks and services that helped them while they were on the job could be an important benefit to extend into the transition to retirement or second careers.

Suicide prevention policy

Mental health and wellness is more than just suicide prevention, but given the higher suicide rates found in both the military and law enforcement environments than in the general population, it is important to note that the DoD has made substantial investments in the area of suicide prevention. The investment in recognizing the extent of the problem places them ahead of the law enforcement profession in prevention efforts.

In November 2017, the Office of the Under Secretary of Defense for Personnel and Readiness issued DoD Instruction 6490.16,[32] which established policies and assigned responsibilities for the Defense Suicide Prevention Program, incorporating earlier directives into a single issuance. It begins with an overview of DoD policy regarding suicide prevention:

> "It is DoD policy that the DoD:
>
> a. Make substantial efforts to reduce suicide.

b. Foster a command climate that:

(1) Encourages personnel to seek help and build resilience.

(2) Increases awareness about behavioral healthcare and reduces the stigma for personnel who seek behavioral healthcare, in accordance with DoD Instruction (DoDI) 6490.08.

(3) Protects the privacy of personnel seeking or receiving treatment relating to suicidal behavior, consistent with applicable standards, including DoD 5400.11-R, DoD 6025.18-R, and DoDI 6490.08. This includes data collected over the course of suicide prevention, intervention, and postvention activities.

c. Provide personnel continuous access to quality behavioral healthcare and other supportive services, including crisis services; foster collaboration of DoD suicide prevention efforts; and services to strengthen readiness and resilience of DoD personnel and their dependents.

d. Provide DoD Components with a training competency framework on suicide prevention.

e. Develop program standards and critical procedures for suicide prevention, intervention, and postvention that reflect a holistic approach.

f. Collect and consolidate surveillance data of suicides and suicide attempts for reporting and analysis for members of Active Component and SELRES, and for suicides by Service members' dependents using consistent collection, reporting, and analysis of suicides and suicide attempts. This includes suicide-related behaviors data from the Department of Defense Suicide Event Report (DoDSER) submitted by the DoD Components in a timely manner to support suicide prevention efforts.

g. Promote lethal means access measures for suicide prevention, in accordance with Section 3 of this issuance.

h. Encourage unit memorial ceremonies and services when a Service member dies by suicide.

i. Implement the Department of Defense Strategy for Suicide Prevention (DSSP), which is modeled after the National Strategy for Suicide Prevention and encompasses the comprehensive policy on prevention of suicide among Service members, as required by Section 582 of PL 112-239.

j. Foster collaboration, cooperation, and coordination among stakeholders, including other federal agencies; appropriate public, private, and international entities; and appropriate institutions of higher education to support suicide prevention policies and programs in accordance with Section 591 of PL 114-92."[33]

Recommendation 6. Support the development of model policies and implementation guidance for law enforcement agencies to make substantial efforts to reduce suicide.

Policy on its own, of course, does not mean anything without practical implementation. But policy is an important starting place. Policies not only tell us the operational standards of agencies but also are statements on what is important and valued.

The introductory language of the DoD instruction on suicide prevention offers a starting point because a law enforcement agency of any size could establish a policy that fosters a climate that encourages personnel to seek help, builds

resilience, and reduces stigma around behavioral healthcare. In fact, the statement of intent captured in policy could play an important role in changing the climate within an agency by demonstrating that the mental health of its personnel and help-seeking behavior is valued.

Other sections of the DoD guidance may also offer potential models for basic law enforcement policy development at the agency level, including on the protection of privacy for individuals making use of intervention and support services. Also the case studies on law enforcement mental health and wellness conducted under the auspices of the LEMHWA offer some examples of agencies with established programs that have incorporated some aspects of operations into departmental policy, most often around information privacy.

But a systematic effort to develop model policies and implementation guidance could include a more comprehensive review of what currently exists, how pieces from different experiences could fit together, and how it could vary from federal law enforcement agencies to smaller local and tribal departments. It could also include other suicide prevention experts in the discussion, particularly those who have worked with first responders and military personnel. Model policy development should also look at issues regarding data collection, retention, and privacy and what agencies can protect versus what they must share with the public about suicide prevention and other wellness efforts. Consideration must also be given to how agencies memorialize employees who die by suicide.[34]

The DoD Suicide Event Report

The annual DoD Suicide Event Report (DoDSER), first published in 2007, is the principal suicide surveillance tool of the DoD and an important data point in the DoD's efforts to prevent future suicides. Without accurate, detailed, and timely information on suicides and suicide attempts, prevention and postvention programs are less likely to be effective and any evaluation of program effectiveness is impossible.

The DoDSER reports on the contextual factors of suicides and attempts by service members, including event circumstances, medical and behavioral health factors, job-related factors, lifestyle stressors, and demographics. In all more than 500 data elements are a part of the survey. This type of detailed information, even with all personally identifiable information redacted, is invaluable to those in the organization charged with designing and evaluating the DoD's suicide prevention programs, policies, and strategies. As was stated in a forum of police leaders on the topic of law enforcement suicide several years ago, "we cannot prevent that which we do not acknowledge."[35] In addition to transparently acknowledging the problem of service member suicide, the DoDSER provides a relatively comprehensive picture of the problem across the service branches and allows the DoD to look for common risk factors and patterns that may be mitigatable.

The 2016 report was released in June of 2018. In light of the earlier discussion on how men are less likely to engage in help-seeking behaviors, it is interesting to note that one of their findings was that "communication of suicidal thoughts and feelings [was] either not made or [not] recognized in 64.9 percent of suicide cases."[36] Another important finding is that "firearms were the method of injury most often identified in suicide cases (62.2 percent). The majority (94.6 percent) of the firearms used were personal possessions, with only 3.8 percent of firearm deaths resulting from self-directed use of a military-issued weapon."[37] Other findings include the fact that nearly half of those who died by suicide had at least one current or past behavioral health diagnosis, and substance abuse and anxiety were among the most common.

Also interesting is that for both suicides and suicide attempts, a majority of the individuals had had contact with the MHS in the 90 days prior to the incident.

These are examples of the types of contextual information that is critically important to organizational efforts to improve wellness and prevent suicides. If a high percentage of the cases involved near-term contact with the health system prior to the incident, were there opportunities to intervene? If in two-thirds of cases there were no identifiable help-seeking behaviors noted, is that because the individual really hid it well or because the wider community lacks training and awareness on the signs of suicide and what to do if you see those signs in someone you know?

The Veterans Crisis Line (VCL, discussed further in Crisis Hotlines beginning on page 19) provides information on warning signs of suicide that everyone should be aware of including the following:

- Anxiety, agitation, sleeplessness, or mood swings
- Feeling excessive guilt, shame, or sense of failure
- Engaging in risky activities without thinking
- Increasing alcohol or drug misuse
- Neglecting personal welfare
- Deteriorating physical appearance
- Withdrawing from family and friends
- Showing violent behavior, like punching a hole in the wall or getting into fights
- Giving away prized possessions[38]

Recommendation 7. Support the creation of a Law Enforcement Suicide Event Report surveillance system, possibly beginning with a focus on federal law enforcement agencies.

Since the DOJ established the National OSW Group in 2011, the issue of law enforcement suicide has repeatedly come up in discussions, always noting that we in fact know very little about the circumstances of law enforcement suicide or even the number that take place each year. A number of reasons why this is the case have been discussed in law enforcement circles over the years, and although general cultural reluctance to acknowledge suicides is a part of it, efforts to protect the survivors also become a factor—death by suicide can lead to a loss of survivor benefits or the denial of funeral honors. Agencies that do not want to hurt the survivors further can therefore be incentivized to remain silent about suicides.

But even for agencies that acknowledge suicides, an unintentional misclassification as an accidental or undetermined death is still possible, and we understand very little of the causes. There is no widespread, systematic effort to look at law enforcement suicides and their circumstances the way there is about line-of-duty deaths through the FBI's LEOKA (Law Enforcement Officers Killed and Assaulted) program and the National Law Enforcement Officers Memorial Fund's (NLEOMF) analysis efforts. Two small nonprofits, the Badge of Life and Blue HELP, provide some of the best estimates we have of the number of suicides in law enforcement each year, and they consistently show them exceeding line-of-duty deaths. Furthermore, we have seen recently that suicides are not always isolated events, and once there is one suicide in an agency others may follow. For example, at the time of this writing, the Chicago Police Department had experienced four suicides

in four months.[39] Questions about whether these stories are tragic coincidences or clusters of evidence of systemic risk factors cannot be answered without more rigorous data collection and research efforts.

