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Overlooked and Undervalued Police Officer Mental Health: A Crucial Consideration in the Era of Reform

Across the United States, an unprecedented number of people from a diverse range of backgrounds are gathering in troves to demand that police reform comes to fruition. The origin of these demands stem from the necessity of the Black Lives Movement to address systemic racism in response to a string of Black deaths at the hands of police brutality; however, these demands have also shed light on other significant issues plaguing US police departments. Surprisingly, very little attention has been given to one of the most prevalent issues throughout law enforcement that directly impacts community safety: Police Officer Mental Health. Police officers are suffering from epidemic levels of certain mental illnesses because they are systematically avoiding treatment for them. Disturbingly, in a 2017 survey, 59.4% of officers reportedly felt that receiving treatment is a sign of "personal failure" (Stuart 18). This unhealthy perspective is engrained in police culture, where mental health disorders are heavily stigmatized. As a matter of fact, an officer can be considered unfit for duty if their mental health records are exposed, potentially resulting in the loss of a job (Redman). Resultantly, many police opt to suffer in silence to everyone's detriment, including their own…

Two days after Thanksgiving 2014, recently retired police officer David Colegrove shot himself dead in his pickup truck after battling trauma-related mental health issues for most of his career (Colegrove). In Colegrove's first year of policing he was involved in a shooting, and after being cleared of misconduct he was immediately sent back to the line of duty without any counseling or support (Colegrove). Colegrove began to suffer from persistent stress-related

symptoms that he attempted to numb by drinking alcohol (Colegrove). Years of untreated suffering turned an amicable man into what his wife describes as “an angry, paranoid, cynical character, or an emotional wreck who could not stop crying,” who was “unable to cope with change, uncertainty, or the most basic daily challenges”(Colegrove). David Colegrove opted to never seek treatment so that he could “survive and thrive in the law enforcement culture,” where seeking mental healthcare can have serious consequences and is generally perceived as a weakness (Colegrove).

Police officers suffer from undiagnosed and untreated mental health issues at alarming rates. Despite mental health services being offered by most departments, officers methodically avoid using them. Seeking mental health treatment is notoriously undervalued, not always confidential, and stigmatized across US police departments; these factors cultivate a dangerous culture of treatment avoidance. Moreover, officers suffering from untreated mental health conditions pose a direct threat to themselves and the public. We deserve the security of knowing that our streets are patrolled by level-headed individuals who have the mental faculties to handle the inherent stressors of their duties. This paper will identify the mental health conditions more common in law enforcement, with an emphasis on PTSD and substance abuse disorder due to their prevalence and dangerous symptoms. Furthermore, it will examine why police officer mental health commonly goes undiagnosed and untreated. Finally, it will examine ways to destigmatize seeking mental health services.

Due to a lack of centralized policies regarding police officer mental health, combined with widespread underreporting, the real number of police officers suffering from mental illness remains unknown. Even without a full report, evidence shows that police officers are suffering from posttraumatic stress disorder (PTSD), compassion fatigue, substance abuse disorder, and

depression at higher rates than the general population (Fox). There are several common policework stressors that may result in or exacerbate mental health conditions, including witnessing trauma, threats of physical harm, intense working hours, poor co-worker relations, and public resentment (Violanti, et al.). Despite these factors being detrimental to mental health, it is normal for officers to not seek treatment. Evidence of avoiding treatment can be found in the tragically high police officer suicide rates that are climbing annually (Barr). For example, in 2019 there were 228 police officer suicides reported, 'higher than all other line-of-duty suicides combined' (Mahbubani and McLaughlin). Furthermore, police with untreated mental illnesses are not only a threat to themselves, but also to the communities they serve. Concerningly, one of the mental illnesses that is most threatening to community safety is also one of the most common.

One in five police officers have a diagnosis of posttraumatic stress disorder, with up to 34% reporting some of the symptoms necessary for diagnosis; these numbers are likely even higher due to the underreporting of symptoms (Kirschman). That is over five times higher than the estimated 3.5% of US adults suffering from PTSD ("What is Posttraumatic Stress Disorder?"). In order to receive a diagnosis of PTSD, an officer must exhibit a combination of concerning symptoms, such as intrusive thoughts; exaggerated startle response; angry outbursts; difficulty concentrating; hypervigilance; reckless behavior; exaggerated negative beliefs about oneself, others, or the world; an inability to experience positive emotions; and avoidance (Center). These symptoms are not conducive to the quick decision-making required in life or death situations.

