

IMPLEMENTING PEER CONDUCTED MENTAL HEALTH AND WELLNESS CHECKS
IN RURAL LAW ENFORCEMENT: A QUALITY IMPROVEMENT PROJECT

by

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DEDICATION

This work could not have been done without the support and sacrifices of my husband and daughter. We all share in the success of this accomplishment. Thank you for everything.

I would also like to thank the law enforcement officers who pulled back the curtain to their private culture and allowed my involvement. I hope this information and our project can result in positive changes for rural law enforcement officers throughout the state. Thank you for your service to our community

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ABSTRACT

Background and purpose: Law enforcement officers in the United States are at a significantly increased risk of suicide and mental health challenges, accompanied with increased perceptions of stigma that limits mental health resource utilization. These trends are even more prominent among rural law enforcement officers compared to their urban counterparts. The purpose of this quality improvement project was to assist a rural law enforcement detachment in decreasing mental health stigma through implementation of peer conducted mental health and wellness check-ins.

Methods: Baseline and progressive trends of stigma were assessed through the Attitudes About Mental Illness and its Treatment Scale (AMIS) following implementation of peer conducted proactive mental health support check-ins in the detachment.

Intervention: This project utilized peer support law enforcement members to facilitate scheduled check-in's and discuss predetermined mental health topics while facilitating access of additional resources and education that could improve health outcomes.

Results: A small rural law enforcement detachment conducted peer facilitated mental health and wellness checks with its full team of six team members. Evaluation of the AMIS assessments and personal feedback indicated that these meetings decreased reports of stigma and increased open discussion of mental health issues.

Conclusion: Conclusive support for this intervention cannot be ascertained due to the small sample size and short duration of evaluation. However, this initiative indicates a framework for initiating similar processes in other areas and reveals a promising acceptance and trend of utilization and support by involved law enforcement members.

Keywords: mental health, law enforcement, stigma, peer support, suicide

CHAPTER ONE

REVIEW OF LITERATURE

Background

Active law enforcement officers are more likely to die by suicide than by on-duty incidents (United States Department of Justice [DOJ], 2019a; Ramchand, 2018; Violanti & Steege, 2021) and departments in small rural locations experience a significantly higher rate of suicide completion in comparison to their larger urban counterparts (Violanti et al., 2019). Nonprofit organization Blue H.E.L.P began compiling statistics of first responder suicides in 2016 and has found in that time that there were 182 to 248 reported first responder suicides annually in the United States, the majority of whom were law enforcement officers (Blue H.E.L.P., 2022). Law enforcement officers are estimated to experience an average of 900 traumatic events in the duration of their career and experience higher rates of subsequent Post-Traumatic Stress Disorder (PTSD) when compared to that of the general public (McQuerrey Tuttle et al., 2019; DOJ, 2019a). When comparing PTSD rates after trauma exposure in law enforcement to civilians in the general population, law enforcement officers have been found to develop PTSD at rates 12.90% higher than trauma-exposed civilians (Boland & Salami, 2020). Conversely, law enforcement officers are significantly less likely to seek or utilize mental health resources in comparison to the general population (Boland & Salami, 2020). The most common mental health concerns in law enforcement include sleep disturbances, depression, excessive alcohol use, and PTSD symptoms (Boland & Salami, 2020; DOJ, 2019a). These symptoms lead to higher rates of burnout and position turnover, increased aggression in community

engagements, and increased mental health crises and suicides in law enforcement (Dixon, 2021; McQuerry Tuttle et al., 2019). The necessary continued work on the frontlines during the Coronavirus pandemic has resulted in increased law enforcement stress and anxiety, further exacerbating mental health and wellness concerns (Drew & Martin, 2021). There is a significant need for preventative and supportive mental health initiatives in law enforcement in order to improve health outcomes for law enforcement personnel and improve community safety outcomes.

Identification of the Problem

The United States Law Enforcement Mental Health and Wellness Act was passed in 2017 in order to promote officer mental health and wellness in response to increasing stress, provocation, and public distrust leading to further rates of mental health exacerbation throughout the nation (DOJ, 2017; DOJ, 2019a). The state law enforcement organization at the focus of this quality improvement project have established and funded mental health resources for their members to include an available mental health specialist provider, telehealth therapy options, and peer support training. Barriers to utilizing available mental health resources have largely resulted due to a cultural and public stigma of accessing mental health resources. This is not an obstacle unique to only this law enforcement organization, as law enforcement officers most commonly reported barrier to utilizing mental health resources is stigma (Velazquez & Hernandez, 2019; Wheeler et al., 2018). Stigma is often a compounded phenomenon of public opinion stigma, self-stigma, and organizational stigma (Velazquez & Hernandez, 2019).

Current Stigma Trends

Negative public stigma towards law enforcement by the local and general community adversely correlates with law enforcement personnel's willingness to disclose or access mental health resources and positively correlates with perceived occupational stress (DOJ, 2019a; Karaffa & Koch, 2016). Events such as protests and displays of public aggravation towards the general law enforcement population also increase the likelihood of law enforcement personnel's development of mental health concerns (Dixon, 2021; Galovski et al., 2016). Proximity and direct exposure to violence is not needed to result in increased stress from focused public aggravation, but the level in media exposure of events directly correlates with increased levels of distress measured in law enforcement (Galovski et al., 2016). Current public opinion and legislation is negatively impacting law enforcement wellbeing and psychological stress with nationwide protests and riots insinuating a negative stigma towards law enforcement and legislation initiatives to defund law enforcement agencies (DOJ, 2019a; Dixon, 2021).

Long existing stigma pressures are observed in common law enforcement subculture, which has resulted from conforming to expansive societal expectations of masculinity, emotional control, and independence; while organizational stigma reinforces this ideal (Velazquez & Hernandez, 2019). Organizational stigma and self-stigma often occur in law enforcement when an individual is identified to possess characteristics or symptoms that oppose the skewed personal perspective of law enforcement expectations (Hofer & Savell, 2021; Velazquez & Hernandez, 2019; Wheeler et al., 2018). These compounded factors result in the stigma barrier that most often prevents early intervention and support of mental health concerns in law enforcement.

Proposed Intervention

The aim of this scholarly project is to assist this rural law enforcement detachment in developing a form of mental health and wellness check-ins that are efficacious and accepted by the personnel involved, then to articulate the process so that it can be replicated in other detachments within the organization. The law enforcement detachment at the focus of this scholarly project agreed to implement an intervention based on supportive evidence and the recommendations of the United States Law Enforcement Mental Health and Wellness Act (DOJ, 2017; DOJ, 2019a) for incorporating proactive mental health and wellness checks into their established annual individual and group meetings. This will involve open questions on mental health and wellness topics, education of symptoms and risk factors for mental health concerns, and supportive and trustworthy responses to colleague disclosures. The areas of inquiry will be based on the most common causes and symptoms of concern in the general profession and the local detachment's needs. These will be written, collaboratively developed, and evolved with the organization's mental health specialist, leadership team, and peer support group. The leadership of this detachment are currently trained and involved with a statewide program for law enforcement peer support of mental health concerns. This organization has funded and established mental health resources such as a mental health specialist, facilitated telehealth therapy, and ability to approve time off for mental health concerns during crisis. These resources are not readily utilized by the law enforcement personnel, and the primary goal of integrating mental health and wellness-checks into established meetings will be to reduce stigma of mental health concerns, increase knowledge of common mental health symptoms, better understand

barriers faced by rural law enforcement, and encourage trust and utilization of available resources.

Rational for Intervention

Occupations like that of law enforcement encourage self-reliance and resilience, but commonly struggle with a stigma towards mental health that can create a barrier of mistrust in mental health providers and access of mental health resources (DOJ, 2017; DOJ, 2019a; Velazquez & Hernandez, 2019). It has been found that prior standards of formal screening for mental health concerns is not effective for this population, rather that informal personal conversations and observation with peers or leadership trained in mental health issues is better accepted and more efficacious (Vermetten et al., 2014). Law enforcement personnel have been found to alter their behaviors based on their expectation of the group or organizational norms, while concurrently officers are noted to have a lower than actual perception of their colleague's willingness to seek mental health resources (Karaffa & Koch, 2016). Programs geared towards altering the groups perception of this misconception and by normalizing discussion and experience of mental health symptoms in response to occupational stress and traumatic events, subsequently decreases the negative stigma of mental health topics and resource utilization (Lane et al., 2021; Karaffa & Koch, 2016).

A secondary and less commonly discussed factor that is known to contribute to increased negative mental health effects is excessive workload and increased workplace stressors of law enforcement (Santa Maria et al., 2018). This includes expected occupational hazards such as rotating schedules, the need for constant vigilance, and interrupted sleep schedules; but can be further exacerbated with poor leadership management, time pressures, inappropriate staff

shortages, and excessive shift work (Santa Maria et al., 2018). Regular scheduled opportunities for open dialogue with leadership can facilitate awareness and collaborative address to reduce workplace stressors and has been shown to reduce emotional exhaustion and burnout in the profession (Santa Maria et al., 2018).