The creation of a law enforcement suicide event report surveillance system modeled on the DoDSER is critically needed to understand suicide in law enforcement. Any data collected must also be analyzed to inform prevention, training, and practice. Are there officer job assignments that are riskier than others? Discernable patterns in age, tenure, or experience? Guessing what the risks and barriers are is no substitute for rigorous research. Research partnerships with public health or academic organizations may provide the analytic capabilities needed to support the data collection efforts. In recognition of the complexity of collecting, managing, and analyzing these data, as of 2018 Badge of Life is no longer making their statistics public and is instead "promoting the mandatory reporting of all suicides by chief law enforcement executives into a national repository."[40]

Recognizing that collecting sufficiently detailed information across thousands of agencies would be an incredibly challenging task, one way to begin would be with the creation of a federal law enforcement suicide event report, bringing together data on suicides and suicide attempts from the DOJ, the DHS, and other federal agencies with sworn officers. Although federal law enforcement work is recognizably different than that of much state and local work, the problem of suicide in the workforce is known to be there as well. In addition to providing valuable information to the federal law enforcement agencies on how to better protect their own officers, a multiyear surveillance of the federal agency experience could provide insights into risks in state, local, and tribal agencies.

Crisis Hotlines

There is no large-scale academic evidence for the efficacy of crisis lines‡ for the mental health and wellness of law enforcement personnel. In addition, the efficacy of crisis hotlines in preventing suicides has not yet been empirically proven for the general population. However, it is the opinion of our interviewees that, in spite of the need for deeper research, crisis lines are an important tool for addressing mental health generally and suicide specifically for law enforcement officers. It is important to note that while crisis lines address any number of mental health scenarios, most of the research centers on suicide and suicidal ideation and so this discussion will also necessarily center on suicide. Our interviewees stressed that while suicide prevention is of paramount importance, it is critical to ensure that officers have access to services far before reaching the point of suicidal ideation. As one interviewee said, "If they are already at that point, just keep them away from a weapon." Crisis lines may be a uniquely effective tool at one point of intervention, but mental health services ought to be comprehensive and ongoing. "We need to provide mental health care as primary care," said one federal interviewee, "not simply reactive care."

Findings and limitations: The available data

Proving that a suicide has been prevented is difficult to measure in an academically rigorous fashion, partly because it is nearly impossible to create a randomized trial and partly because privacy concerns can inhibit follow-up calls or pre- or post-testing. Furthermore, there may be a population self-selection problem: Those who reach out to a crisis line may be less disposed to self-harm or may be more desirous of being talked down from suicidal ideation. It is even more difficult to prove efficacy for prevention of self-harm or harm that does not reach the threshold for suicidal ideation. While any comprehensive attempt to address officer mental health and wellness must be far broader in scope than suicide prevention, most research on crisis lines involves suicidal ideation and includes metrics concerning suicide. It remains unclear if law enforcement employees are at special risk for suicide, but we do know that the success rate for suicide by firearm is the highest of any suicide method (82.5 percent of suicides attempted with a firearm are successful).[41] Because officers have ready access to firearms, the risk of success is potentially much higher. Therefore, officers must have equally ready access to crisis counselors at all times. Crisis hotlines offer an opportune solution to the acute crisis of suicidal ideation.

The available research shows that responders at crisis lines can reduce distress over the course of a call for both suicidal[42] and nonsuicidal crisis callers.[43] A study of a national general population crisis line found that half of callers reported seeking additional care after reaching out to a crisis line in follow-up calls.[44] Similarly, the VA's suicide hotline has demonstrated success in engaging veterans in crisis and connecting them with services.[45] Crisis lines are a promising addition to the suite of services needed to support officer mental health and wellness.

‡ This report uses "crisis lines" broadly to refer to any type of always-available service people feeling troubled can contact for advice and referral, including what may be called hotlines, helplines, live chat, text, suicide prevention lines, and so on.

Recommendation 8. Support rigorous research that can evaluate the efficacy of crisis lines and, if supported, provide data toward considering them an evidence-based practice.

The current insufficiency of data in this area is not due to the services provided by crisis lines but rather to a lack of dedicated research. Research on crisis lines generally and the usefulness of crisis lines to law enforcement specifically would allow services to be tailored to the law enforcement population based on need rather than supposition. Research is needed to establish the skills needed by counselors, the best practices on a call, and the best means of service referral and privacy maintenance. Crisis lines can also provide invaluable data on law enforcement suicide. This type of research can be carried out within existing programs while incurring a limited time or financial burden. Experts should be consulted on how best to collect, protect, and use the data already collected by crisis lines to help create an accurate understanding of mental health crises amongst law enforcement officers. In the end, evidence-based research, not anecdotal reports, should govern which programs are promoted and funded.

Veterans Crisis Line and Military Crisis Line

The VCL was launched in 2007 and allows either veterans in crisis or their loved ones to call, text, or chat online confidentially with a qualified VA responder. Its call takers are backed up by a referral network of professional service providers located in each of the VA medical centers around the country. As of late 2018, the VA states that since its creation, the VCL has answered more than 3.5 million calls and dispatched emergency services to callers in crisis nearly 100,000 times. The program's anonymous chat service, introduced in 2009, has engaged in more than 413,000 chats, and the text-messaging service has responded to nearly 98,000 texts. All together the call line, chat, and text services provide veterans with single point of entry access to confidential, round-the-clock support.

The Military Crisis Line (MCL) is a joint resource of the DoD and the VA. Promoted to active service members in crisis and their families, it connects them to the professionals at the VCL through its own brand identity. The ultimate referrals for service may be routed differently for active service members than for those covered by the VA, but the system and toll-free number are the same. What is important to callers in crisis is not only that is the call confidential but also that the person answering the phone is someone who can identify with the military culture and experience and will know how to refer callers to service providers with similar knowledge. And one seemingly small but key aspect of the VCL/MCL program is that it provides public information on what to expect when making the call, including the exact language a caller will hear when the phone is answered (or the chat or text response for those contact methods). Given that fear of the unknown can be a significant barrier to help-seeking behavior, providing military personnel, veterans, and their loved ones with clear, easy-to-find and -understand information about what exactly will happen when they place the call is an important demystifying step.

Another component of the program is the Veterans Self-Check Quiz.[46] Created in conjunction with the American Foundation for Suicide Prevention, it offers a safe, easy way for an individual to learn whether stress and depression might be affecting them. The quiz takes less than 10 minutes to complete, and it is reviewed by a chat responder who will then leave a personal response offering options for follow-up in a secure website, usually

within 10–15 minutes. The individual who completed the quiz then decides what to do next. They can continue talking with a responder through the chat without identifying themselves, get a referral to see someone in person, or decide to do nothing further at that time.

The MCL itself is actually serviced by the National Suicide Prevention Lifeline, with military or veteran callers told to press 1 when they call to reach someone who will understand their unique needs and the service networks they have access to. The U.S. Substance Abuse and Mental Health Services Administration launched the Suicide Prevention Lifeline on January 1, 2005. Vibrant Emotional Health, the administrator of the grant, works with its partners—the National Association of State Mental Health Program Directors, National Council for Behavioral Health, and others—to manage the project along with Living Works, Inc., an internationally respected organization specializing in suicide intervention skills training. And its work is independently evaluated by a federally funded investigation team from Columbia University's Research Foundation for Mental Hygiene.[47]

Crisis lines for law enforcement

In our interviews, we received specific and useful feedback regarding the specific needs of the law enforcement community. There are obstacles to using services that are unique to law enforcement, both culturally and structurally, and any expansion or support of crisis lines for law enforcement personnel should take these into account.

A recurring theme in our interviews was the pressure that shift work places on normal access to services. For example, an officer working the night shift may not be able to get to a doctor's office in normal working hours for preventive care check-ups. If the officer has a co-parent who works during normal working hours, it can be extremely difficult for either parent to take a child to the doctor. Multiple interviewees remarked on the importance of access to health and mental health services 24 hours a day; crisis lines can operate 24 hours a day. In addition, they are location-independent. This means that an officer can access a crisis line without being physically present and ensure total anonymity for callers.

Many of our interviewees were from larger agencies. When asked what resources they needed to ensure officer mental health and wellness, we received a surprising and near-unanimous response: Focus on smaller agencies. A representative from a national organization said, "Every large agency is connected to crisis services." A chief from a major city department said, "Honestly, the large agencies can take care of their own. If Congress is going to take action, we'd advocate that resources focus on smaller agencies that can't afford their own programs." An urban district sheriff said, "I'm more worried about the doughnut districts, frankly. We're fine, but the surrounding counties don't have the resources or the manpower."

Firefighters and emergency medical technicians (EMT) have a dedicated national crisis line[48] supported by the National Volunteer Fire Council. Rigorous data are collected on firefighter and EMT suicides by the Firefighter Behavioral Health Alliance.[49] The centralized services and data collection help to provide the most useful interventions. The disaggregated nature of state and local law enforcement more closely mirrors that of the fire service but as practiced puts the onus on each department to provide services and many are simply without the resources to do so.