Although the symptoms of PTSD are destructive enough to an officer's health on their own, they also commonly occur alongside a substance abuse disorder. Substance abuse is a common means of coping for police officers, consequently this puts community safety at greater

risk. It is estimated that one in four police officers meet the criteria for drug or alcohol abuse−three times higher than the rate in the general population (Cidambi). A Google search of "police officers drinking at work," provides plentiful anecdotal evidence. Moreover, it is not uncommon for PTSD and substance abuse to occur together (Elbogen, et al.). When a substance abuse issue is combined with PTSD, it can cause a greater propensity for acting violently (Elbogen, et al.). In a 2009 study on war veterans, the relationship between substance abuse, posttraumatic stress, and violence was measured. The results indicate that the combination of abusing alcohol and struggling with PTSD produces a greater susceptibility to violence than suffering from either condition alone (Elbogen, et al.). Untreated PTSD, combined with unhealthy coping methods and a gun, is a potential disaster waiting to happen.

Such a disaster occurred in 2013 when California police officer Jairo Acosta killed a schizophrenic man named Sonny Lam inside his apartment (Sullivan). Acosta was never criminally charged for the murder (Sullivan). In a departure from the norm, attorney Melissa Nord won access to Jairo Acosta's medical records in a civil lawsuit, shedding light on some concerning factors (Sullivan). The records showed that Acosta had been suffering from severe PTSD ever since his time in the military, but never sought treatment; nor did he report it to his superiors (Sullivan). Furthermore, according to his departmental record, Acosta once pulled out a gun and threatened a fellow community officer, and another time kicked down the door of an empty house after thinking someone had thrown a rock at his patrol car (Sullivan). Even so, despite his medical history, disciplinary record, and his behavior being ruled in the civil lawsuit as "'malicious, oppressive or in reckless regard' of Lam's constitutional rights," Acosta is still working as a detective and has yet to report his condition to his superiors, who have not required

any follow-up from him (Sullivan). This type of outcome will continue to persist across US police departments until change occurs.

It is challenging to establish the importance and acceptability of seeking treatment in a professional culture that does not universally or at least generally champion its value. The lack of emphasis put on the importance of mentally healthy police officers perpetuates an environment where seeking treatment is not the norm. Further contributing to the denormalization of seeking treatment is a lack of standard protocol that US police departments follow to ensure mentally healthy police officers. Insufficient standard protocol creates confusion among officers regarding whether their treatment will remain confidential or not, as well as the consequences they may face for seeking treatment. Moreover, because departments are not establishing the importance and acceptability of mental health treatment, police officers are internally stigmatizing their mental illnesses, as well as one another's.

US police departments have no centralized policies or standard procedures for how to treat police officer mental illness. Standards are necessary because they clearly explain what is expected of officers, while also establishing what they can expect. Currently, accessibility to treatment, cost of treatment, evaluating methodology, and emphasis put on the importance of treatment varies in each of the over 17,000 agencies ("Law Enforcement Mental Health" 15). Variable approaches to addressing police officer mental health make it difficult to cultivate a professional culture where mental fitness is as important as physical fitness.

Evidence of this variability can be found in when departments choose to administer psychological evaluations. The lack of standard protocol of when and how psychological evaluations are administered to police officers creates confusion about their purpose. A tenth of agencies do not even use psychological evaluation or drug testing tools during recruitment, while

those that do so very rarely use them past recruitment because department heads dismiss them as too expensive or unnecessary (Roufa; O'Hara). Often, only after an incident of misconduct is an officer required to undergo an evaluation or see a therapist, and even that is not a requirement in every police department (Hubbard). By only requiring that officers get evaluated when they do something wrong, this sends the message to police officers that addressing mental health is considered making a mistake, further disincentivizing seeking treatment. Furthermore, this situation also disincentivizes honesty, establishing an unhealthy message that transparency regarding vulnerability is considered a liability.