Benefit for Individuals

Having scheduled meetings for education and assessment of mental health symptoms allows for opportunities to engage in self-identification of concerns and maladaptive skills for early address to support mental health and wellness (DOJ, 2019a; Richards et al., 2021) Regular reminders and facilitation of available mental health resources increase the likelihood that law enforcement personnel would be mindful of outside resources if needed (DOJ, 2019a; Richards et al., 2021). Early intervention and improvement of workload stressors and structural obstacles can reduce the likelihood of stress progressing to emotional exhaustion, which would decrease the risk of developing mental health concerns or experiencing a crisis (Santa Maria et al., 2018). Improved support from leadership and colleagues can enhance an individual's ability to cope with stress and trauma as well as encourage individuals to identify openly with the group, in turn creating a sense of community and limiting isolation (Millard, 2020; Violanti & Steege, 2021). These factors can improve the resilience of law enforcement personnel to manage the strains and occupational hazards of the field with less negative impacts to their own mental health in the duration of their career and reduce the risks of developing depression, PTSD, or anxiety disorders (DOJ, 2019a; Hofer & Savell, 2021; Millard, 2020; Santa Maria et al., 2018). Early intervention and improved stress levels can also improve physiologic health outcomes for law enforcement personnel by reducing associated physical symptoms commonly associated with

psychologic concerns such as stomach pain, insomnia, and headaches (DOJ, 2019a; Santa Maria et al., 2018).

Benefit for the Community

Emotional exhaustion and psychological stress are noted to influence law enforcement response in conflict situations with civilians by producing an increased correlation in the use of violent force (Dixon, 2021, Santa Maria et al., 2018). Emotional exhaustion can also lead to increased violence and anger outbursts in a law enforcement member's personal life with increased trends of spousal violence and poor family relationships (Santa Maria et al., 2018). Improved mental health and wellbeing in law enforcement can decrease the rates of burnout, attrition, and staffing shortages in law enforcement; consequently, improving the ability of law enforcement to respond to crises and have the manpower to safely manage complex situations (Richards et al., 2021; Santa Maria et al., 2018).

Review of Literature

Search Method

Information was screened based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) principles.

Databases. The databases utilized for this project's review of literature include CINAHL, Cochrane, Medline, Ovid, Public Health Database, ProQuest Central, and Google scholar. The articles considered during this review included only full-text peer-reviewed information between the publication years of 2012 and 2022.

Terms Used. The terms used for this review include “law enforcement officer mental health trends,” “law enforcement suicide rates,” “Law Enforcement Mental Health and Wellness Act,” “mental health stigma in law enforcement,” “stigma reduction in law enforcement,” “mental health peer support in law enforcement,” “mental health in rural law enforcement,” and “mental health checks in law enforcement.”

Broadening of Scope. Due to the lack of available current research on this topic, the scope of research was broadened to include that of general first responders and military personnel. These populations were identified due to similar regular exposure to trauma and organizational structuring when compared to that of law enforcement. Therefore, the term “law enforcement” was substituted with “first responders” for all of the searched terms. The term “military” was also used as a substitute when reviewing intervention efficacy due to the recent nature of the studies in law enforcement limiting completed research.

Limitations of Research. Much of the current research has been initiated based on funding and encouragement of the United States Law Enforcement Mental Health and Wellness Act (DOJ, 2017). This created a greater recent assortment of statistical analysis and recommendations, but the data pool and interventional efficacy has not yet been developed to a degree that provides comprehensive support.

What Contributes to Mental Concern Development

Mental Health Concern. There is a general assumption that mental health concerns arise in law enforcement officers after they encounter an acute traumatic experience; while in reality, the development of mental health concerns is a much more complex and gradual process for

many individuals within this profession. The everyday stressors of work, home life, and physical impacts caused by the occupation compound with the trauma of critical and violent incidents at work to increase the likelihood of developing mental health symptoms or experiencing a crisis over time (Craddock & Telesco, 2021; Boland & Salami, 2020; Hofer & Savell, 2021). The significant public and occupational stigma and scrutiny experienced by those in this profession can reenforce the sense of self-stigma which compounds and encourages maladaptive coping skills and sense of isolation that precipitates mental health crisis (Hofer & Savell, 2021; Karaffa & Koch, 2016). Mental health concerns can present in a wide variety of ways, while in others may not be noticeable to the individual law enforcement officer or those around them or may appear suddenly without warning (Craddock & Telesco, 2021; Mumford et al., 2021). Law enforcement personnel are often screened as generally healthy with the exception of maladaptive coping skills, such as risky drinking or prescription pill misuse (Mumford et al., 2021), but further assessment indicates that mental health conditions can present even years after traumatic event experiences or a prolonged amount of time in the profession (Stanley et al., 2016, Soomro & Yanos, 2018). There is also a significant portion of law enforcement who do present with identifiable mental health conditions like anxiety, depression, insomnia, and PTSD who are apprehensive to get treatment due to stigma or fear of punitive organizational reactions (Antony et al., 2020; Boland & Salami, 2020; DOJ, 2019a). These mental health concerns are noted to have a negative financial productivity cost of an estimated \$4489 annually per officer (Hofer & Savell, 2022).

Rural Law Enforcement Impacts. In the United States, 49% of law enforcement agencies are considered ‘small’ and employ less than 10 officers full-time (Violanti et al., 2015).

Emotional exhaustion and burnout in small and rural areas of law enforcement have resulted in attrition rates of 18.2%, almost double that of larger agencies rates of 10.2% (Violanti et al., 2015). Rural officers are at an increased risk of stress and psychological effects of trauma due to often being the only officer on duty without available backup, having personal relationships with civilians involved in traumatic events, being readily identified as law-enforcement when off duty, and being required to manage a greater workload (Violanti et al., 2015). Rural law enforcement personnel are less likely to utilize mental health resources due to confidentiality concerns and have less available organizational support during times of stress (Violanti et al., 2015).

Suicide Risk. It is crucial to include an assessment of general wellness, officer stress, and burnout; as suicide has been indicated to occur in law enforcement officers due to emotional reactions to stress when they would not have likely met criteria for a formal psychiatric diagnosis (Nick, 2015, Violanti et al., 2015). Increased exposure in responding to suicide attempts and deaths is correlated with an increased likelihood of suicidal behavior in law enforcement (Cerel et al., 2018). Studies estimate that between 50% and upwards of 73% of law enforcement officers personally knew an officer who had died by suicide (Cerel et al., 2018). Suicide rates in small law enforcement departments are significantly higher than those of larger urban departments and have been noted to be four times that of the national suicide rates (Violanti et al., 2015).

Physical Concerns. Chronic stress and prolonged struggle with mental health effects can compound on the physical body and result in physical comorbidities as law enforcement personnel become older (Craddock & Telesco, 2021; Wagner et al., 2020). Chronic stress can

result in diminished neuroendocrine function that can in turn negatively impact cognitive decision-making capabilities (Hofer & Savell, 2021). As law enforcement personnel age, they are subject to disproportionate increases in cardiovascular disease risks, which is associated with increased stress and sleep disorders (Everding et al., 2016). Individuals with PTSD or significant chronic stress may notice that they struggle with sleep, headaches, fatigue, gastrointestinal concerns, and compromised immune response on a regular basis (Vermetten et al., 2014).

Recommendations to Address Concerns

The intervention of integrating mental health and wellness discussion into individual and group meetings allows law enforcement leadership to model acceptance of mental health symptoms or validate reported stressors. To be effective, the organization must alleviate fear of professional consequences when endorsing mental health concerns (DOJ, 2019a; Hofer & Savell, 2021). This can be done by ensuring transparency of policies and procedures of mental health concerns and crisis response procedures, as well as provide clear information of career concerns if applicable (Hofer & Savell, 2021). Law enforcement leadership must model and set a high standard expectation of confidentiality in order to create a comfortable environment for personnel disclosures (Vermetten et al., 2014, DOJ, 2019a). Social support from colleagues with the ability to share struggles and identify shared values result in improved resiliency and reduced emotional exhaustion (DOJ, 2019a, Vermetten et al., 2014; Santa Maria et al., 2018). This can be facilitated with regular team building opportunities and encouraged conversations on the topics of values and struggles in the field (Santa Maria et al., 2018). Through leadership support in individual meetings and group discussions, the detachment has an opportunity to reduce the stigma of endorsing mental health concerns, identify potential areas of improvement for

workplace stress, provide education of the normal reactionary symptoms of trauma and those of greater mental health concerns, and share knowledge and resources to enhance resiliency and early interventions.

Primary Prevention. Primary prevention measures of mental health symptoms in law enforcement have often included isolated brief formal education trainings and screening tools. The use of screening with formal questionnaires has not been found to be effective in occupations with a masculine culture and where mental health is stigmatized (Vermetten et al., 2014). Similarly, short formal training activities on topics such as stress reduction, relaxation techniques, communication, and emotional modeling have been found to have no statistical significance on improved mental health outcomes in multiple studies (Antony et al., 2020). It has been found to be more effective to utilize informal supportive check-ins conducted by peer support or trusted leadership within these populations (Vermetten et al., 2014; Department of Justice, 2019, Hofer & Savell, 2021). The current recommendations of the United States Law Enforcement Mental Health and Wellness Act disclose that there is not a clear picture yet of what should be included in mental health checks or what format they recommend (DOJ, 2017; DOJ, 2019a; DOJ, 2019b). However, it is stated that the most crucial component of mental health check efficacy is that their leadership and colleagues display confidentiality and trustworthiness with the information shared (DOJ, 2019a). Regular training for leadership and for the general law enforcement detachment should be conducted to educate on mental health risk factors, presenting symptoms, and warning signs to reduce stigma and ensure ability to identify areas of concern in themselves and their peers early on in addition to regular established check-ins for a holistic approach.