Interviewees repeatedly made the point that it is difficult for an officer to open up to someone who might not "get it." Working in law enforcement exposes officers to very specific stressors, and while a well-intentioned councilor can sympathize, he or she may not be able to empathize. Anecdotally, we were told that officers are more likely to reach out to peers, especially if there was a good departmental culture around mental health and wellness. However, the anonymity of a crisis line may be appealing to an officer who is personally concerned about speaking about mental health within the workplace. Crisis lines staffed by law enforcement or former law enforcement officers could be an optimal entry point for officers experiencing a mental health crisis. There are currently two operational crisis lines focused exclusively on law enforcement: Cop2Cop and Copline.

Cop2Cop, which is featured in the case studies report, was launched in 1998 as a joint effort between the State of New Jersey Department of Human Services Division of Mental Health and the University Behavioral Health Care unit at Rutgers University.[50] It was the first program of its kind. The hotline is always open, staffed by retired law enforcement officers, and available to officers and their families. The program was later expanded to include all first responders.

Copline was started in 2006 to take the core concept of Cop2Cop national. Copline is similar to Cop2Cop: It is operational 24 hours a day, seven days a week; it is staffed by retired law enforcement personnel; and it is confidential. Unlike Cop2Cop, which is publicly funded, Copline is a registered nonprofit. It has attained an international presence.

Recommendation 9. Support the expansion of crisis lines for law enforcement that are staffed with call-takers and counselors with a law enforcement background.

Interviews and anecdotal reports suggest that law enforcement officers may be more willing to engage with counselors who have also worked in law enforcement. We suggest that crisis lines for law enforcement be staffed, to the highest degree possible, with counselors who come from a law enforcement background. Specialized training will be required for counselors with and without law enforcement experience.

Counselors with law enforcement experience will require training in mental health crisis response. While some law enforcement officers receive a good deal of training in mental health crises, this training is from a public safety standpoint. They will need to retrain as counselors, and appropriate trainings need to be identified. Research demonstrates that crisis line workers are more effective when they have more experience. A large-scale study from Canada and the United States demonstrated that there was no significant difference in call outcomes between paid professional counselors and volunteer counselors. Instead, counselors who had more than 140 hours of call experience had significantly better outcomes on calls.[51] Furthermore, counselors who demonstrated empathy and respect had better call outcomes.

Counselors without law enforcement experiences may be necessary and useful. Whether serving as specialists or general responders, civilian counselors will need to retrain on their specific population. Possible opportunities include ride-

alongs, time spent embedded in a department, specialized trainings, or other options entirely. Experts should be engaged to design and test effective trainings for civilian counselors.

Recommendation 10. Consider support for a national crisis line for law enforcement.

If Congress chooses to support crisis lines as an intervention for law enforcement mental health crises, support should be provided for a national crisis line. The deference shown to the needs of small, rural, and geographically diverse departments by all of the interviewees indicates that any measures to expand crisis lines should include and in fact be designed around the needs of underresourced departments. Therefore, any crisis line expansion should be national in scope, as should data collection efforts. All state and local law enforcement agencies should have access to lines. Department leadership should be briefed on what the lines offer and how they can support departments.

Critically, the crisis line should offer not only crisis counseling but also referrals to vetted local providers. One of the great successes of the VCL is the national scope that allows its counselors and specialists to make direct referrals to vetted local suicide prevention coordinators so clients and callers ready to engage with services can connect with appropriate and available care. Removing obstacles to engaging with care increases the likelihood of engaging with care. In the same study that studied volunteers, only 42 percent of callers who committed to seeking care followed through.[52] If crisis line counselors can refer to vetted local service providers, those referrals may save lives. Whether that means expanding the VA's model of piggybacking on the infrastructure of the National Suicide Prevention Lifeline, or creating a parallel service, or expanding statewide programs like Cop2Cop to all states and territories, enabling counselors to refer callers to local services is of critical importance to expanding crisis line access.

Mental Health Checks

The general public has been taught to believe that regular well-patient visits with a doctor are important not just for early detection of potentially serious physical issues but also for simple routine maintenance of health. Similarly, semiannual prophylactic dental cleanings are understood to keep teeth healthier and safer than they would be if the dentist only saw the patient when something was observably wrong. Likewise, research demonstrates the usefulness of check-ups and check-ins to screen for unhealthy behaviors such as substance abuse.[53] The idea behind recurring mental health check programs that have been adopted by some law enforcement agencies is similar: Practice routine observation to improve early detection or even prevent serious mental issues.

Research does not conclusively support comprehensive routine physical exams for asymptomatic adults. As far back as 1981 the American College of Physicians noted that "present data are not adequate evidence justifying annual complete examination of the asymptomatic patient at low medical risk."[54] And as recently as 2013 in a metaanalysis of 14 randomized trials comparing health checks to no health checks, researchers found that the health checks did not reduce morbidity or mortality whether overall, cardiovascular, or cancer-related.[55] And for mental health checks for the otherwise asymptomatic adult, the evidence is simply not known. It may seem intuitive to some that preventive mental health care is likely to be helpful,[56] and there appears to be increasing acceptance of mental health checks as an effective approach for mitigating the emotional rigors of a career in policing. However, in-depth research on the benefits of such care and the most effective methods for implementing mental health check programs remains to be conducted.

At the same time, the stress of police work is well known. Speak with any veteran police officer and they will be able to share work-related experiences that are incomparable to those in most other professions, that had a significant psychological impact on them, and for which they never received counseling or professional support. Anecdotally, there is broad understanding within the field that alcohol abuse, divorce, hypertension, and depression are occupational hazards that equal or surpass threats of violent encounters posed by patrolling and fighting crime. The data also support this reality. In 2017, 46 officers were fatally shot in the line of duty while more than three times as many died by suicide.[57] So law enforcement officers may not universally qualify as asymptomatic patients at low risk; they may therefore benefit from proactive screening.

Despite intense demands on their psyches, law enforcement officers' mental health needs are often overlooked until a response is necessitated by negative behavior or a significant event. Even when resources are available, many officers will not seek help voluntarily—either because they do not recognize their need for emotional support or because of the strong stigma in American policing associated with seeking emotional support.

> "In police culture, a major obstacle that impedes the maintenance of psychological health is the stigma attached to asking for help. Law enforcement culture values strength, self-reliance, controlled emotions, and competency in handling personal problems. These values discourage help-seeking behavior, and there is a sense of having lost control by asking someone else to help fix the problem. If these values are held too rigidly, an officer can feel weak, embarrassed, and like a failure for seeking help from others. One study found

> that stigma and help-seeking attitudes were inversely related. In other words, a person facing a higher level of stigma for seeking help was less likely to have a help-seeking attitude. This generates concern for officers who unconditionally conform to the traditional values of law enforcement culture—they will be more likely to avoid seeking help, even when distressed, and potentially pay the price of detrimental health effects."[58]

This situation is slowly improving, but there is still a long way to go. One expert interviewed said, "There are obstacles to officers seeking the help they need. Number one is stigma—the fear in seeking help. The field has done a lot better recently at getting away from its culture that stigmatized needing any kind of help. But we now need to help officers understand that needing help is not a weakness and that getting help does not put their future assignments in jeopardy."

Officers can be fearful of being considered weak or untrustworthy; concerned that seeking help will lead to sanctions or loss of professional opportunities; or wary of other perceptions. In these instances, officers are often unlikely to seek help even privately—doubting their treatment will remain confidential or be understood.

Their fears may not be without merit; some departments have policies requiring mental health treatment be reported, especially if it involves medication. Even when that is not the case, the small and communal nature of many departments, along with regressive attitudes about emotional health, can render stigmatization a real threat.

When stigma does not prevent an officer from seeking support, self-recognition and access to services can also present challenges. While effective in some situations, a reliance on voluntary referral causes some officers to fall through the cracks. The result: Law enforcement supervisors, mental health providers, fellow officers, and family members are often unable to identify the need for emotional support or services before a debilitating effect on the officer is evident.

There is no large-scale or sufficiently rigorous research on the efficacy (or lack thereof) of mental health checks—at any regular interval—for law enforcement professionals. It has been suggested that even without evidence of their efficacy, proactive mental health checks have become a growing practice among first responders. In the 2017 employee assistance program (EAP) manual for employees of Barnes–Jewish Children's Hospital in Boston, Cynthia Hovis writes, "First responders, police, fire departments, military personnel, and medical staff started the practice [of annual mental health check-ups] in recent years."[59] The National Surveillance of Police Suicides study conducted by the Badge of Life Police Mental Health Foundation "tentatively attributes [an 11-percent drop in police suicides in a four-year period] to . . . 'the increased willingness of officers, many of them younger, to seek professional assistance'–not only when they have a problem but also through preventive measures such as annual mental health checkups."[60] But these discussions do not point to particular programs or to organizations that use them. There is no formal indication of how many U.S. law enforcement agencies have implemented mental health checks or even a clear picture of just what such checks entail, but among law enforcement executives and clinicians who specialize in supporting law enforcement officers, they are a slowly increasing approach to prophylactically mitigating the inherent stress of the profession rather than waiting for problematic symptoms to appear.