Unfortunately, even departments that more regularly use evaluating tools or mandatory therapy still face the issue of officers hiding their conditions out of fear that their treatment will not remain confidential (O'Hara). Access to confidential treatment is not always a guarantee for law enforcement. Psychological evaluations are rarely guaranteed to be "off the record," in addition to HIPAA laws not protecting the confidential use of department peer mentor programs, and police crisis lines (Anderson; "Law Enforcement Mental Health" 41). Furthermore, because they are public servants, "an officer's mental health care may be discoverable on the public record, be used in court proceedings, or affect employment eligibility" ("Law Enforcement Mental Health" 41). Some agencies even require that officers report if they are seeing a counselor or taking medication, perpetuating the lack of desire to seek help to avoid potential consequences (Olson and Wasilewski). A police officer with a mental health condition cannot win under a structure where there are possible negative repercussions no matter what they do. The message under this structure is that a police officer must choose between the security of their job or the taking care of their mental health. Not only is this unethical to demand of any human

being, but it results in a culture of treatment avoidance, with widespread underreporting of symptoms (Fox). Moreover, it denigrates the idea of proactive mental healthcare.

Proactive mental healthcare is crucial to a psychologically fit police force. Ron Clark, chairman for the police officer mental health advocacy organization, Badge of Life, notes that it is not uncommon to see "Get help when you need it" messages on police bulletin boards, but that it is actually a matter of getting help "*before* they need it,"(O'Hara). Routine mental health care before there is a major issue is crucial in policing because the amount of secondary trauma that they experience as an inherent part of the profession. Trying to convince police officers of this will be difficult until department policies reflect the importance and acceptability of proactive mental healthcare. Policies that promote proactive mental healthcare are also needed to combat the internal and peer stigmatization of mental illness that is plaguing departments across the nation.

Internal stigmatization of psychological conditions is perpetuated by the hypermasculine culture of US police departments. Many officers feel that asking for help is a sign of weakness−not reflective of the strong, self-reliant image that police officers *should* have (Johnson 29). The demographic of US police forces is a direct cause for the prevalence of this false perception. In 2018, 85.3% of the police force was male, which has a direct correlation with the avoidance of seeking treatment ("Police Officers"). "Evidence suggests that men are significantly less likely to use mental health services in response to a mental health issue in comparison with women" (Whitley). This is attributed to the unrealistic image that ideal American masculinity is being a man who is never in need of help (Whitley). Proof of this can be found in the unhealthy coping mechanisms used by men as a replacement for support. Men account for three-quarters of both suicides and substance abuse addictions in the US (Whitley). It

is not a coincidence that the statistics in the general population are like those in the toxically masculine culture of American law enforcement. Police officers perpetuate this toxic culture by not only stigmatizing their own mental health issues, but also one another's.

Peer stigma regarding mental health struggles is common practice in law enforcement culture. For example, in a 2017 survey given to 133 police officers about the stigma of reporting mental illness, 85% of officers reported that they would avoid telling a supervisor about a mental health crisis and 62% would anticipate discrimination, while the majority of police officers reported not feeling comfortable patrolling with a fellow officer who has a mental health condition (Stuart 18,20). Furthermore, in 2018 90% of the Los Angeles police force surveyed reported that seeking mental health support was stigmatized (Mahbubani and McLaughlin). If mental health were championed as a common challenge that is undeserving of judgement, then it would not be so steeped in stigmatism. Instead, officers are resorting to passing harsh judgements, indicative of a toxic culture where uncontrolled psychological challenges run high and emotions remain opaque. Stigmatization of mental health is fueling peer incivility; whereas peer incivility is further exacerbating stigmatization. The mental health stigma found in police departments reflects US society.

In the history of the US, mental illness has been on the receiving end of a great deal of societal incivility, perceived as weak, crazy, or "other." Stigmatizing mental health disorders has been used as a fuel to justify incivility toward people who are suffering. Rejection is common practice, exemplified by the fact that "individuals with mental illness are more likely to experience housing and employment discrimination, and homelessness, compared to people without mental illness" (Parcesepe and Cabassa). Any number of these outcomes can result in an individual avoiding treatment out of fear. As a matter of fact, fewer than 40% of people suffering

from severe mental illnesses are treated on a regular basis (Ahmedani). Although stigma is not the only barrier to getting people support, it does play a significant role. Unfortunately, the police force is the direct reflection of US society− that rejects mental health care as a socially acceptable practice.

