Barriers and Opportunities for Suicide Prevention Among Correctional Officers: An Issue Brief for Clinicians

Suicide Prevention Resource Center

This document was funded by the Suicide Prevention Resource Center (SPRC) at the University of Oklahoma Health Sciences Center. SPRC is supported by a grant from the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), under Grant No. 1H79SM083028. The views, opinions, and content expressed in this product do not necessarily reflect the views, opinions, or policies of HHS, SAMHSA, or CMHS.

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Suggested Citation

Suicide Prevention Resource Center. (2023). *Barriers and opportunities for suicide prevention among correctional officers: An issue brief for clinicians*. https://sprc.org/wp-content/uploads/Correctional-Officers-Brief.pdf.

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INTRODUCTION

Correctional officers work a tough beat in law enforcement. Their job—keeping incarcerated persons and the public safe—involves working in a highly challenging environment with daily threats of physical, emotional, and mental harm. Suicide rates among correctional officers are much higher than those in the general population, but suicide among correctional officers remains an under-addressed problem in the field of suicide prevention. Drawing on research and the expertise of correctional researchers, officers, and clinicians, this issue brief describes the problem of suicide among correctional officers and identifies barriers and opportunities for suicide prevention efforts in the correctional officer workforce in the United States, with an emphasis on what clinicians can do to promote resilience, identify risk, and intervene clinically. This issue brief also identifies resources for additional learning about this topic.

BACKGROUND

In 2023, there were approximately 363,250 correctional officers and jailers in correctional facilities across the United States[1] supervising more than 5 million persons.[2] Correctional officers play an integral role in the functioning of the U.S. prison system and serve as front-line personnel in prison institutions. Correctional officers are charged with supervising incarcerated persons, enforcing rules and regulations, and maintaining order in the correctional environment.[3]

DID YOU KNOW?

The average life expectancy of a correctional officer is 60 years, compared to approximately 76 years for the general adult population.[17,18]

Occupational stress and injury

Correctional officers work under dangerous conditions, and corrections is widely reported to be among the most stressful occupations.[4] Correctional employees and others who work in the field report consistently high levels of stress in their work. Some of the stressors are occupational or operational in nature, while others are related to exposure to violence or other traumatic experiences.[4,5]

Correctional facilities must operate continuously (i.e., 24/7). Thus, correctional work often entails long shifts under difficult working conditions, and a national staffing crisis has exacerbated this problem by compelling administrators to require correctional officers to regularly work overtime.[6] Other occupational stressors reported by correctional officers include ineffectual supervision, a highly regulated environment that limits worker autonomy, and interpersonal conflict in the workplace.

Correctional officers are often injured on the job, experiencing some of the highest rates of non-fatal occupational injuries leading to absenteeism of any occupation.[7,8] Further, due to exposure to chronic stressors and the need for hypervigilance on the job, correctional work contributes to physiological wear and tear on the body caused by disrupted cortisol and glucocorticoid levels.[5,9-11]

Throughout their careers, correctional officers are exposed to a wide range of potentially traumatic experiences, including but not limited to:

- Violence or aggression from incarcerated individuals
- Life-threatening injuries
- Biohazard exposures
- Threats to self or family
- Being taken hostage
- Feeling in danger or fearful of making a life-threatening mistake
- Suicide attempts of incarcerated individuals or coworkers
- Deaths of incarcerated individuals or coworkers

Exposure to violence

In addition to occupational and operational sources of stress, research suggests that correctional officers are exposed to workplace violence, injury, and death at much higher levels than those who work in most other occupations.[6] Although not all correctional officers will be a victim of violence or assault, most will, and the threat of bodily harm is ever present.[12] In one sample, researchers found that 68.7% of Michigan correctional officers reported being exposed to violence, injury, or death.[4,13] Correctional officers are chronically exposed to human suffering in the correctional setting; corrections is among the five occupations that experience the highest levels of exposure to violence.[14] Research shows that exposure to violence has demonstrable impacts on the emotional and psychological health of correctional officers, which compounds the impacts of the routine occupational and operational stressors of correctional work.[15,16]