LEMHWA specifically referred to annual checks, but some interviewees noted that even less-than-annual periodic checks that take into account key career transition points may be just as effective; the support for this concept in the field is based on

a desire to assess mental and emotional wellness regularly, not just at a hiring screen and then in reactive checks following critical incidents.

Mental health checks are typically conceived as a mandatory process of having officers meet with a clinician, members of an internal peer support team, or supervisors to discuss aspects of the officer's work that need emotional navigation. The approach used varies by department, with some focusing on operational debriefings while others look to preventive screenings. For example, in Mundelein, Illinois, a new wellness program implemented in late 2018 requires police officers to meet with a psychologist annually in addition to their physical fitness exam.[61] But mental health checks are distinct from pre-employment screening, fitness-for-duty evaluations, or structured psychological counseling. "'It's not meant to be a fit for duty examination or a head check,' [Police Chief Eric] Guenther said. 'It's really meant to be an outlet and a conversation and a source for coping mechanisms.'"[62]

There is also an increasing belief in the potential need to expand mental health checks to civilian staff, given the recognition that the stress of working on police-related matters and the aftermath of critical incidents also impacts dispatchers, crime scene technicians, and victim advocates, and other nonsworn staff.

Advocates of implementing mental health checks believe they can be beneficial in several ways. When they are a requirement for all officers, they can significantly reduce stigma associated with engaging in discussions about stressful aspects of the job. Chief Guenther of the Mundelein Police Department noted that voluntary check-ins with a police psychologist were ineffective because nonrequired check-ins seldom took place at all. "There's too much pride in this profession. You have to be the big tough cop, right? And you can't be seen as being weak."[63] In departments that make mental health checks mandatory for all officers or for specific units, engaging in discussion about stressors is less likely to be perceived as the exclusive domain of officers unable to cope with the demands of the profession or who are considered to be at risk. Moreover, the challenge of having officers independently recognize when they may need to seek support is reduced. Mental health checks may essentially infuse nonclinical services into the department and help identify those in need of structured treatment.

When conducted in group settings, mental health checks are often viewed and positioned as group "rap sessions" rather than a one-on-one opportunity for officers to share any individual concerns in a safe, nontreatment setting. Group sessions are believed by some to have positive benefits. They can enable positive peer influences and create understanding by officers that the challenges they face are not unique and do not stem from individual shortcomings. Group mental health checks can also encourage ongoing positive peer exchange and normalize the understanding that stress requiring attention is an inherent part of the profession.

Approaches

Some law enforcement agencies have mental health checks exclusively following stressful incidents when there is a perceived need to assess or respond to the emotional state of officers, and others implement regularly scheduled mental health checks as an ongoing approach for supporting officers or identifying those who may benefit from structured treatment. Mental health checks are sometimes implemented for patrol units, specialized units (e.g., SWAT, Violent Crimes Task Force, child welfare, sex crimes, etc.), or for all sworn officers within a department. The approach used varies by department.

Immediate post-incident mental health checks

One of the more reactive approaches for conducting a mental health check program often borne out of incident-driven necessity, or one aspect of a more comprehensive mental health program, is a post-incident mental health check. This form of a mental health check process or program is often viewed as a type of psychological first aid. The goal of this approach is to ensure that an officer's emotional state is observed and considered immediately following a critical incident and that an officer's need for support does not compromise the department's level of service.

Departments typically assign a mental health incident commander to oversee officer mental health. This individual may serve in this role for only a few days while a more extensive mental health response is organized. Alternatively, they may be the only person dedicated to supporting officers following an incident. The person is usually a trusted police psychologist, a licensed mental health professional, a licensed employee assistance provider, a member of the department's command staff, a departmental chaplain, or the appropriate officer from a neighboring department.

The mental health incident commander's responsibilities typically include the following:

- Monitoring officers' behavior and verbalizations on scene to determine if anyone needs immediate assistance
- Ensuring that a mental health provider or supervisor checks in with *all* officers involved before the end of shift
- Being available to consult with the chief and command staff as appropriate and permissible by policy
- Sharing information about available mental health resources with officers and connecting with officers' family members if needed

Recurring mental health checks

Recurring mental health checks are typically scheduled at regular intervals to provide officers and civilian staff with an opportunity to speak to a trusted and qualified professional with whom they can share any concerns. It is most common that the individual conducting the mental health check be a licensed psychologist who can identify officers in need of counseling and has the ability to provide informal psychological support for minor challenges that an officer may be experiencing.

There is evidence of regular mental health checks being mandated as often as each quarter and as seldom as annually. Some departments also structure their program by scheduling regular hours each month that a mental health service provider is available on premises and allowing officers to voluntarily check in. Other departments' mental health checks are conducted in group settings rather than one on one. Mental health checks typically last between 30 and 90 minutes and provide officers an opportunity to address any issues the officer chooses while not requiring disclosure of concerns. Regardless of the approach, there are some common expectations of recurring mental health check programs:

- Providing officers with readily available access to a professional who is able to support minor challenges they are confronting

- Identifying officers who may be in need of structured counseling or support and working with those officers to provide them with appropriate resources
- Reducing the stigma associated with counseling and accessing services and encouraging officers to focus on their emotional wellness
- Familiarizing officers with a mental health professional so if the need for structured services arises an officer is more likely to engage with that familiar professional
- Helping the practitioner develop a working understanding of the department culture and officers so they are best prepared to provide culturally competent support when the need inevitably arises in the future
- Fostering a culture of emotional wellness within the department and advancing the understanding that high levels of stress are an inextricable part of the profession and are best navigated proactively

U.S. Department of Defense remote mental health check

In an effort to ensure the mental health readiness of military service members preparing to deploy, the DoD, as prescribed by the National Defense Authorization Act of 2010 (Public Law 111-84, 28 Oct 2009, Title VII Health Care Provisions, Section 708), mandates the provision of a "person-to-person" mental health assessment for each member of the Armed Forces deployed in connection with a contingency operation (hostilities against the United States).

For reserve units and their members who do not have readily available access to military healthcare providers before they are called to active duty for deployment, the DoD has implemented the Reserve Health Readiness Mental Health Assessment Program. This mental health check program can be conducted remotely but still ensures a face-to-face mental health assessment. The process includes three stages and is concluded only upon the deploying reservist interacting directly with a trained service provider. This interaction can occur face to face, telephonically, or via a DoD *Telehealth* videolink.

The first stage is a self-report survey that screens for post-traumatic stress disorder (PTSD), depression, stress, alcohol abuse, suicidality, and problematic family relationships and is submitted to remote assessors. If the first stage does not show any areas of concern upon assessment, reservists bypass the second stage and proceed to the third stage, which is the in-person assessment.

The second stage is required only if a reservist's initial self-assessment shows potential areas of concern. This stage is a follow-up self-report survey that further queries the reservist about PTSD and depression symptoms and establishes a more informed evaluation by the trained provider during the third stage.

During the third stage, as part of the in-person assessment, the provider reviews and clarifies the reservist's responses, identifies areas of concern, and refers the reservist for specialty care as appropriate.

While there are aspects of this approach to a mental health check that could be replicated for departments that have limited resources or face other factors that prevent the implementation of an in-house program, there is no guarantee that this approach will fit law enforcement. Preparing reservists for extended deployments away from their jobs, homes, and the protective factors of

their families and communities is a different goal than ensuring the continued wellness of law enforcement officers in the course of their career.

Suggestions for furthering mental health checks in law enforcement

Recommendation 11. Support research to determine the efficacy of mental health checks, establish which approaches are most effective, and provide resources that move law enforcement toward best practices.

The acceptance and support for recurring mental health checks as an integral part of a comprehensive mental health program is based largely on the vision of law enforcement executives and expertise of the clinical professionals with whom they collaborate. The result of these efforts has been the emergence of a call for a proactive method for bringing meaningful support resources to officers in a manner that reduces stigma and helps embed a focus on emotional wellness. However, it is important to ensure the process is defined and understood by everyone involved. One former chief we spoke to noted that in his last department, "our psychologist did periodic evaluations"—i.e., mental or emotional assessments at regular intervals—"for officers in vice, narcotics, [and] SWAT and for people in long-term specialty assignments, but *I wouldn't characterize those as . . . mental health checks*." (Emphasis added.) Providing clarity about what works and how federal, state, and local agencies can implement effective programs is a substantial need. It is equally if not more important to identify the most effective methods for conducting a mental health check program and ensure that any intervention is not unintentionally harmful to officers. Formal research and guidance for the field would ensure that limited resources are spent responsibly and effectively. Even a modest investment in pilot sites could provide critically needed data before large-scale implementation funding is committed to programs of questionable efficacy. This is also true for the initial hiring screening process, where, as one interviewee noted, universal and clear clinical guidelines based in research are needed to determine a person's ability to safely perform the essential functions of law enforcement work. People applying for law enforcement jobs are not blank slates—they bring with them their past experiences and, in some cases, diagnosable conditions—but those need not always be disqualifying.