Ideally, a police officer with an untreated mental illness would be the exception to the rule, however, this is clearly not the case with US law enforcement. The pattern of treatment avoidance indicates a deeply engrained cultural ignorance to the necessity of mental health care in this field of work. From this perspective, US police officers are the prisoners in Plato's Allegory of the Cave−firmly unquestioning of their circumstances. Much like the prisoners in Plato's cave, police officers are ignorant of their ignorance because what counts for normal mental health in policing is incredibly unhealthy to begin with. Police officers antagonize mental health services strictly intended to help them because they perceive them as harmful. As a result of this ignorance, police officers are complicit in their own suffering, much like the prisoners in the cave who internalize their own oppression. In this respect, Police officers are their own worst allies. Moreover, the police officer who does escape this cave of ignorance by receiving mental health treatment, faces ostracization by their fellow officers who remain ignorant to the benefits. What these remaining officers do not know is that they are denying their own liberation from suffering by denying another way of thinking about mental health treatment.

Consequently, not normalizing mental illness as a potential result of the intense demands of policing has caused disjointed policies regarding how to address police officer mental health. Furthermore, disjointed policies perpetuate officer mistrust in mental health care due to a lack of clear expectations that can result in professional consequences. Subjection to professional consequences as a result of police officers seeking treatment reinforces the cultural stigma

surrounding mental health disorders. In this sense, each factor contributing to police officer avoidance of care is interrelated to create cultural ignorance to the benefits of seeking treatment. Therefore, due to the complexity of this issue, a dynamic set of solutions will be required for positive change to occur.

There is not one single solution that can solve a problem as complex as police officers avoiding mental healthcare. Fortunately, in January 2018 the 'Law Enforcement Mental Health and Wellness Act of 2017' was signed into law, releasing a comprehensive report to Congress on the most effective ways that the police officer mental health crisis can be addressed ("Law Enforcement Mental Health" 8). The suggestions gathered within the report are not just the most effective approaches, but also the most replicable throughout all departments ("Law Enforcement Mental Health" 14). Using the most replicable solutions can serve as a compromise in getting improved support to a wide variety of departments, while still maintaining department autonomy. Exploring the efficacy of culturally competent programs to identify, prevent and treat mental illness, in addition to implementing guaranteed confidential care, will help to resolve the entrenched resistance to treatment among US police departments.

Departments that adopt mandatory officer training programs to identify mental health conditions common in policework, in addition to stress resistance training programs, will help to prevent mental illness. For example, step #7 of police psychologist Jack Digliani's "Make it Safe" officer initiative is to implement widespread 'basic training in stress management, stress inoculation, critical incidents, posttraumatic stress,' 'substance use and addiction, and the warning signs of suicide and depression' (Marx). Teaching officers about common conditions and problems faced in the profession will normalize the conversation about mental health, reducing internal and peer stigma. Furthermore, educating police officers helps to assist them in

identifying when they have a problem. Additionally, exposing officers to stress during training (stress inoculation), as well as educating officers about stress reduction techniques will aid in building a more resilient police force. In addition to providing programs for identifying and preventing mental illness, the use of police-specific support programs can aid in treating mental illness.

Police crisis lines and peer support programs provide unique ways of offering support to police officers in different stages of distress. Crisis hotlines provide immediate intervention as a reaction to police officers who are acutely suffering; whereas peer support groups can provide more generalized and preventative support ("Law Enforcement Mental Health" 25,35). Both are crucial in providing care at equally important points in time to ensure a safer police force. Furthermore, they both cater to the specific mental health needs of officers that are inherent to the work they do, unlike what a regular crisis line or community support group can offer. Of further added benefit is the impact that widespread utilization of peer support programs can have to erode engrained stigma. For example, another step of the "Make it Safe" officer initiative suggests that admired members of police departments start conversations about their own mental health battles to lead by example (Marx). This approach aids in sending the important message to police officers that "no human being, no matter how healthy, well trained, or well adjusted, is immune to the long-term effects of cumulative stress or sudden critical incidents" (Anderson). Furthermore, peer support programs assist in normalizing mental health as a conversation among police officers. Although peer support groups and crisis lines are an excellent means of support for struggling officers, they still do not replace the need for clinical help (O'Hara).