Secondary Supportive Measures. The facilitation of individual and group mental health and wellness discussions can assist leadership and departments in supporting their colleagues after traumatic incidents, during incident debriefings, and during high-risk personal life stressors such as marital separations or deaths. Establishing a lower degree of stigma when discussing mental health topics will reduce the pushback and ostracization of law enforcement personnel who voluntarily or mandatorily utilize mental health resources. The normalization of mental health and wellness can facilitate the discussion and utilization of mental health symptom topics in a group to increase the acceptance of normal responses to traumatic events and compounded stressors, as well as facilitate peer support and healthy coping skills during processing periods (Wagner et al., 2020). Therapy modalities such as critical incident debriefing sessions are not sufficient in the place of regular individual and group check-ins, as they may result in reduced anxiety and anger but show no overall difference in improved coping or psychological morbidity after six months when compared to a control group (Antony et al., 2018). However, referrals may be made to a mental health provider or therapy specialist for effective treatment modalities of cognitive behavioral therapy, exposure-based therapy, eye movement desensitization and reprocessing, and drug therapies (Antony et al., 2020; Crowe et al., 2020). Encouragement of leadership, colleagues, and reduced stigma increases the likelihood of a law enforcement officer utilizing the resources and improving their mental health and wellbeing before a crisis develops (Hofer & Savell, 2021; Crowe et al., 2022).

Tertiary Crisis Management. Having regular predictable times to check in about mental health and wellness concerns paired with an increased awareness of mental health conditions and reduced stigma may increase the likelihood of crisis identification in a law enforcement

individual (Daniel & Treece, 2021; Hofer & Savell, 2021). It is crucial to have a clear and transparent policy and guidelines for response within the organization to respond to a crisis mental health concern (DOJ, 2019a). Mandated treatment has been noted to be efficacious in a majority of referred law enforcement personnel when compared to voluntarily enrolled personnel (Hofer & Savell, 2021). If a crisis occurs directly following a traumatic event, normalizing the individual's behavior paired with formal support or treatment may allow the individual to process the incident and after a short leave they will likely be able to return to duty with a significantly lower rate of PTSD or other psychiatric symptoms (Vermetten et al., 2014). Continued peer support and encouragement can increase the health outcomes of the individual in crisis while on leave or in treatment (Hofer & Savell, 2021).

CHAPTER TWO

PROJECT PLAN

Summary of Project Need

This scholarly project will focus on implementing stigma reduction mental health initiatives within a rural law enforcement detachment of a larger organization. Law enforcement organizations across the country are subject to the increased strain of remaining on the front-line through the Coronavirus pandemic (Drew & Martin, 2021), working through intense scrutiny of the public (Dixon, 2021; Galovski et al., 2016), adverse political policies for the occupation (Dixon, 2021), and increasing workloads due to position turnover (Dixon, 2021; McQuerry Tuttle et al., 2019). These strains are amplified by the existing barriers of the masculine police culture and stigma within the law enforcement profession (DOJ, 2019a; Wheeler et al., 2018; Vermetten et al., 2014), as well as the unique stressors of rural law enforcement work (Violanti et al., 2015). The leadership of the detachment at the focus of this project endorses that there is a negative stigma of mental health concerns that are observed to create a significant barrier to mental health resource utilization. Negative stigma of mental health concerns in law enforcement is found to be a significant contributing factor to poor mental health treatment utilization (Boland & Salami, 2020; Karaffa & Koch, 2016; Millard, 2020) and the use of maladaptive coping skills such as use of drugs and alcohol (Boland & Salami, 2020; DOJ, 2019a). Unaddressed mental health concerns can negatively impact law enforcement's family stability and cohesion (Santa Maria et al., 2018), increase violence during on-duty response in stressful situations (Dixon,

2021), and contribute to increased suicide rates in law enforcement personnel (Cerel et al., 2018; Nick, 2015, Violanti et al., 2015).

Problem Statement

The foremost barrier to mental health concern identification, disclosure, and treatment within the law enforcement profession appears to be stigma. Personal discussion with the detachment's leadership indicated that there is organizational support and encouragement of mental health treatment utilization; however, stigma and concerns of maintaining professionalism often results in a barrier to resource access or open discussion of mental health topics among peers. The ability to trust and depend on the team members within this detachment often comes in to focus during crisis situations with potential life-or-death implications. This need to promote trust and dependability has resulted in a high level of individual integration into the established culture, and the idea of endorsing mental health concerns is believed to be hindered by this essential component of the profession according to the leadership of this detachment.

The purpose of this scholarly project is to support and guide a rural law enforcement detachment in implementing peer conducted mental health and wellness checks and facilitating discussion of mental health topics in an organic way that complements existing workflow systems and established mental health resources. This is a concern that requires the creation of an open and safe setting to disclose and discuss issues that arise when discussing mental health topics such as stress, anxiety, and/or substance use. It is recommended that the initiation of mental health checks provided in an informal manner can facilitate early identification of concerns, reduce overall stigma, and encourage resource utilization (DOJ, 2019b). Similar case

studies presented by the Department of Justice (2019b) on behalf of The Law Enforcement Mental Health and Wellness Act have presented comparable interventions that are underway and showing promising results in the reduction of stigma. If appropriately utilized, this intervention has the potential to improve law enforcement retention, promote resilient personal mental health and wellness patterns, and even to reduce the increasing suicide rates and mental health symptom progression in the profession for the included detachment (DOJ, 2019a, DOJ 2019b). The small-scale integration of peer facilitated mental health and wellness checks within the focused detachment can provide a roadmap for the larger state organization to reduce stigma and improve health outcomes on a broader scale.

Law Enforcement Detachment of Focus

The microsystem at the focus of this project is an independent unit of the larger organization macrosystem; which is comprised of dozens of detachments throughout the state all functioning under the same core principles and expectations. This larger organization functions under the core values of *Service, Integrity, and Respect* towards the community and towards their law enforcement members. The organization honors the memory and recognizes the losses from the organization with regular commemoration of “End of Watch” tributes. While they do not have reported on duty losses due to suicide, it is a priority concern of the organization with funding and support for mental health treatment, leave, and offered therapy for all law enforcement members. This law enforcement organization has facilitated a peer support group across the state that is trained in responding to mental health conditions and concerns commonly experienced by its law enforcement members. These peer support members are held to high standards of confidentiality and are publicly identified to the law enforcement population for

voluntary access. The leadership in the detachment of focus are trailblazing members of the peer support group and vocal advocates for the mental health support of law enforcement members. The geographic implications of this microsystem are further constrained by the rural and isolated location in which they work. This places an additional burden when accessing mental health resources. The small rural community also limits privacy in negative experiences or disclosures by its members, creating a greater emphasis on the trust needed to be open about mental health and wellness topics with peers and leadership. The public community surrounding this organization is not perceived by its law enforcement members to be accepting of mental health concerns or encouraging treatment access.

Priority Aim

The aim of this project is to reduce the perceived stigma by law enforcement members of mental health concerns and topics while encouraging the dissemination of available mental health and crisis resources after an individual and group mental health and wellness check conducted by a peer. This intervention aims to create a sense of security when disclosing mental health concerns with a peer and facilitate early intervention to law enforcement members with concerns. The priority short-term aim of this project is to have all members of the detachment engage in mental health and wellness checks with a peer in an individual and group meeting before the end of the year. The priority mid-term goal is to reduce the average law enforcement perceived stigma via the Attitudes about Mental Illness and Its Treatment Scale (AMIS) survey to an averaged low severity after two years of implementation. The priority long-term goal is to have no law enforcement suicides following the stable trend of low stigma average score via the AMIS by three years following implementation