Recommendation 12. Consider methods for establishing remote access or regional mental health check programs at the state or federal level.

Once research has identified promising models for mental health checks, there will inevitably be many law enforcement agencies that will not have the capacity or local access to the necessary professionals to implement an effective program (whether preventively or post-incident). In these instances, having access to a program that allows for remote assessment and engagement with mental health professionals has potential. When the appropriate mental health professionals are not available for an underresourced, rural, or very small department—or simply to gain scales of economy—remote access and regionally oriented programs that serve multiple jurisdictions may be of benefit.

However, for such a program to develop resources, incubation and a collective focus is required. Entities that work at the federal, state, or possibly regional level are best positioned to advance this concept and convene the level of support needed to be effective.

Peer Mentoring Programs

The benefit of the peer in the facilitation of counseling has been well documented for many years in a variety of settings. As long ago as the late 1960s, the mental health profession saw an advantage in peer counseling when C. Eisdorfer and S.E. Golann advanced guidelines for the use of peer counselors in the mental health field.[64] Research has shown that paraprofessionals, which is what a trained peer mentor is relative to a behavioral health practitioner, "frequently achieve clinical outcomes equal to or better than those obtained by professionals."[65] Peer counseling has also been shown to have an effect in the treatment of addictive behavior such as alcoholism.

Peer support and mentoring programs in law enforcement agencies are also not new. Some agencies began making use of peer support in the early 1970s, earning recognition as models for crisis incident management. For example, L.N. Blum has described how in in 1974, the Portland (Oregon) Bureau of Police began a program called the Traumatic Incident Corps. It was established when the department observed that some officers who had been involved in traumatic incidents were still suffering the results of the trauma experienced during those incidents. They saw behaviors such as alcohol and drug abuse, violations of law and departmental policy, and insubordination. Looking to improve how the department dealt with these officers, the bureau turned to other officers who had themselves been involved in trauma.[66] The Boston Police Department also started a critical incident stress peer support program in 1974. Initially similar to what was taking place in Portland, as the program became more effective its scope was expanded to include addressing stress that resulted from employees' financial situations, marital problems, department layoffs, and administrative policy changes.[67]

Current practice

Today, peer-led critical incident stress debriefing (CISD) is widely used in law enforcement agencies in the aftermath of traumatic incidents. Caring for other human beings in a crisis can be incredibly challenging and lead to secondary traumatic stress, so agencies' efforts to help officers process their own emotional reactions are important. However, the evidence to support critical incident debriefing programs as part of preventing secondary traumatic stress is subject to the implementation model used. A 2002 metaanalysis published in the *Lancet* found that Critical Incident Stress Management (CISM)—the most common program model implemented in a variety of first responder fields—was no more effective than no intervention at all in preventing the development of PTSD.[68] This does not mean all CISD practices are ineffective but that it is important for agencies to understand there are different models and protocols for CISD and the choice of protocol matters.

There are also many peer programs that provide support for broader purposes, helping officers struggling with any aspect of their lives that may affect or be affected by the job or even being used to promote healthy lifestyles to all officers. This variety of uses can be seen in a number of the case studies that accompany this report. This use of peer programs to improve overall wellness is also backed by evaluation research: Peer-led health and safety trainings have been shown to have a positive effect on the targeted lifestyle behaviors.[69]

Where peer support programs exist in law enforcement agencies, they succeed because the peer volunteers understand the job of those they seek to support. They do the same job, or they did earlier in their careers. They have also been there, in the same place as the officer in need

of support. This makes them usually much more accessible than a behavioral health professional. "This availability, coupled with a greater ease of interaction, may give the peer the edge needed to do extremely effective intervention in times of crisis. Peers are equals. They would be confidants even if they were not crisis interveners."[70] This is also why peer support programs may exist even when agencies have other EAPs. An EAP may offer many of the same services, but it might not be located where the officer is, or available 24 hours a day, or be staffed with people with direct law enforcement experience.

This is not to dismiss the EAP as a valuable tool in a holistic and multimodal approach to wellness and resiliency. As one individual noted in an interview for this report, while there may be poor EAPs out there, in general they likely have an undeservedly negative reputation and one that is most likely perpetuated by people who have never made any use of an EAP. But he added, "I like to tell people that [in my experience] you cannot raise three teenaged daughters and not use [the] EAP."

Peer support programs are sometimes under the auspices of chaplaincy programs, which some interviews noted can help reassure officers that their engagement with the program will be kept confidential. And chaplaincy programs are an important piece of wellness support in agencies even when they are not connected to peer support programs. But even when programs are housed elsewhere, clear confidentiality rules are important to their success. The team that worked on the mental wellness case studies found that an occasional downside of efforts to ensure confidentiality is that these important programs don't always keep the types of statistics that can help demonstrate performance success that can be necessary to securing ongoing funding. Another challenge one individual noted was that "there can be perceptions [among command staff] of peer mentoring programs not holding people accountable." He went on to note that there are questions about how much do you invest in a person who may ultimately be disciplined as a result of their actions, but that "I think you can take a general approach of separating the person from the employee and balance confidentiality and assistance with accountability by considering the egregiousness of behavior." And the more clear policies are up front, particularly in terms of what lines cannot be crossed no matter what, the better.

Recommendation 13. Support the expansion of peer support programs to ensure all officers have access to this important wellness service.

Whether as the entry point to professional psychological services or as the end point for career and life advice, it is clear that law enforcement officers value peer support programs and that they are critically important to officers' well-being. Research on organizational connectedness has shown that the quality of peer relationships and organizational support of them are correlated with self-reported stress among officers, making both formal and informal peer networks critical to both organizational and individual resiliency.[71] One interviewee also suggested that ongoing career mentoring can serve as a type of mental health check-in.

And these efforts need to be led by officers whom people in the organizations trust and admire (working in consultation with professional behavioral health specialists). Command-level endorsement of the idea of taking care of yourself both physically and mentally is important, but it does not exceed the importance of the program being perceived as independent of management. Multiple interviewees noted that quiet but consistent support from senior leadership was critical to program success but that care must be taken so that command staff are not seen to be the ones pushing or forcing employees to use the

services. The drive to use services comes from peers or immediate supervisors. Modeling the use of services can be important for senior leaders to do, however, as part of the process of normalizing help-seeking behavior. The inclusion of retirees in the peer support network can also improve perceptions of independence.

Recommendation 14. Support the expansion of peer programs to include broader health and wellness, not just critical incident stress.

Even for agencies that have peer support programs for those involved in critical incidents, serving in certain types of assignments, or involved in shootings, there is room to grow the programs to cover a wider range of issues—both personal and professional—that can impact officers throughout their careers. Peer programs that are involved in stress management training and mentoring young officers as well as assisting with advice on things like sleep, nutrition, finances, marriage and child rearing, balancing a career with caring for elderly parents, and all the other things can affect the officer on the job can raise their presence and profile with officers. Not only does this help show officers that they matter—that they are valued as people as well as employees—but it can also help break down the stigma of seeking assistance when in crisis. Reaching out to peer mentors you already know is always going to be easier than reaching out to strangers.

Obstacles to adoption

But despite the longstanding practice and available evidence on the efficacy of peer support programs, they are not ubiquitous, and some departments face ongoing challenges to supporting well-trained peer programs. For very small agencies, the perception of confidentiality can be difficult to achieve even if there are strong peers in the department and the means to train and support them. For larger agencies, maintaining the network of peer mentors can be a challenge. It can be demanding work in its own right—so the peer mentors themselves need ongoing training and support. As departments appear to be moving in the direction of more holistic wellness programs, this movement may address the increasing demands of peer mentors risking exceeding the time and expertise of any one individual, particularly for those who are volunteering to serve their fellow officers in addition to their regular job duties.

Recommendation 15. Support alternative models to agency specific peer programs, such as through regional collaborations or labor organizations.

Part of the support for expansion of peer support programs should also explore alternative models for administering programs. For example, regional programs could be used to assist smaller agencies who may be unable to support an in-house program. In a regional or statewide effort, volunteers from multiple departments or even networks of retirees can provide peer support services to a broader area. This type of regionalized effort still allows for the program to be a bridge to locally available professional services when appropriate. It also can encourage trust in confidentiality by allowing officers to seek assistance and advice from a peer who can understand the experience without being a coworker in the same small department.