One way to assure officers are receiving periodic clinical help is through required wellness checks. Standardized mandatory periodic wellness checks performed by a clinician

eliminate the possibility of a police officer completely avoiding care, as well as not recognizing that they need it; however, they must be used as a means of supporting officers instead of measuring fitness for duty ("Law Enforcement Mental Health" 32). Making wellness checks a routine, yet important part of police work will assuage police officer fears of profession retaliation, encouraging them to report honestly ("Law Enforcement Mental Health" 35). Moreover, when everyone is expected to undergo the same wellness checks, it begins to normalize the pursuit of mental health support, "fostering a culture of emotional wellness" ("Law Enforcement Mental Health" 32). These wellness checks will also provide law enforcement officials with the opportunity to screen for specific struggles common in law enforcement, such as PTSD and substance abuse disorder, in order to more promptly administer the appropriate treatment plans ("Law Enforcement Mental Health" 35).

Although there is merit in ensuring that police receive professional support at least occasionally, critics of using mandatory mental health screening complain that it is not worth it. Costs and disingenuous reporting fuel the opposition to periodically administering wellness checks. A mental health evaluation costs an average of $750 an officer; however, considering that an officer with an untreated mental health issue costs an extra $4,489 annually in productivity costs, it is worth looking into whether it is more financially beneficial overall to use mandatory evaluating tools to catch symptoms (Collins; Fox). Furthermore, those opposed to making it a requirement feel as though the outcome of forcing care is not as impactful because officers will report what they think a clinician wants to hear out of fear "that a revelation regarding temper, substance abuse or even minor misconduct will be reported and result in disciplinary action" (O'Hara). There is a lack of trust between police officer and clinician due to no standard policies on how to evaluate police officer mental health. The creation of standard

policies and procedures will help to dissolve this mistrust by reassuring officers that results will not vary depending on who they are evaluated by. At the same time, evaluating methodology is not the only thing that needs standardizing to establish trust between police officer and clinician.

To make the addition of peer support groups, police crisis lines, and wellness checks worthwhile, it is crucial to clarify what treatment options are guaranteed to be confidential. Centralized policies must be put in place to establish which avenues of treatment are confidential versus what is being used to gauge professional ability. To accomplish this, model legislation should be created to provide such protections and clarifications ("Law Enforcement Mental Health" 42). Although there are circumstances that call for an officer's mental health history to be reviewed as a measurement of their ability to do their job, clear-cut distinctions should be made for when that is the intended purpose. Providing guaranteed privacy to pursue treatment will assist in resolving professional stigma, encourage officers to seek help, and promote the idea of sharing transparently.

In the words of Sonny Lam's attorney, '"transparency allows for different observations from different people who have different skill sets,"' (Sullivan). As of now, the lack of transparency is contributing to a major deficit in accurate research on the extent of police officer mental health challenges. The resulting lack of empirical evidence makes it difficult to measure the efficacy of available treatment options. More credible information available to police departments and clinicians will allow for the creation of improved treatment methodology. Although providing confidential spaces seems counterintuitive to the goal of obtaining more information, it may assist in getting officers to share more accurately in the long run. There is substantial value to creating a culture where reporting is honest because clinicians can still use

this data to improve general understanding and treatment plans, without jeopardizing an officer's privacy.

All the provided solutions must act together to assist in shifting police culture toward championing mental health care. With that being said, any solutions offered will not be as effective without an overall shift in US culture where acting civilly toward those suffering from mental illness becomes the norm. Civility challenges us to act with compassion toward those that we may not fully understand, thus engaging with someone who has a mental illness challenges us to do exactly this. Working at King County crisis-line, it breaks my heart to hear the volume of people who are battling mental illness that cannot even seek refuge with their own families. So often these individuals feel misunderstood and unsupported by the people that know them best, let alone by the rest of the world. Change desperately needs to occur. Mental illness can affect anybody at any time– no one is immune from its grips. Therefore, we must advocate for the societal normalization of using mental health services.