Table 1: Scholarly Project Model

SMART Goals	Inputs	Activities	Outputs	Short-Term Goals <i>(Aims at one year)</i>	Mid-Term Goals <i>(Aims at two years)</i>	Long Term Goals <i>(Aims after three years of low stigma)</i>	Potential Barriers
<p>Each member of the detachment will have an individual mental health and wellness check in on a biannual basis by peer</p> <p>The detachment will facilitate one meeting annually for a group mental health and wellness check with open resource discussion</p> <p>Grant and organizationally funded resources will be verified, and resources will be shared on an annual basis by organization leadership</p>	<p>DPNP Student</p> <p>Detachment leadership members</p> <p>Individual detachment members</p> <p>Organization's contract Mental Health Specialist</p> <p>Law Enforcement Mental Health and Wellness Act established grant-funded resources</p> <p>Law Enforcement Mental Health and Wellness Act recommendations</p> <p>Organization's Peer Support team members</p> <p>Local crisis resources</p>	<p>Training of leadership on mental health concerns by Peer Support</p> <p>Confirming crisis and referral pathway for individuals who request help</p> <p>Completion of AMIS Survey by all members</p> <p>Facilitating mental health Peer Support training for those who are open to doing so</p> <p>Integrating of feedback on mental health and recommendations for improvement</p>	<p>Leadership's attendance and training in mental health topics, provided to organization's Peer Support team</p> <p>Additional time allocated for mental health and wellness assessment during individual assessments and annual detachment meetings</p> <p>Voluntary feedback from troopers to improve implementation</p> <p>Facilitation pathway to mental health resources directly if needed</p>	<p>Increased discussion of mental health and wellness topics in the organization and reduced stigma</p> <p>Endorsed and displayed comfort in law enforcement members in discussing concerns</p> <p>Improved response to peers in crisis</p> <p>Increased awareness of areas for improvement within the work environment</p> <p>Increased peer support and communication of stressors</p>	<p>Reduce the perception of stigma towards mental illness within the detachment to a low level</p> <p>Improve the work environment for law enforcement members based on endorsed concerns</p> <p>Offer additional training and support for law enforcement members based on discussed concerns and mental health and wellness symptoms</p> <p>Increased utilization of available mental health resources</p>	<p>Improved stress levels and perception of workplace mental health support</p> <p>Reduced rates of staff turnover due to mental health challenges</p> <p>Improved response with community members in times of stress</p> <p>Improved sense of belonging and membership within the team</p> <p>Improved health and wellness outcomes</p> <p>Reduced suicide rates for active and retired law enforcement</p>	<p>Engrained mental health stigma in law enforcement</p> <p>Concerns of punitive action by leadership</p> <p>Poor relationship with established mental health resources</p> <p>Lack of flexibility for organizational changes</p> <p>Inappropriate response from leadership to concerns</p> <p>Ineffective buy-in from organization of activity beneficence</p> <p>Poor response from individuals during check-ins</p>

Context

The law enforcement detachment at the focus of this scholarly project is a small rural unit of a large statewide organization. It is comprised of nine law enforcement members who are responsible for covering and responding to calls across approximately 1700 square miles of both tribal and state land. Recently, there has been an increased struggle with maintaining a full census of law enforcement members in this area, further amplifying the physiologic and psychological strain on the individuals responsible for responding to crises in this area. The focus team is comprised of one Captain, one Sergeant, six additional team members, and an accessible off-site organization funded mental health provider. These members are not providing identifying demographic information in conjunction with the AMIS survey, and all result trends are presented in average scores to protect anonymity.

PDSA Framework

The facilitation of this intervention is following prior optional mental health initiatives that were found to be ineffective due to internal stigma barrier. It is likely that this initiative will be met with unexpected challenges that must be addressed during facilitation. The model identified to be the most appropriate supportive framework for this project is the Plan-Do-Study-Act (PDSA) framework. This framework has been shown to enable the identification of themes and issues when implementing trailblazing or broad measures in a diverse organization (Audette et al., 2017; Leis & Shojania, 2017). This framework provides an outline for the initial steps of compiling and articulating the components of this intervention, followed by enacting the proposed plan, studying the results, and identifying barriers or hinderances, then using this

information to enact changes and restarting the framework cycle again with new information (Audette et al., 2017; Leis & Shojania, 2017).

Intervention and Implementation

While it is noted to be most efficacious when discussions are open and flexible within this population (Santa Maria et al., 2018), the peer facilitating the mental health checks requests an outline of some major topics and education points that should be covered. To do this, outlines will be drafted through collaboration with the detachment leadership, the organization mental health provider, and based upon the recommendations of the Federal Law Enforcement Mental Health and Wellness Act recommendations and findings (DOJ, 2017; DOJ, 2019a; DOJ, 2019b). It is expected that each mental health and wellness check-in will focus on three decided topics of concern. These mental health checks will be supported by the standards, resources, and crisis response established by the organization's existing peer support group. Expected barriers that may need to be overcome include concerns of punitive action in response to endorsed concerns, lack of established trust and comfort in disclosing concerns, distrust in the available mental health resources, and established law enforcement culture stigma towards mental health symptoms. The scheduling of the mental health and wellness checks will fall into established meetings already conducted on a biannual basis within the organization. There is an understanding that additional time may be needed to effectively facilitate these check-ins during both the individual and group meetings. There is buy-in from the detachment's leadership to preemptively invest this time. They plan to quantify the average time needed and salary costs post-intervention initiation in order to better budget for it in the future. It is not expected to exceed or strain the current allocated salary budget for the detachment.

Plan Phase

The first component of this framework is to *plan* which involves compiling current research, data, and guidelines to determine an appropriate approach to address an issue and measurement tool to determine intervention efficacy (Audette et al., 2017; Leis & Shojania, 2017). The initial steps of this project involve understanding the legal and policy guidelines and expectations of the organization when it comes to endorsement of mental health concerns. These must be well understood, accessible to the detachment members, and summarized prior to the first mental health and wellness check-in. A collaborative effort will then be made to identify three topics selected as priority focus for the detachment by the project lead, detachment leadership, and the organizations mental health provider prior to the meetings. The project lead will write an outline including causes, symptoms, coping techniques, and risk factors associated with the topics to ensure that the peer support member facilitating the check-in can enable a conversation with the same foundational principals with all members. This can also ensure educational points can be offered when concerns are presented to proactively address the concern. While this is a beneficial component to the project, it is crucial to remember that the priority aim of this intervention is not to act as a mental health crisis resource, but improve the stigma associated with discussing mental health topics and promote available resources to all law enforcement members involved. While the collaborative efforts of the planning phase are underway, leadership of the detachment will distribute the AMIS survey to all detachment members via a word document in an email to be returned to the project lead for baseline data compilation by January 31, 2023. These will be anonymously evaluated and presented in an average and spread assessment for each of the 11 items on the survey.

Do Phase

The *do* phase of this quality improvement project will involve a detachment peer support member scheduling and conducting one individual mental health and wellness check in with each individual in the organization. These check-ins are planned to correlate following regular biannual scheduled check-ins with leadership to reduce the need for additional coverage of crisis calls in the area and to reduce the need for salary coverage for a second meeting. This will also involve posing the same three topics discussed in the individual check-in following a group meeting to facilitate open feedback and discussion of the stressors and concerns being experienced by the detachment members. Following the completion of all individual and group check-ins, detachment leadership will email out the same AMIS survey to all members and return the anonymous word documents to the project lead for compilation of results by March 1, 2023.

Study Phase

The *study* phase of this quality improvement project will require evaluating the results of the AMIS scale by item to determine change in average score and interpret the impact of facilitating open conversation of mental health topics via a mental health and wellness check-in. Collaboration will occur with the peers who conducted the individual mental health checks to determine common reports and concerns from the law enforcement members. Open dialogue with the team will also be considered to determine how the mental health check facilitation can be improved upon in the next implementation cycle.

Act Phase

The *act* phase of this quality improvement project will involve using the information obtained in the study phase of the project in order to propagate improved measures and response to the law enforcement team. Advocacy for change in workplace structure, policy changes, or avenues for support and education will be employed to proactively mitigate stressors when possible. Changes to how the mental health and wellness checks are conducted should also be enacted in order to enhance efficacy and comfort for those involved with them. The attempt to integrate additional mental health resources from the community and those offered through the organization should also be a priority concern during the act phase of this process.