Rank-and-file organizations and labor unions may be a vehicle for delivering this type of non–agency based model of service delivery. More than one interview noted that in places where labor unions have contracted their own EAP providers the arrangement has generally been a positive development—helping to offset some of the general suspiciousness around confidentiality that officers have. In fact, regardless of where a program is housed, labor organization support and

engagement is critical. When new programs are created, perceptions of the owner or champion of the work can make or break program success. When labor organizations endorse programming and local providers, officers see those services as being for them.

Recommendation 16. Support training programs for peer mentors for peer support programs to expand.

Agencies need to make serious investments in selection, training, and oversight of formal peer mentors.

Peer mentors need to be nonthreatening and confident in being able to recognize the signs of problems because people aren't generally good at identifying their own. Training is particularly important to building programs that are not single modality efforts. Not all approaches and treatments work the same for everyone, so comprehensive programs that can help officers find the right treatment fit for their needs is also important. Building programs that are trusted to assist officers in need but not viewed as overriding agency needs to hold people accountable to their own behaviors is also a balance made easier by having well-trained peer mentors with behavioral health professionals supporting their work.

Peer mentor training is not a single event but an ongoing investment in the program and its peer mentor staff, whether they are departmental employees or local retirees. Ensuring that peer programs have access to training that they can be sure is relevant and useful in a law enforcement context is critical.

Any support for the expansion of peer support services within agencies also must not overlook the need to support the peers themselves. It can be emotionally draining and demanding work to help those in crisis—and peer supporters are not themselves behavioral health professionals. Programs need to consider the long-term exposure risks of retraumatizing experiences and ensure consulting relationships exist with psychologists, psychiatrists, or other mental health experts. This is particularly important for programs that identify peer mentors based on their previous experience with critical incidents, such as when support officers in shooting cases must have experienced a shooting themselves. While this experience can be invaluable, it can also lead to additional trauma for the mentor.

Recommendation 17. Remember all the types of agencies, including federal, when supporting peer programs for law enforcement.

Often when we think of law enforcement, we focus on the state or municipal officers we see on patrol on our highways and in our neighborhoods. But thousands of law enforcement professionals are sheriffs' deputies who work in courts and corrections. Many other officers are assigned to special units like homicide, sex crimes, narcotics, and others, sometimes working undercover. While many of the same stressors and health impacts exist for these officers, there are also others, particularly for those working in jails. Federal law enforcement officers face similar stressors and risks, but in a different work environment. Efforts to expand peer support programs for law enforcement need to cross all types of law enforcement. Support to expand programs in federal agencies may look different than similar efforts in state, local, or tribal agencies. Regardless of setting, the basic principles are the same: Provide support where officers are, be responsive to the experiences of officers, and support the whole health and wellness of officers.

Additional Recommendations to Support the Mental Health and Wellness of Federal, State, Local, and Tribal Law Enforcement Officers

This report primarily sought to respond to the specific matters raised in LEMHWA, namely around peer support, crisis lines, annual mental health checks, and potential models from the DoD and the VA that could have applicability in law enforcement. However, in the course of conducting the research and consultation necessary to that task, we identified some additional broader themes concerning support for the mental health needs of law enforcement. In this section we look at the importance of privacy protection and resilience training, the needs of civilian support staff, and the benefits of whole-health approaches to officer wellness.

Privacy considerations are key to the success of peer-led programs

Protection of their privacy, both internally in a department and externally, is a major concern for officers seeking mental health care.

Internally, officers may face ridicule or professional scrutiny for engaging with what one interviewee referred to as "the sad clown club," also known as the departmental mental health offerings. One interviewee said, "Every department will say that they have an EAP, but unless you have a departmental culture of mental health and wellness, it is an open secret that getting help can jeopardize your job." Officers are aware that there is a departmental liability to fielding officers with ongoing mental health concerns. A federal interviewee said, "There are always agents who are simply going to pencil-whip the fitness-for-duty assessment. You can't really prevent that." Although all officers understand the importance of medical and psychological fitness for duty, undue pressure within a department may keep officers from seeking help, preferring to appear as fit as possible and return to active duty in the shortest possible time. Other officers may have financial commitments that make the risk of unpaid time away from work untenable. Education, clear policy, and consistent processes may help officers take personal responsibility for their fitness, rather than hiding concerns that can be treated successfully and confidentially without endangering their employment.

Externally, officers are public servants. Unless the strictest privacy standards are maintained, an officer's mental health care may be discoverable on the public record, be used in court proceedings, or affect employment eligibility. One federal interviewee said that his component had been making aggressive efforts to limit the impact that mental health treatment has on procedures such as background checks for security clearance so that agents would not avoid treatment for fear of curbing career advancement.

HIPAA, the Health Insurance Portability and Accountability Act of 1996, is what most people think of as protecting their personal health information from public disclosure. But not everyone is a HIPAA-covered provider—it applies to doctors, psychologists, clinics, and pharmacies as well insurance companies and government-funded programs like Medicare, Medicaid, and veterans' health programs. It does not apply to peer-run crisis lines or in-agency peer support programs. Clergy-penitent privilege prevents clergy from being required to disclose confidential communications in a court proceeding, and that is why some peer

support programs are run out of chaplaincy offices in law enforcement agencies. But not all programs can realistically be managed and maintained by ordained clergy, and there is no guarantee that privilege would extend to lay staff working under a chaplain's purview.

Even if most people are not aware that speaking with an employer-run crisis line or peer program has no privacy guarantee, all of our interviews made it clear that officers are. And if law enforcement officers are going to be encouraged to call peer crisis lines or make use of other peer-support services, they will need to know that what they say will be kept confidential. They need to have confidence that what they say will not be subject to public disclosure either to their chain of command—possibly jeopardizing their career—or subject to discovery in judicial proceedings, possibly jeopardizing both themselves and their agency.

Knowing that the public can potentially access sensitive personal information may ultimately deter officers from seeking treatment. This may be of particular concern for smaller jurisdictions—most especially tribal communities—where there are limited service providers and other natural limits on privacy.

Recommendation 18. Improve legislative privacy protections for officers seeking assistance from peer crisis lines and other peer-support programs.

Very few states offer this kind of privacy protection for crisis lines and other programs run by agencies or active duty law enforcement volunteers. In 2009 Washington State enacted legislation saying that "All communications to crisis referral services by employees and volunteers of law enforcement, correctional, firefighting, and emergency services agencies, and all records related to the communications, shall be confidential."[72] Unsurprisingly, there are multiple public safety crisis lines with referral services based in Washington State. Indiana enacted legislation effective in 2017 that exempts critical incident stress management service communications from being subpoenaed.[73] Illinois introduced similar, but more expansive, legislation that would create the Law Enforcement Support Program Confidentiality Act. If passed, this law would have

> "[Provided] that information, omissions, confessions, or other communication obtained by a participant in a peer support program involving a peer support counselor from a law enforcement officer, public safety employee, peace officer, firefighter, or emergency services personnel shall be considered confidential information and shall not be released to any person or entity, including, but not limited to, a court, administrative agency or tribunal, or public officer or employer, unless: (1) to the extent it appears necessary to prevent the commission of an act that is likely to result in a clear imminent risk of serious physical injury or death of a person or persons; (2) when required by court order; or (3) when, after full disclosure has been provided, the person who made the confession, admission, or other communication has given specific written consent."[§]

Guidance or model legislation is needed to ensure officers can make use of peer-run support services without fear of disclosure of private health information. Furthermore, efforts to expand the usefulness of peer-led support programs should be paired with efforts to collect meaningful data. Guidance is needed on how best to securely collect and protect vital data so aggregated and anonymized data can be collected and analyzed to evaluate program effectiveness.

§ This was in the enrolled language of H.B. 5231, 100th Gen. Assemb., Reg. Sess. (Ill. 2018) but was removed by amendment in final passage of Public Act 100-0911. It is expected that it will be addressed in the next session of the Illinois General Assembly.

Building resilient officers begins, but does not end, in the academy

Resilience is the ability to cope with and recover from stress, adversity, and trauma. One interview subject observed that while he had long thought about the need to hire resilient people to work in this demanding career, he has come to learn that resiliency may not be innate and that it definitely can be taught. Recognizing this, some of the departmental wellness programs featured in the wellness case studies (such as Indianapolis and Milwaukee) are housed in or attached to the agency's training facility. Another chief recounted that in his former departments he gave every recruit a copy of Dr. Kevin Gilmartin's book, *Emotional Survival for Law Enforcement*, and tried to always bring Dr. Gilmartin to speak to his academy classes about what recruits could expect on the job and how to mitigate the stress and trauma risks. His hope that was that these future officers would avoid the worst effects of trauma exposure, be less afraid to seek assistance, and understand the cycle of recovery from trauma exposure. "With this hopefully they never reach the point of self-medication or self-harm." And yet another interview pointed out that the work of people like Dr. Gilmartin and others are critical to reminding cops that they are "not just cops;" they are also people with relationships and interests and responsibilities away from the job, and those things are important to their ability to be resilient.