Nowhere is normalization of using mental health services more necessary than within the US police force, where the combination of mental illness and authority can be lethal. Despite trauma and stress being a routine part of policework, addressing it is not. Police officer mental health is notoriously overlooked and undervalued by those in charge. Consequently, police officers are suffering from epidemic levels of stress-related disorders and avoiding treatment for them. Treatment avoidance is being fueled by a lack of standards that normalize the acceptability of using mental health services and clarify officer expectations. Resultantly, these lacking standards fuel police officer mistrust in mental health care, promoting dishonesty and the stigmatization of mental health issues.

Measures must be taken to address this toxic culture, starting with new standards for addressing police officer mental health. The suggestions in the Law Enforcement Mental Health and Wellness Act provide a framework for how departments can move forward in assuring officers are getting the care that they need. However, these are *suggestions* and not enforceable by law; therefore, it will take community activism to raise awareness so that these suggestions are put into action. Raising awareness must not simply entail pointing to cosmetic solutions for a more mentally healthy police force. Instead, a movement must occur to shed light on how easy it can be for us to not think for ourselves, so much so that we can cause our own suffering. This level of awareness is foundational for a not just a healthier police force, but also a country that values mental health care as a routine aspect of life. It is in all our best interests to take care of our mental health, and it most certainly is for people whose job is to protect and serve us. Police officer mental health *must* be an aspect of any level of US police reform so that meaningful change may occur.

WORK CITED

Ahmedani, Brian K. “Mental Health Stigma: Society, Individuals, and the Profession.” *Journal of Social Work Values and Ethics*, U.S. National Library of Medicine, 2011, www.ncbi.nlm.nih.gov/pmc/articles/PMC3248273/.

Anderson, Beverly. *Confidentiality in Counseling: What Police Officers Need To Know - Police Stress Management - Gift From Within - PTSD Resources*, 23 Feb. 2019, www.giftfromwithin.org/html/Police-Officers-Seeking-Counseling.html.

Barr, Luke. “Record Number of US Police Officers Died by Suicide in 2019, Advocacy Group Says.” *ABC News*, ABC News Network, 2 Jan. 2020, 12:29 pm, abcnews.go.com/Politics/record-number-us-police-officers-died-suicide-2019/story?id=68031484.

Center for Substance Abuse Treatment (US). “Exhibit 1.3-4, DSM-5 Diagnostic Criteria for PTSD - Trauma-Informed Care in Behavioral Health Services - NCBI Bookshelf.” *Trauma-Informed Care in Behavioral Health Services.*, U.S. National Library of Medicine, 1 Jan. 1970, www.ncbi.nlm.nih.gov/books/NBK207191/box/part1_ch3.box16/.

Cidambi, Indra. “Police and Addiction.” *Psychology Today*, Sussex Publishers, 30 Mar. 2018, www.psychologytoday.com/us/blog/sure-recovery/201803/police-and-addiction.

Colegrove, Kim. “My Husband's Suicide: Recognizing Predictors of Police Suicide.” *In Public Safety*, 8 Aug. 2018, inpublicsafety.com/2018/08/my-husbands-suicide-recognizing-predictors-of-police-suicide/.

Collins, David. “Report Calls for Routine Psychiatric Testing for Police.” *WBAL*, WBAL, 9 Oct. 2017, www.wbaltv.com/article/report-calls-for-routine-psychiatric-testing-of-police-officers/7102873.

Elbogen, Eric B., et al. "Violent behaviour and post-traumatic stress disorder in US Iraq and Afghanistan veterans." *The British Journal of Psychiatry* 204.5 (2014): 368-375.

Fox, Justin, et al. “Mental-Health Conditions, Barriers to Care, and Productivity Loss among Officers in an Urban Police Department.” *Connecticut Medicine*, U.S. National Library of Medicine, Oct. 2012, www.ncbi.nlm.nih.gov/pmc/articles/PMC4089972/.

Hubbard, Saul. “Bill Would Mandate Counseling for Police.” *Guard*, The Register-Guard, 7 Feb. 2018, www.registerguard.com/rg/news/local/36418167-75/oregon-legislators-propose-mandatory-mental-health-counseling-for-police-officers.html.csp.