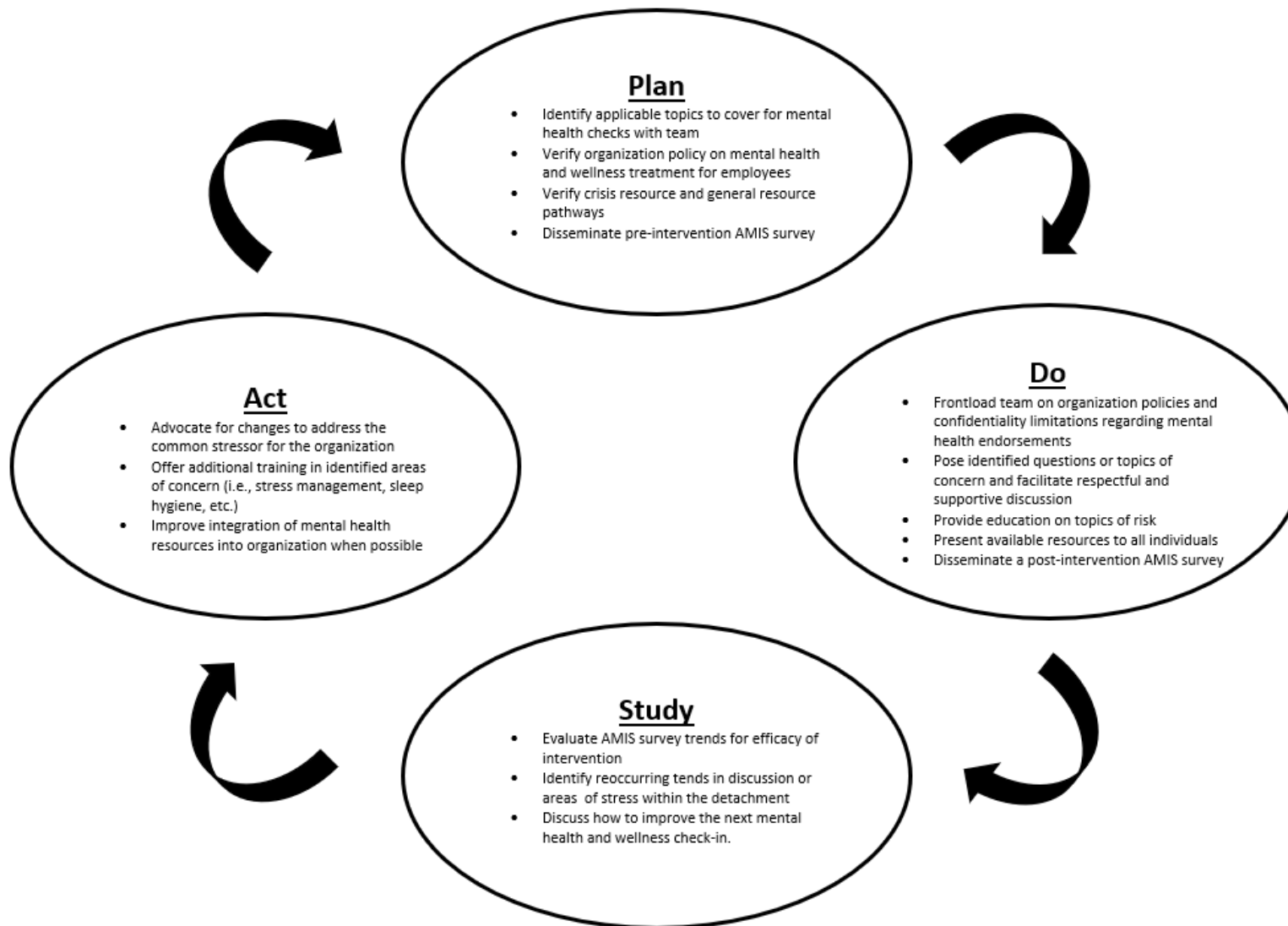


Figure 1: PDSA Implementation Summary

Table 2: Timeline of Phase Activities

<u>Phase Cycle</u>	<u>Activity/Estimated Accomplishment Date</u>		<u>Potential Barrier Mitigation Action</u>
Plan Phase	Outline three topics of concern to discuss at Mental health and wellness check-ins	January 31, 2023	Compile a full reference of organizational policy regarding mental health concern endorsement. Create a detachment statement of non-punitive action based on endorsements or stressor verbalization. Outline a crisis referral pathway for use if needed.
	Disperse a pre-intervention AMIS survey to be anonymously completed by all team members	Disperse January 7, 2023; Have all surveys in by January 31, 2023	
	Confirm available resources with organization mental health provider.	January 31, 2023	
Do Phase	Schedule and conduct individual check-ins with a peer member.	Completed by March 1, 2023	Ensure crisis response coverage by alternative law enforcement members so the meeting can be conducted without interruption. Share mental health resources available to all team members to utilize if needed and they are uncomfortable endorsing concerns.
	Schedule and conduct group mental health and wellness discussions with the full detachment.	Completed by March 1, 2023	
	Obtain a post-intervention AMIS survey from all detachment members following their last meeting.	By March 1, 2023	
Study Phase	Evaluate the trend and average score of AMIS survey by line item to see change in stigma after discussion.	March 31, 2023	Evaluate AMIS result trends. Provide an opportunity for detachment members to give honest feedback of the intervention for improvement, through written or verbal means.
	Discuss stressors and concern trends most frequently brought up or emphasized during check-ins.	March 31, 2023	
Act Phase	Leadership should advocate for structural or local process improvements if stressors indicated to be excessive by detachment members.	April 30, 2023	Base response on officer AMIS results and common themes of concerns or stressors. Integrate external mental health resources when possible.
	Organize mental health and wellness education opportunities for those who are interested with organizational mental health provider based on identified topics of significance during check-ins.	April 30, 2023	
	Begin the process of planning for subsequent mental health and wellness check-ins and improving the process for the future PDSA cycle.	April 30, 2023	

Evaluation

Evaluation of the efficacy of this project in the immediate short-term will be done through an anonymous assessment of the law enforcement officer's stigma towards individuals with mental illness through a pre and post-test survey with the Attitudes About Mental Illness and its Treatment Scale (AMIS), originally developed by Kobau et al. (2009) with collaboration from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Prevention (CDC) for use in the general public. This tool has found to be valid when used in the law enforcement population (Soomaro & Yanos, 2018). This scale includes eleven items measured on a 5-point Likert scale to correlate with the strength of support or disagreement with each item (Soomaro & Yanos, 2018, Kobau et al., 2009). The results of these surveys will be evaluated by average and spread comparison for each item of the pre and post-test responses to determine if mental health checks and group discussion of mental health and wellness improves the perception of stigma.

Efficacy will also be assessed subjectively by the detachment's leadership to determine if there are additional barriers to facilitating open conversations about mental health topics. The leadership staff will also need to evaluate if the individual law enforcement members require additional assurances from their organization to be willing to engage in mental health conversations during these meetings.

Statement	Strongly Agree	Moderately Agree	Neutral	Moderately Disagree	Strongly Disagree
I believe a person with mental illness is a danger to others.					
I believe a person with mental illness is unpredictable.					
I believe a person with mental illness is hard to talk with.					
I believe a person with mental illness would improve if given treatment and support.					
I believe a person with mental illness feels the way we all do at times.					
I believe a person with mental illness could pull himself or herself together if he or she wanted.					
I believe a person with mental illness can eventually recover.					
I believe a person with mental illness can be as successful at work as others.					
Treatment can help people with mental illness lead normal lives.					
People are generally caring and sympathetic to people with mental illness.					
I believe a person with mental illness has only himself/herself to blame for his/her condition.					

Figure 3: The Attitudes about Mental Illness and Its Treatment Scale (Kobau et al., 2009)

Table 3: Smart Goals

<p>SMART Goal #1: Three topics will be identified and outlined by the law enforcement detachment leadership, organization mental health provider, and project lead prior to mental health check-ins.</p> <p>This goal is established to ensure that the topics brought up for discussion are prudent and considerate of current stressors and situations experienced by the team members.</p> <ul style="list-style-type: none"> • Project lead will collaborate with stakeholders to identify top three mental health and wellness topics to cover. Additional resources and statistics are to be pulled from existing research to support discussion. <ul style="list-style-type: none"> ○ Outlined education tools will include background information, exemplar symptoms and presentations, potential contributing factors, protective factors and coping skills, and resources for further education for each topic. • Project lead will disseminate outline to the peer support members who will be conducting mental health checks. <ul style="list-style-type: none"> ○ This will involve a meeting discussing the items of the tool and confirming understanding of the resources provided to support accurate dissemination with law enforcement members. ○ Amendments may be made to the outline during the meeting. A final outline for mental health check-ins will be sent to detachment leadership and peer support members for use. 		
Data to be collected	Method of Collection and who is responsible	Planned data analysis
Current mental health and wellness concerns on a local and state level.	Project lead will compile and summarize qualitative and quantitative data from state organizations and national law enforcement initiatives such as the Federal Mental Health and Wellness Act (DOJ, 2019a; DOJ, 2019b). This information will be shared with the larger team of stakeholders and clarified before being included in the outline.	Assessment of peer review and population of focus comparable measures and studies for recommendations and supportive measures.
Resources and supportive recommendations that can be made to support mental health and wellness outcomes.		Personal evaluation and contact with recommended resources by team to ensure that they are appropriate for the population of law enforcement officers and still available for access if needed.
<p>SMART Goal #2: All detachment members will attend and engage in one individual and one group mental health and wellness check-in prior to March 1, 2023.</p> <p>The implementation time and dates are variable to provide flexibility to accommodate individual and community needs.</p> <ul style="list-style-type: none"> • Detachment leadership is responsible for scheduling individual and group meetings and arranging alternative coverage for emergency calls during that time. • It is expected that each member attends one individual and group mental health and wellness check-in, which will be conducted following standard staff individual and group meetings that have been a standard requirement of the organization. 		
Data to be collected	Method of Collection and who is responsible	Planned data analysis
Quantity of individual mental health and wellness check-ins completed.	Meeting attendance will be confirmed by detachment leadership.	Simple numeric analysis of members who completed their meetings versus total detachment count.
Quantity of individuals in attendance at the group mental health and wellness check-ins completed.		Simple numeric analysis of members in attendance versus total detachment count.
<p>SMART Goal #3: All detachment members will complete a pre-intervention AMIS baseline survey by January 31, 2023, and a post-intervention AMIS by March 1, 2023.</p> <p>This goal is established to ensure that an appropriate baseline and post-intervention perspective can be evaluated.</p> <ul style="list-style-type: none"> • The AMIS is an eleven-item survey that will be provided via word document to detachment leadership for distribution via email to all members. <ul style="list-style-type: none"> ○ There will be multiple methods of returning these surveys based on individual preference. These can be printed and turned into the detachment office or returned to the project lead. They may also be scanned to leadership members or to the project lead directly. • Project lead will be available for members with questions about the survey to ensure that any clarification can be made in a timely manner if needed. 		
Data to be collected	Method of Collection and who is responsible	Planned data analysis
Eleven items to determine severity of mental health stigma measured on a five level Likert scale.	Original distribution will be done by leadership via email through a work email system. Collection method is variable based on the preference of the individual returning the survey for anonymity's sake. This is expected to be sufficient due to the small population being surveyed.	Each item will be evaluated by the project lead for the average score of each item with pre- and post-intervention results.