It must not be ignored, however, that it is difficult to promote and build resilience in stressed organizations. Since 2008, most departments have experienced resource shortfalls across personnel, equipment, and training, and many interviewees pointed out the ongoing pressure to do more with less impacts officer morale. This is combined with challenges of recruitment and retention that have been exacerbated by a national discourse that makes many officers feel that both their profession and their professionalism are undervalued. In this environment, the organizational climate adds stress to what is already recognized as one of the most stressful occupations. Research is beginning to show that law enforcement officers operating under stress may well be at greater risk of making errors that can compromise their performance and public safety.[74] In addition, the chronic stressors of police work can have a significant adverse impact on both physical and psychological health.[75]

But there is hope that developing stress resilience and self-regulation skills in officers can mitigate the negative effects of stress on decision-making.[76] In addition to learning to quickly regain their balance, both psychologically and physiologically, after intense moments on the job, officers can also be given tools to help them manage thoughts and emotions that come up long after incidents have passed. Data suggest that "training in resilience building and self-regulation skills could significantly benefit police organizations by improving judgment and decision-making"[77] and decreasing the frequency of on-the-job errors that can result in injuries, death, and even legal liabilities.

Recommendation 19. Support the identification, development, and delivery of successful resiliency training programs for both academy and periodic in-service settings.

There is a growing body of evidence in support of increased resilience training in the academy both in terms of understanding the risks and in teaching skills that can help mitigate exposure to stress. There are agencies—including some of those featured in the case studies report—that have begun to bring resiliency training in their academies and in-service training programs, but it is not universal. And in an academy setting these discussions are fairly academic, as the recruits have no on-the-job experience. So retraining on both awareness and skills throughout a career is also

key. It is generally accepted that health prevention interventions work best when there are follow-up refreshers to reinforce knowledge and skills.[78]

This training should include information on the physical effects of stress, skills to moderate the physiological responses to stress, the normalization of help-seeking behavior, and information on the benefits of peer support. Evaluation work of one such training model as implemented in Australia also suggests that training programs should focus on positive attributes—what they termed a "strength focused approach and narrative"—and the building of social cohesion among officers. This is supported by research that suggests that a sense of workplace connectedness is a vital protective factor against depression.[79] And this is also consistent with research that has taken place in law enforcement agencies that shows that organizational factors have a greater impact on individual's levels of stress than operational factors.[80] Particularly for federal, state, and larger municipal agencies that run their own academies, this promotion of workplace connectedness can begin in the academy setting where recruits are future co-workers.

While there are existing training programs that focus on the positive strengths of police officers and remind them of what motivated them to serve, and those training programs can be a starting point, they are most often applied as one-time trainings in either the academy or at a single point in a career. Additional support to build out training programs that support officers through the many phases of their career and refresh their skills in modulating their stress response is also important. In addition, the use of on-line training modalities for supplemental or refresher training may be an efficient way of providing large-scale reinforcement training for the more than 800,000 law enforcement officers working in this country at any given time.

Recommendation 20. Support training programs that promote the universal application of preventive interventions, including skills to manage stress.

In the preventive services world, interventions are generally classified as universal, selective, or indicated. The first applies to everyone in the population, the second to a group identified as being at greater risk, and the third to individuals who are symptomatic. Peer support and crisis lines primarily address the needs of the symptomatic. Critical incident stress management or other psychological health checks for trauma exposure for those in special assignments or present at major critical events address the selective population at specific greater risk. But whole career training speaks to the universal, and the use of this universal application has two potential benefits. First, there is a demonstrated population health benefit from the preventative application of information; individuals do not need to be suffering before exposure to treatment. Exposure may help those individuals better self-identify when they are in need of help in the future. They are more aware of the signs and have a better sense of what seeking help will involve. Second, universal exposure provides intervention for everyone, and no one is stigmatized.

A critical area for this universally applied training is in the area of teaching officers to manage their stress response more adaptively. Broader access to resilience training throughout a career is important because when individuals are under stress, the body's sympathetic nervous system response can be triggered, raising their heartrate, reducing the ability to think critically, and potentially leading to declines in operational performance. In light of a growing field of study examining how people working in high stress jobs can be taught to manage their response to trauma and stress through things like breath work, mindfulness, and meditation, support to greatly expand law enforcement's access to this is potentially a key

tool in a comprehensive approach to mental health and wellness. Those who make use of these self-regulation skills in their daily work can improve their job performance, their health, and their engagement with their personal lives.

Civilian staff must not be forgotten

To the extent that there is increased focus on mental health and wellness in law enforcement, it has largely been focused on the needs of sworn officers. However, as we were researching the provision of mental health services with law enforcement executives, membership organizations, clinicians, and others, there was a consistent prompting to ensure that the needs of civilian staff were not overlooked.

Quantifying and qualifying the provision of mental health services for sworn officers uncovered a scarcity of empirical findings. Looking into services provided for civilian staff of law enforcement agencies produced even less definitive information. The reason for this may be twofold:

1. Mental health and wellness services provided to civilian staff are hard to enumerate because their services are generally intermixed with the vast population of active municipal employees respectively. As such, they are empirically indistinguishable from all municipal employees.

2. Services for civilian staff can be unintentionally overlooked by policy makers given the lower profile nature of their responsibilities and status within law enforcement agencies, their relatively scant numbers compared to sworn officers, the perception that they are sufficiently distant from duties that cause mental health–related stress, and the fact that they generally are not supported by strong, profession-specific advocacy organizations.

Regardless of the reasons, there were numerous anecdotal arguments made during the development of this report that encouraged consideration of expanding services to include civilian employees.

Recommendation 21. Encourage departments to make support available to nonsworn employees on the same terms as their sworn colleagues whenever possible.

The civilian staff most often mentioned as warranting enhanced services were dispatch, forensic, and crime scene investigation staff. It was argued that they engage in the same incidents that cause stress for officers, just in a different capacity. It was also stated that the inherent inability for dispatchers to achieve situational closure for the more stressful incidents they encounter is a particular cause of challenges. Simply making wellness programs available to these civilian staff members may benefit their personal wellness as well as overall agency operational readiness.

Whole health programs are the goal, but there is no single approach that will succeed everywhere

Throughout this report, the focus has primarily been on mitigating mental health challenges inherent to a career in law enforcement. However, several of the experts consulted while developing this report and during previous convenings on officer safety and wellness saw mental health challenges as part of the continuum of inherently impactful aspects of a career in law enforcement.

Attendees at the October 2017 OSW Group meeting discussed factors that endanger officers' physical health. For example, they have little time to eat during their shifts and their diets may suffer. Shift work and overtime or the need to hold a second job may lead to inadequate sleep. Poor

nutrition coupled with lack of exercise can lead to obesity, diabetes, hypertension, and an increased risk for cardiovascular disease. These risks exist even before the emotional stress of the job is added into the equation.

Recommendation 22. The development of programs that promote whole health and officer resilience should be the goal of the profession.

The mutual dependency of physical and mental health is undeniable. In the case studies report, we see repeated evidence that successful officer wellness initiatives address a variety of physical health conditions alongside mental wellness components.[81] In interviews, police physicians reiterated several main areas of focus that should be given high priority in every law enforcement agency as the building blocks of officer resilience:

> "Tactical trauma care. Law enforcement agencies must have standardized equipment, including trauma care kits, and training in tactical trauma care such as hemorrhage control. When an officer is shot or otherwise falls victim to trauma, the first responder to the scene is often a fellow officer.
>
> Cardiac screening. The risk of heart disease appears higher among police officers than the general population and may be exacerbated by the acute surge of adrenaline that officers experience in critical incidents. When officers are not in good physical health the job is inherently more dangerous.
>
> Fitness. Lack of fitness is a health risk for officers and a liability for their agencies. Every agency should promote fitness goals for all of its officers. In addition, agencies should consider a benefit or reward structure for those who meet or exceed them.
>
> Overweight and obesity. The risk of shift work and having a sedentary job places law enforcement officers at higher risk of being overweight or obese, both of which increase the risk of heart disease and stroke and make the law enforcement officer less successful in certain job related performance measures.
>
> Emotional or mental health. On a daily basis, law enforcement officers see small traumas that, over time, can have as significant an impact as a major incident. This can lead to a higher risk of self-medicating behaviors such as alcohol use."[82]

The DoD and the VA clearly recognize the connectedness of physical and mental health, as together they provide a robust network of integrated programs and services for our nation's active duty and reserve personnel, our veterans, their spouses, and their children. These programs include the spiritual and the secular, the preventive and the reactive; they strive for as many points of access to service as possible. This network is built on the backbone of the TRICARE health care system and continues to evolve in ways that strive to reduce stigma, expand access, and meet the unique mental health needs of our military personnel and their families.