Johnson, Samantha F., "Investigating Barriers to Mental Health Care in Law Enforcement Officers" (2016). Electronic Theses and Dissertations. Paper 3154. https://dc.etsu.edu/etd/3154

Kirschman, Ellen. “Cops and PTSD.” *Psychology Today*, Sussex Publishers, 30 Nov. 2018, www.psychologytoday.com/us/blog/cop-doc/201811/cops-and-ptsd.

“Law Enforcement Mental Health and Wellness (LEMHWA) Program Resources.” *COPS OFFICE*, cops.usdoj.gov/lemhwaresources.

Mahbubani, Rhea, and Kelly McLaughlin. “Police Officers Stigmatize Seeking Help for Mental-Health Issues. It Could Be Damaging for the Communities They're Supposed to Serve and Protect.” *Insider*, Insider, 14 June 2020, www.insider.com/police-officers-stress-mental-health-stigma-impacting-public-2020-6.

Marx, John. “Consider a Proactive Annual Check In.” *Cops Alive Police Wellness and Resilience to Stress Career Survival*, 21 Dec. 2017, www.copsalive.com/consider-a-proactive-annual-check-in/.

O'Hara, Andy. “The Importance Of Therapy For Police Personnel.” *Law Officer*", 5 Feb. 2017, www.lawofficer.com/the-importance-of-therapy-for-police-personnel/.

Olson, Althea, and Mike Wasilewski. “Suffering in Silence: Mental Health and Stigma in Policing.” *Police1*, 7 Sept. 2016, www.policeone.com/police-products/human-resources/articles/suffering-in-silence-mental-health-and-stigma-in-policing-mjOp9cyzKIPz4jMz/.

Papazoglou, Konstantinos, et al. “Police Compassion Fatigue.” FBI Law Enforcement Bulletin, Apr. 2020, pp. 1–13. EBSCOhost, search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=143166473&site=ehost-live&scope=site.

Parcesepe, Angela M, and Leopoldo J Cabassa. “Public Stigma of Mental Illness in the United States: a Systematic Literature Review.” *Administration and Policy in Mental Health*, U.S. National Library of Medicine, Sept. 2013, www.ncbi.nlm.nih.gov/pmc/articles/PMC3835659/.

“Police Officers.” *Data USA*, 2018, datausa.io/profile/soc/police-officers.

Roufa, Timothy. “Learn About the Psychological Tests and Screening for Police Officers.” *The Balance Careers*, 4 Aug. 2019, www.thebalancecareers.com/psychological-exams-and-screening-for-police-officers-974785.

Redman, Jessika. January, et al. “Why Do Cops Avoid Counseling? Eight Myths about Law Enforcement Officers and Mental Health Treatment.” *Counseling Today*, 3 Mar. 2020, ct.counseling.org/2018/01/why-do-cops-avoid-counseling-eight-myths-about-law-enforcement-officers-and-mental-health-treatment/.

Stuart, Heather. "Mental illness stigma expressed by police to police." *The Israel Journal of Psychiatry and Related Sciences* 54.1 (2017): 18-23.

Sullivan, Molly. “An Officer with PTSD Fatally Shot a Mentally Ill Man. He's Still on the Force.” *Sacbee*, The Sacramento Bee, 10 Sept. 2018, www.sacbee.com/news/local/article217460190.html.

Violanti, John M, et al. “Police Stressors and Health: a State-of-the-Art Review.” *Policing (Bradford, England)*, U.S. National Library of Medicine, Nov. 2017, www.ncbi.nlm.nih.gov/pmc/articles/PMC6400077/.

“What Is Posttraumatic Stress Disorder?” *What Is PTSD?,* 2013, www.psychiatry.org/patients-families/ptsd/what-is-ptsd#:~:text=PTSD%20affects%20approximately%203.5%20percent,as%20men%20to%20have%20PTSD.

Whitley, Rob. “Men's Mental Health: A Silent Crisis.” *Psychology Today*, Sussex Publishers, 6 Feb. 2017, www.psychologytoday.com/us/blog/talking-about-men/201702/mens-mental-health-silent-crisis.