CHAPTER THREE

QUALITY IMPROVEMENT MANUSCRIPT

Introduction

Active law enforcement officers (LEOs) in the United States are more likely to die from suicide than they are from any other on-duty incidents (United States Department of Justice [DOJ], 2019a). Evaluation of first responder suicides has been tracked since 2016 and indicates that there have been 182 to 248 reported suicides annually in the United States, majority of who were LEOs (Blue H.E.L.P., 2022). This estimate of law enforcement suicides is believed to be a significant underreporting of actual suicide completion due to stigma concerns from families and organizations (Blue H.E.L.P., 2022). LEOs also have an increased risk of developing Post Traumatic Stress Disorder (PTSD) at a rate 12.90% higher than comparable civilian populations with trauma history, while also being significantly less likely than civilians to use mental health resource supports (Boland & Salami, 2020). Concurrently, LEOs are at an increased risk of developing sleep disturbance conditions, increased alcohol use, and depression symptoms; which can be reduced and mitigated with appropriate mental health support (Boland & Salami, 2020; DOJ, 2019a; Richards et al., 2021). LEOs are at an increased risk of a multitude of negative health outcomes due to mental health concerns, while mental health resources and supports often fail to reach this population in time to mitigate potential negative outcomes.

Law enforcement is an occupation that exposes its officers to traumatic events on a regular basis while subsequently requiring self-reliance, resilience, and constant consideration of action while consequently having barriers of significant stigma and limited access of mental

health resources (DOJ, 2017; DOJ, 2019a; Velazquez & Hernandez, 2019). A portion of this stigma that occurs inside the agencies has been found to be disproportionately influenced by the perception of peer's overall opinion of mental health conditions and access of mental health resources (Karaffa & Koch, 2016). When LEOs become aware of their peer's acceptance of mental health resource utilization and access of treatment, there is an improvement in the overall stigma perception within the organization and in an individual's self-stigma (Karaffa & Koch, 2016). Quality improvement initiatives that are formal and structured have demonstrated limited efficacy in this population; however, initiatives that are informal, supportive, normalize mental health concerns, and are conducted by peers have been observed to be effective and better accepted (Karaffa & Koch, 2016; Vermetten et al., 2014).

Literature Review

LEOs are exposed to an estimated 900 traumatic events in the duration of their career (Tuttle McQuerrey et al., 2019). Cumulative trauma leads to increased rates of mental health concerns, physiological illness, and general trauma symptom presentation (Velazquez & Hernandez, 2019). Current displays of public aggravation towards general law enforcement and increased negative stigma of law enforcement has enhanced the intensity of perceived occupational stress, increased noted mental health concerns, and decreased LEOs willingness to disclose concerns and access mental health resources (DOJ, 2019a; Galovski et al., 2016; Karaffa & Koch, 2016). These factors have been compounded with the everyday professional stressors of the job and the physical impacts of the profession resulting in an increased likelihood of experiencing a crisis (Craddock & Telesco, 2021; Boland & Salami, 2020; Hofer & Savell,

2021). Mental health concerns can develop slowly over time and progress into a crisis, or a crisis may occur suddenly without warning (Craddock & Telesco, 2021; Mumford et al., 2021).

Rural Implications

Negative emotional effects and burnout in small rural departments cause attrition rates nearly double that of urban departments (Violanti et al., 2019). This has resulted in an increased workload in rural departments, decreased rate of having available back-up if needed, and increased responsibility to cover additional shifts (Violanti et al., 2019). Rural LEOs are also more likely to experience the stressor of knowing the civilians involved in calls or traumatic events, while being less likely to use mental health resources due to perceived confidentiality concerns and having less access to organizational resources (Violanti et al., 2019). Increased exposure to suicide attempts and deaths is correlated with an increased likelihood of suicidal behavior in LEOs, while suicide rates in rural law enforcement offices are found to be four times that of national civilian suicide rates and significantly higher than urban agencies (Cerel et al., 2018; Violanti et al., 2019).

Long-Term Implications of Unaddressed Concerns

Unaddressed, mental health concerns can lead to higher rates of law enforcement burnout and occupation turnover, increased aggression and use of force in community engagements, and increased episodes of mental health crisis and suicide (Dixon, 2021; Tuttle McQuerry et al., 2019). Providing avenues to increase mental health and wellness in the law enforcement community has the ability to improve the quality of life in individual officers, reduce rates of suicide in this population, and improve community safety with retained officers and less aggressive interactions (Tuttle McQuerry et al., 2019). It would benefit both the community, law enforcement members,

and their families to proactively address mental health concerns and facilitate supportive factors to promote resilience and stability in this population.

Stigma

Stigma is often thought of as a negative perception or stereotype that leads to a negative attitude, opinion, or undesirable experience. LEO stigma towards mental health initiatives and afflictions are often a compounded result of both public opinion stigma, self-stigma, and organization cultural stigma (Velazquez & Hernandez, 2019). Mental health stigma has been identified as one of the leading barriers preventing access of mental health resources by LEOs (DOJ, 2019a; Velazquez & Hernandez, 2019; Wheeler et al., 2018). The perception of increased public scrutiny subsequently reinforces the sense of self-stigma, promotes the development of maladaptive coping skills, and enhances the feelings of isolation by LEOs (Hofer & Savell, 2021; Karaffa & Koch, 2016). The use of peer support models has been found to be beneficial in reducing self-stigma and perceived organizational stigma in law enforcement organizations (DOJ, 2019b; Millard, 2017).

Quality Improvement Initiative

The small rural law enforcement detachment at the focus of this quality improvement project has experienced personal impacts within their team in the past due to mental health crises of fellow LEOs. Additional interventions have been trialed by this organization to address LEO mental health concerns through facilitation of an organizationally funded mental health provider, supportive treatment leave or desk duty opportunities for officers struggling with mental health, and the training and initiation of peer support team members who can assist and respond to

mental health concerns in their peers. Unfortunately, there has been a poor response to these interventions and hesitance of resource access for LEOs in this organization. The goal of leadership in this law enforcement detachment is to improve cultural acceptance of mental health and wellness topics among their team and to increase access and utilization of resources for mental health and wellness support.

Law Enforcement Mental Health and Wellness Act

The United States Congress passed funding and recommendations in the Law Enforcement Mental Health and Wellness Act in 2017 to outline expectations for better support of LEOs; who are responding to increased stress, on-duty provocation, and public distrust (DOJ, 2017; DOJ, 2019a). The congressional presentation also included a series of case study recommendations of how to implement mental health support and proactive programs within law enforcement departments that improve health outcomes and reduce stigma (DOJ, 2019b). One of the recommendations indicated the efficacy of informal mental health check-ins to support early identification of concerns, reduce department stigma of mental health topics, and facilitate resource utilization (DOJ, 2019a; DOJ, 2019b). A collaborative discussion of the law enforcement organization's established abilities and resources identified this framework to be the most ideal to address current barriers and LEO needs.

Project Design Rationale

Following the Law Enforcement Mental Health and Wellness Act (DOJ, 2019a) recommendation of regularly scheduled, peer conducted mental health and wellness check-ins, the aim of this quality improvement project was to reduce mental health stigma and assess the

acceptance and utilization of available resources to support mental health wellbeing by the LEOs. The purpose of this project was to formalize an implementation method that can be applied to similar populations of law enforcement within the organization and provide a tool that could be used to indicate changes of stigma perception of mental health concerns with progressive interventions and support. The information and process elicited during this quality improvement project will provide guidance for future implementations meant to decrease the internal and self-stigma of mental health concerns and encourage the utilization of available mental health resources. The participating rural law enforcement detachment included six current LEOs, a sergeant, and captain responsible for responding to the needs of a rural area encompassing more than 1700 square miles of both tribal and nontribal land. The agency team members are all males between the ages of 24 and 50. This team is predominantly Caucasian with one Hispanic officer, and a diverse range of past law enforcement and military history.

Framework

The framework selected for this quality improvement project is the Plan-Do-Study-Act (PDSA) framework (Nelson et al., 2007). This framework was selected due to its ability to facilitate trailblazing measures in complex organizations in a way that adapts to challenges and unforeseen barriers and propels the project forward with consideration of changes in real time (Audette et al., 2017; Leis & Shojania, 2017). This framework has been beneficial as the detachment adjusted schedules to accommodate covering for a fellow officer who had been injured on-duty and to respond to the needs of fluctuating community calls for assistance during scheduled peer check-in times.