A similar array of evidence-based health, wellness, stress reduction, and resilience programs needs to be developed, supported by organizational leaders, and encouraged within all agencies. One model that agencies could be encouraged to look at is Total Worker Health, which addresses many of the issues experienced by officers as well as a litany of other challenges faced by their families and the public.[83] When this interrelatedness of physical and mental wellness is addressed by law enforcement agencies, that holistic attention will lead to healthier, more resilient officers.

Conclusion

Crisis lines, mental health checks, and peer and family support programs can be key components of effective law enforcement mental health and wellness programs provided they are appropriately researched and resourced.

Crisis lines are a promising part of the necessary suite of services required to support and sustain officer mental health and wellness. To be effective, they should (1) be staffed whenever possible by counselors with law enforcement experience, (2) be staffed with counselors trained specifically on the needs of law enforcement officers, (3) have adequate privacy controls both to ensure collection of good data and to protect the clients who call for service, and (4) enable referral to vetted local service providers for callers ready to engage with interventions. In addition, they should be studied aggressively so that the evidentiary basis for the practice may be demonstrated.

While there is no universally accepted structure for mental health check programs, examples of programs that are believed to be effective do exist throughout American law enforcement. They are conducted using various approaches—often based on the needs and interests of a department, the culture of a department, a department's budget, the stance of prevailing police unions, and other factors.

The beneficial effects of peer counseling in law enforcement have been documented in studies with both federal agents and police officers.[84] And key to the success of any peer support program is providing appropriate training and ongoing support and supervision for the peers. Careful identification and selection procedures for peers are also crucial. They need to be people in the agency whom other officers will trust and view as understanding. And they need to have links to mental and behavioral health professionals to be able to provide a bridge to more traditional care.

But even beyond these, some additional ideas from the DoD and the VA experience could be replicated in the law enforcement context. This report has looked to highlight some of the possibilities, but we do so recognizing that not every law enforcement agency or community is going to be starting from the same place. Interest in and support for expanding programs and services and for exploring comprehensive approaches to wellness are going to be important going forward. Many DoD and VA programs are supported behind the scenes by networks of clinicians and service providers. It is one thing to build the public campaign or the resource page or call line and encourage officers in crisis to use it. It is another thing to have a network of trained professionals behind the campaign, resource page, or call line where those officers can be referred for ongoing, affordable, and convenient care. And as the DoD and VA demonstrate, none of this is possible without a leadership mandate and broad agency support.

We would be remiss if we closed this report without speaking to why law enforcement–specific care is important and thank Congress for this opportunity to address this critical need. As was mentioned in one interview, "I don't know of another workforce that is more skeptical than cops," and that for mental health professionals working in this arena, "a cop is going to size you up quick and you risk being written off as . . . not able to understand the 'real' world they operate in." This is not a criticism of law enforcement officers; in fact, an ability to quickly assess a situation is exactly what we train officers to develop as a vital skill in keeping both themselves and their communities safe. But it means many practitioners we have spoken to have noted that

clinicians and behavioral health programs will only get one chance to make a first impression. And this perception is backed up by researchers who have noted that for a program to be sustainable, the focus needs to be on feasibility, acceptance to law enforcement community members, and attractiveness to providers.[85]

Put another way, ecological validity may be more important than scientific efficacy. Or, real-world perceptions are potentially more critical to program acceptance than evaluative outcomes. The use of law enforcement community–based participatory research to identify, design, and evaluate programs that support law enforcement wellness may very well improve the chance of program acceptance within the profession. And these efforts to bring researchers and clinicians directly into the world of law enforcement will only stand to increase their understanding of the unique nature of the job.

Congress clearly understands this important next step of educating clinicians on the climate and culture of law enforcement in order to increase program and service acceptance. Section 3 of the Law Enforcement Mental Health and Wellness Act states that "the Attorney General, in coordination with the Secretary of Health and Human Services (HHS), shall develop resources to educate mental health providers about the culture of Federal, State, tribal, and local law enforcement agencies and evidence-based therapies for mental health issues common to Federal, State, local, and tribal law enforcement officers." The DOJ looks forward to working with the HHS on this effort over the coming year, along with continuing its many other efforts to support the mental health and wellness of our nation's law enforcement officers. Increased information and educational materials for agency leaders and clinicians combined with increased support for peer support, crisis lines, mental health checks, and training as described in this report will greatly improve the health and wellness of the men and women who dedicate themselves to the public safety of all our communities.

Appendix A. Recommendations

1. Support the creation of a public service campaign around law enforcement officer mental health and wellness in conjunction with National Mental Health Month.

2. Support the development of resources for community-based clinicians who interact with law enforcement and their families to help them better understand some of the unique risks facing their clients and what resources may be available to them as members of the first responder community.

3. Support programs to embed mental health professionals in law enforcement agencies.

4. Support programs for law enforcement family readiness at the federal, state, and local level.

5. Encourage departments to allow retired law enforcement officers to make use of departmental peer support programs for a select period of time post-retirement or separation.

6. Support the development of model policies and implementation guidance for law enforcement agencies to make substantial efforts to reduce suicide.

7. Support the creation of a Law Enforcement Suicide Event Report surveillance system, possibly beginning with a focus on federal law enforcement agencies.

8. Support rigorous research that can evaluate the efficacy of crisis lines and, if supported, provide data toward considering them an evidence-based practice.

9. Support the expansion of crisis lines for law enforcement that are staffed with call-takers and counselors with a law enforcement background.

10. Consider support for a national crisis line for law enforcement.

11. Support research to determine the efficacy of mental health checks, establish which approaches are most effective, and provide resources that move law enforcement toward best practices.

12. Consider methods for establishing remote access or regional mental health check programs at the state or federal level.

13. Support the expansion of peer support programs to ensure all officers have access to this important wellness service.

14. Support the expansion of peer programs to include broader health and wellness, not just critical incident stress.

15. Support alternative models to agency specific peer programs, such as through regional collaborations or labor organizations.

16. Support training programs for peer mentors for peer support programs to expand.

17. Remember all the types of agencies, including federal, when supporting peer programs for law enforcement.

18. Improve legislative privacy protections for officers seeking assistance from peer crisis lines and other peer-support programs.

19. Support the identification, development, and delivery of successful resiliency training programs for both academy and periodic in-service settings.

20. Support training programs that promote the universal application of preventive interventions, including skills to manage stress.

21. Encourage departments to make support available to nonsworn employees on the same terms as their sworn colleagues whenever possible.

22. The development of programs that promote whole health and officer resilience should be the goal of the profession.

Appendix B. Abbreviations, Acronyms, and Initialisms

BJA	Bureau of Justice Assistance
COPS Office	Office of Community Oriented Policing Services
DHA	Defense Health Agency
DHS	U.S. Department of Homeland Security
DoD	U.S. Department of Defense
DoDSER	Department of Defense Suicide Event Report
DOJ	U.S. Department of Justice
EAP	employee assistance program
EBH	embedded behavioral health
EMT	emergency medical technician
FRG	family readiness group
FY	fiscal year
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
LEMHWA	Law Enforcement Mental Health and Wellness Act
LEOKA	Law Enforcement Officers Killed in Action
MCL	Military Crisis Line
MHS	Military Health System
NLEOMF	National Law Enforcement Officers Memorial Fund
OSW Group	Officer Safety and Wellness Group
PTSD	post-traumatic stress disorder
SWAT	special weapons and tactics
VA	U.S. Department of Veterans Affairs
VALOR	Violence Against Law Enforcement Officers and Ensuring Officer Resilience and Survivability
VCL	Veterans Crisis Line
VHB	virtual hope box

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Additional Recommendations

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Conclusion

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Good mental and psychological health is just as essential as good physical health for law enforcement officers to be effective in keeping our country and our communities safe from crime and violence. With the passage of the Law Enforcement Mental Health and Wellness Act, Congress took an important step in improving the delivery of and access to mental health and wellness services that will help our nation's more than 800,000 federal, state, local, and tribal law enforcement officers. Many things, including strong relationships with the community, help keep officers safe on the job. This act called for the U.S. Department of Justice (DOJ) to submit a report to Congress on mental health practices and services in the U.S. Departments of Defense and Veterans Affairs that could be adopted by federal, state, local, or tribal law enforcement agencies and containing recommendations to Congress on effectiveness of crisis lines for law enforcement officers, efficacy of annual mental health checks for law enforcement officers, expansion of peer mentoring programs, and ensuring privacy considerations for these types of programs. The DOJ is pleased to respond to this requirement of the act with this report.

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