Methods

This project utilized the framework of Plan-Do Study-Act to introduce a peer facilitated mental health and wellness check-in program similar to the case study described in the Law Enforcement Mental Health and Wellness Act report (DOJ, 2019b) within the rural law enforcement detachment of focus. The outcomes of this intervention were measured by both qualitative and quantitative actions to support the initiative.

Measure of Improvement

To assess general improvement of stigma on mental health topics within the law enforcement detachment, a short assessment was utilized to evaluate the trend in perception with the standardized tool of the Attitudes About Mental Illness and its Treatment Scale (AMIS) that had been published and validated by Kobau et al. (2009). This assessment tool was developed for use in the general American population with collaboration from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Prevention (CDC) agency (Kobau et al., 2009). This tool has recently been validated for use specifically with the law enforcement population (Soomaro & Yanos, 2018). The AMIS tool includes eleven broad questions to be responded to on a five-point Likert scale with options ranging from strongly agree to strongly disagree and is to be evaluated by average report for each question (Soomaro & Yanos, 2018, Kobau et al., 2009).

Plan Phase

The *plan* phase of this quality improvement project involved ensuring that the intervention met guidelines of the larger organization, federal standards delineated by the Law

Enforcement Mental Health and Wellness Act, and current evidence of efficacious interventions with this population (DOJ, 2019a). The planning phase also required incorporating feedback from the leadership members of this detachment to ensure that the LEOs feel secure in their ability to discuss their concerns without fear of punitive or scrutinous action if they make a mental health endorsement, which required prefacing interactions with supportive occupational policy and trustworthy peers to confide in. The collaboration of this author and the organization's leadership also identified three key topics to discuss in the mental health and wellness check-ins with drafted questions and supportive education and resources to provide all LEOs during their check-in. The topics identified for discussion included the everyday work stressors of the profession, sleep habits, and trauma exposure response symptoms and coping strategies.

Do Phase

The *do* phase of this quality improvement project involved initial distribution of the voluntary AMIS preliminary-assessment and general information on the incorporation of a mental health and wellness check-in in conjunction with their routine bi-annual check-in. These check-ins were scheduled with all officers in the detachment, without requirement of engagement if the officer was uncomfortable. It was decided through collaboration with the detachment leadership that all check-ins would be conducted by the sergeant of the detachment due to his positive personal relationships and less punitive role within the detachment. The sergeant was able to meet with all six LEOs, who were open to discussing all predetermined topics. There was some difficulty identifying times to conduct check-ins due to a high emergency call frequency that required immediate response. This phase concluded with the

second distribution of the AMIS post check-in survey for voluntary fulfillment by LEOs who completed their mental health and wellness check-in.

Data Collection. All AMIS assessments were voluntarily filled out by each individual officer who participated in a peer check-in. LEOs had the ability to print the assessment and leave an anonymous copy in the leadership members box, email it to leadership, or anonymously fax it from the organization's office to this author's email. No demographic information was collected in conjunction with these surveys to protect LEO anonymity and encourage honest responses. These surveys were saved only by cataloging numbers and were reported only by average results to the organization at the summation of data collection.

Study Phase: Initial Results

The *study* phase compared LEO's AMIS assessment results at preliminary baseline and post check-in to assess for changes in stigma attitude following the peer conducted mental health and wellness check-in. An average mean score for each question of the AMIS assessment was produced and compared at pre and post check-in intervals to identify changes in mental health stigma trend among the LEOs. Each question on the AMIS is responded to in a five option Likert scale ranging from "strongly agree" scored at a 2 to "strongly disagree" scored at a -2 with the selection of "neutral" being scored as a 0. The statistical significance of the data could not be identified due to the small sample size of this data and lack of a control group. Preliminary AMIS assessments were obtained by five of the six LEOs, with one member abstaining from participation. Post check-in AMIS assessments were submitted for all six of the LEOs that engaged in the mental health and wellness check-ins.

Table 1: AMIS Survey Results

AMIS Survey Item	Baseline Survey Mean Score (n=5)	Post check-in Mean Score (n=6)
I believe a person with mental illness is a danger to others.	-0.2	-0.17
I believe a person with mental illness is unpredictable.	0.2	-0.17
I believe a person with mental illness is hard to talk with.	-0.4	-1
I believe a person with mental illness would improve if given treatment and support.	1.2	1
I believe a person with mental illness feels the way we all do at times.	0.2	0.5
I believe a person with mental illness could pull himself or herself together if he or she wanted.	0	0.67
I believe a person with mental illness can eventually recover.	0.8	1.34
I believe a person with mental illness can be as successful at work as others.	1.6	1.5
Treatment can help people with mental illness lead normal lives.	1.4	1.17
People are generally caring and sympathetic to people with mental illness.	-0.2	-0.17
I believe a person with mental illness has only himself/herself to blame for his/her condition.	-1.2	-1.34

Key: Value Response Correlation

Likert Choice Option	Numeric Value
Strongly Agree	2
Moderately Agree	1
Neutral	0
Moderately Disagree	-1
Strongly Disagree	-2

Act Phase

The *act* phase of this quality improvement project was based on the identified needs of the LEOs. In the case of this detachment, the recent on-duty assault of a LEO which left him severely injured had increased feelings of anger and fear within the team. Future plans for the act phase of addressing the LEOs concerns may include creating group opportunities for debriefing the incident and arranging supplemental coverage from leadership to be available for call-out if back-up is needed and only one officer is scheduled. The timeframe for this phase is meant to incorporate the actions taken up to the next implementation of mental health and wellness check-ins, at which time the PDSA cycle will repeat.

Results Interpretation

One of the most beneficial outcomes of this intervention was the display of acceptance by the LEOs in this rural detachment in engaging in discussion of mental health topics. Evaluation of the AMIS results indicated moderate improvement or insignificant change in stigma in most of the assessments, with notable improvement in two key areas. There was a significant change in LEO belief that a person with mental illness is difficult to talk to; indicated by a preliminary average score of -0.4 to a summative average of -1. A second significant change is that the LEOs improved belief that individuals with mental illness can eventually recover with a preliminary score of 0.8 to the summative score of 1.34. The peer facilitator of these mental health check-ins reported that each member verbalized feeling comfortable sharing their concerns and was open to learning about available mental health resources. Additional feedback provided indicated that there was a popular desire to continue these mental health check-ins on a biannual basis.

Discussion

Law enforcement in rural areas are at an increased risk and disadvantage when it comes to mental health concerns. Creating a supportive and responsive internal community with a reduced stigma of mental health concerns can increase LEO knowledge and recognition of mental health and wellness symptoms, access of available mental health resources, and the sense of having a supportive community. By broadening the implementation of peer conducted mental health and wellness checks, a further reduction of stigma may be seen throughout the larger law enforcement organization at the focus of this study. A necessary component of implementing this model is ensuring that LEOs conducting mental health check-ins must be respectful of endorsed concerns, trusted by their peers, and able to facilitate connections to mental health resources if needed. Continued use of the AMIS assessment at the summation of each biannual check-in would encourage identification of interventions producing significant change in stigma levels among the officers. These results and other efficacious developments will continue to be reported for national dissemination (DOJ, 2019a; DOJ, 2019b).

Ethical Considerations

Prior to screening members of the law enforcement detachment, approval was received by the agencies Human Resources department, organizational leadership, and through the Institutional Review Board at Montana State University. The LEOs are provided policy protections from punitive or disciplinary action due to mental health concern endorsements and this protection is clearly articulated by leadership and peer support members prior to any interventions.

Limitations

This project was unable to determine statistical significance due to the small sample size, short time-period of evaluation, and the generalized presentation of results to protect the LEOs' anonymity. The potential for biased responses from LEOs may have resulted from the voluntary nature of AMIS participation. The results of this quality improvement project are limited due to regional and cultural factors of the population of focus and the results are not necessarily generalizable to all rural law enforcement populations.

Conclusion

The results of this quality improvement project indicate beneficence in peer conducted mental health and wellness check-ins in law enforcement on the factors of stigma and improving education and mental health resource access. These results are particularly promising for rural law enforcement agencies, where there are additional barriers to LEOs access of outside mental health resources with a concurrent increased risk of suicide and mental health crises. Utilizing peers to conduct mental health and wellness check-in's creates trust among the internal law enforcement community and can facilitate trust in outside mental health resources if needed. Regular scheduled discussion of mental health topics that display the organizations support of LEOs' mental health concerns without punitive consequences, has the ability to reduce the stigma of mental health concerns throughout the organization and reduce the barrier it creates in law enforcement culture. Regular use and evaluation of the AMIS survey provides an avenue for quantitative identification of change in stigma trends over time. If this intervention is broadened throughout the larger organization, it could reduce the risk of LEO suicides and mental health

crisis development, improve officer retention, and reduce violent engagements in tense community interactions with law enforcement.

CHAPTER FOUR

REFLECTION ON DNP ESSENTIALS

Educational Development of Essential Competencies

My curriculum at Montana State University supported the development of doctoral nursing practice (DNP) Essential I: Scientific Underpinnings for Practice, through foundational skill development and enhanced competency of nursing action preparation (AANC, 2006). This essential was supported by my learning in courses Evidence Based Practice I and II. These courses developed my competency in identifying reliable sources of research, ability to interpret presented research, and evaluation and proposal of recommendations that could be applied to a population or community of focus. During my work in these courses, I had an opportunity to explore two diverse topics and appraise research on the medical conditions of diabetic neuropathy as well as discuss allopathic measures and integrative meditation treatments for management of anxiety disorders. I also learned frameworks for and practiced using rapid critical appraisal tools to assist my interpretation of both qualitative and quantitative research. An additional course that supported my development of this essential, was Statistical Applications, where I was able to learn about the role of statistics in research, practice evaluating and comparing statistics of various research articles, and articulate how these variations in research could be meaningful when considering integrating research principals into my own practice.

The second DNP essential involves understanding organizational and systems leadership for quality improvement and systems thinking (AANC, 2006). This competency is meant to prepare students to be able to develop and evaluate care delivery models that are tailored to

unique patient and community needs with an emphasis on accountability for cost efficacy, safety, and effective interdisciplinary care. My course work in Advanced Practice Nursing Leadership provided a historical foundation and theory approach for both practice level and systems level care delivery models. While working within this course I was able to develop my own personal model of leadership and come up with interdisciplinary approaches to facilitate change in the healthcare field and practice supporting leaders as an active follower. Understanding the cost analysis and budgeting portion of healthcare was accomplished through my coursework in Finance and Budget of Healthcare Systems. In this course I was able to conduct a cost-benefit analysis and create proposals for budget improving initiatives based on cost analysis interpretations. Additionally, I had the opportunity to create an analysis of how healthcare policy from a federal and state level can impact population health outcomes; particularly when discussing substance abuse in tribal communities.

My curriculum development of DNP Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice, was incorporated into most courses, particularly during the Program Planning & Evaluation, Outcomes, & Quality Improvement course (AANC, 2006). Within this class I worked in a team to gather research and summarize the need for an initiative of postpartum depression screening in a rural community. This project involved incorporating gathered evidence-based research to support identification of the problem, delineation of how to measure improvement in outcomes, and identification of an appropriate intervention to address the problem for the unique population. My education on this topic and creation of a project proposal provided an emphasis on understanding guidelines, which policies and procedures to consider, identifying an applicable framework, hypothesizing a timeline, and interdisciplinary

involvement methods. This provided a holistic view of the complexities of fulfilling DNP essential III and ensuring that any quality improvement project approached in my clinical practice is considered with extensive thought and supported by well-rounded evidence.

My curricular preparation of DNP Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care (AANC, 2006), was best supported by my coursework in Healthcare Informatics and Design of Healthcare Delivery Systems courses. DNP essential IV requires that graduates are able to select and design programs that monitor healthcare outcomes (AANC, 2006), which was supported with my work in Design of Healthcare Delivery Systems. In this course, I was able to learn how to utilize a variety of systems engineering tools such as microsystem assessments, lean healthcare models, value stream maps, and A3 reports. Practice with and evaluation of my use of these tools will increase my efficacy using them in practice. My coursework in Healthcare Informatics provided a foundational knowledge of healthcare informatics technology and knowledge of how to implement these processes into practice, how to evaluate and improve patient healthcare literacy, and methods for evaluation of information technology tool implementation. My project in this course centered around implementing a healthcare provider compassion fatigue evaluation tool, which supported this DNP essential by displaying that technology can be used to support providers beyond direct patient care.

The curriculum provided to support DNP Essential V: Health Care Policy for Advocacy in Health Care, is designed to encourage student leadership and critical analysis of policy proposals and development (AANC, 2006). This essential also supports students' knowledge on how to educate others on a policy's impact on patient outcomes and the importance of social

justice action (AANC, 2006). The primary course developing the foundation for this essential was Ethics, Law, and Policy for Advocacy in Healthcare where we had an opportunity to learn foundational skills for and then display our ability to interpret policy through a legal limitation and ethical lens, as well as write a letter for policy change and supportive advocacy to a local legislative member.

DNP Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes requires supporting students' development in interprofessional understanding, communication, and collaboration (AANC, 2006). This concept was integrated throughout our curriculum on topics from implementing quality improvement projects to developing interdisciplinary care teams for complex patients. The course that comes to mind as the foundational building block for this concept is the Advanced Practice Nursing Leadership course. In this course we had an opportunity to practice giving communication feedback and learning to improve collaboration with our peers. We were also provided a foundational knowledge of what the nurse practitioner role is and how this role integrates in an interprofessional team.

The curriculum development supporting DNP Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health, are established to identify population health issues, understand how psychosocial and cultural issues can impact health, and propose and integrate care delivery models that better support the needs of a population (AANC, 2006). This essential was supported by my learning in our Vulnerability and Health Care in Diverse Populations course, where I had an opportunity to work with a team and provide an assessment of the needs of the tribal population in my community on the Flathead reservation. A beneficial

component of this activity was also the process of educating my classmates about the healthcare needs of this population and learning about other diverse populations within the state. These assessments provided an overview and practice with assessing health disparities and learning about the psychosocial and cultural considerations that could help and hinder health initiatives within those populations.

Lastly, DNP Essential VIII: Advanced Nursing Practice (AANC, 2006), was supported by a significant portion of our final semesters in the program. This essential ensures that students are prepared to conduct comprehensive and systematic health assessments as well as be able to identify and implement nursing interventions, select pharmacologic support, and provide therapeutic supports for patients in each unique case (AANC, 2006). The assessment portion of this essential was supported through the foundational education provided in our Diagnostic Reasoning and Advance Health Assessment courses. The development of my knowledge of medications and how to best utilize them with patients was provided over the course of two semesters with a Pharmacology and Psychopharmacology course where we learned about the scientific and supportive research of medications and identified appropriate medications to select in various case studies. My course work in Psychotherapeutic Modalities provided an opportunity to dive into the principles that make therapeutic interventions effective during patient interactions. I had an opportunity to observe various types of interventions applied in case situations with patients in my therapy clinicals and was able to apply some of these techniques effectively in my own patient led interactions.

Quality Improvement Project Competency Development

The foundation of my quality improvement project was guided by DNP Essential I: Scientific Underpinnings for Practice and DNP Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice (AACN, 2006). This project has been guided by integrated research and trends on mental health concerns in the population of law enforcement. The intervention applied was guided by established research and by the federal recommendations through the Law Enforcement Mental Health and Wellness Act (DOJ, 2019a); as well as by integrating monitoring tools utilized by comparable populations in the military and validated in similar law enforcement populations. These scientific underpinnings have ensured that the organizations efforts have an increased potential to have long-term efficacious benefits as well as collateral support and encouragement by parallel agencies that could provide avenues for surpassing barriers and complications that may become apparent during the course of broader implementation.

This project incorporates DNP Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking (AACN, 2006), through collaborative identification of an intervention that will meet the current and future needs of the population of rural law enforcement officers. The quality improvement project designed is aligned with federal recommendations to allow for avenues for funding and provides considerations to the ethical and sensitive nature of the needs of the population. This project was completed with interdisciplinary feedback to align with the systems and workflow of the law enforcement agency of focus.

DNP Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes (AACN, 2006) was utilized when collaborating to orient the organizations

guidelines with the guidelines for mental health and wellness initiatives. This collaboration also created an outline for accessing resources that can provide mental health services outside of the law enforcement organization if needed by a law enforcement individual.

The overarching goal for this scholarly project is delineated by DNP Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health (AACN, 2006). This essential guided the consideration for law enforcement psychosocial and diversity factors while developing, implementing, and evaluating the intervention created to prevent future mental health crises and improve the overall health outcomes of the population. This method related directly to the cultural, occupational, and community dimensions of health improvement in the law enforcement population.

Future Career Impacts

These competencies provide a firm foundation for effective and safe psychiatric mental health nursing practice in the future. I feel that both my curriculum development and clinical experiences have allowed me to develop the required foundational knowledge and skills of the profession, as well as practice these skills with patients in the presence of a preceptor to ensure that my actions were effective and appropriate. I appreciate that a significant portion of our curriculum was developed to support DNP essentials I and III with a focus on scientific research and interpreting evidence-based practice data to guide practice decisions and changes (AACN, 2006). This will support my future practice in adjusting to changes in data and scientific evidence on interventions and medications used. In my future career, I will be working with an assortment of diverse populations, such as rural farmers, Native American people, Hutterite and Amish communities, as well as diverse Americans serving in Montana army stations. The

support and growth with DNP essential VII will strengthen my ability to tailor care plans to these unique and diverse populations to better produce positive patient outcomes (AACN, 2006). The most crucial and foundational skills of a psychiatric mental health nursing practitioner are provided in alignment with DNP essential VIII which supports effective and efficient assessment and care plan design and implementation (AACN, 2006). This essential has been practiced over four clinical semesters to ensure appropriate learning and effective ability to conduct the required components of the profession. These foundational skills will ensure that even on my first day in clinical practice, I will be able to safely assess patients and make treatment recommendations.

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APPENDIX

Figure A: Literature Review Flowchart