Trauma

In studies of correctional officer health, the occupational hazards of correctional work and exposure to traumatic events have been associated with mental health problems.[19] One study showed that hazardous working conditions increased the likelihood that officers would experience mental health problems such as anxiety, depression, and posttraumatic stress disorder (PTSD).[20] Other research shows that correctional officers have some of the highest rates of burnout, sleep disorders, and PTSD of all U.S. workers.[6,12,16,21-26] A study published in 2012 estimated that, among correctional officers in 49 U.S. states and 3 U.S. territories, the prevalence of past-month PTSD was 27% based on PTSD criteria in the fourth edition of the Diagnostic and Statistical Manual (DSM-IV).[6] In a study of Washington State Department of Corrections employees in 2013, 27% of employees screened positive for past-month PTSD, and 19% met diagnostic criteria for past-month PTSD based on DSM-IV criteria. The rates of PTSD in that study were found to be equivalent to, and in some cases higher than, rates among veterans of the wars in Iraq and Afghanistan.[19]

Voices of Lived Experience

Correctional officers routinely provide life-saving care in emergencies in correctional facilities, an aspect of the job that is rarely recognized outside the profession. Rick Field, a retired correctional administrator, explains that correctional officers are frequently called upon to save lives and alleviate human suffering, not only among incarcerated individuals but also among other officers.

For example, during his career Field witnessed several instances where correctional officers effectively intervened to prevent suicide attempts, provide aid to incarcerated individuals with life-threatening injuries, and save the lives of fellow officers experiencing their own mental health crisis or who were at risk of self-harm while on duty.

SUICIDE AMONG CORRECTIONAL OFFICERS

Although there are few comprehensive, high-quality efforts to collect data on suicide among correctional officers, evidence from routinely collected mortality data suggest that suicide rates are elevated among law enforcement officers generally and correctional officers specifically.[16,27] There are currently no reliable national prevalence estimates for correctional officer suicide, but researchers have used data from the National Occupational Mortality Surveillance System (NOMS) to estimate the relative incidence of suicide among correctional officers. One study found that the incidence of suicide among correctional officers was approximately 39% higher than among the general working age population, with a more recent analysis finding that the relative incidence might be closer to 41% higher.[28,29] Research also suggests that correctional officers have a higher suicide rate than workers in other public safety occupations (police officers, firefighters, emergency medical technicians, and paramedics).[30] According to an assessment using NOMS data spanning 11 years (1999, 2003-2004, 2007-2014) across 26 states, the suicide rate among correctional officers was 34% higher than among other law enforcement personnel.[31]

To better understand the nature and extent of the problem of suicide among correctional officers, in 2020 the U.S. Congress mandated that the U.S. Office of the Attorney General begin collecting data on suicide in law enforcement, including corrections, and the Federal Bureau of Investigation launched the Law Enforcement Suicide Data Collection (LESDC) effort. Although the LESDC program is in its infancy and the data are quite limited, in 2022, LESDC reported there were 32 suicides and 9 attempted suicides across just 22 reporting agencies. Among the 32 suicide decedents, 24 were active-duty officers and 8 were retired. Data from LESDC show that most suicides and suicide attempts occurred at the individual's home, and firearms were the most common method, followed by intentional drug overdose. Geographically, most suicides and suicide attempts occurred in the South, followed by the West, Midwest, and Northeast.[32]

DID YOU KNOW?

Research suggests that correctional officers have a higher suicide rate than workers in other public safety occupations.[30]

BARRIERS TO SUICIDE PREVENTION IN CORRECTIONAL SETTINGS

Stigma

Despite significant progress in recent years, mental illness and suicide remain stigmatized in society.[33] This stigma is especially pronounced in public safety occupations, like corrections, where there is an expectation of toughness and a culture characterized by machismo.[29,34] Signs of weakness are preyed upon in prison culture and scorned in officer occupational culture.[5,34] In this context, correctional officers may be reluctant to reveal mental health problems, including suicidal ideation, to coworkers or administrators. Some correctional officers will intentionally hide health problems out of fear of being shamed, bullied, or considered unfit for duty. In a profession where strength is a prevailing value, mental health problems are often (inaccurately) perceived as signs of weakness.[34]

"It was clearly on his mind; leaving was on his mind . . . but, but he would he lose face if he did, like his masculinity would be . . . because, because . . . this is what these guys do . . . the guys that quit, the guys that break . . . that's why they have so much difficulty getting guys to step forward to talk about their stresses because you're supposed to just take it. You're supposed to just be able to adapt, and shut up, and move on."

"He didn't. He didn't want any help. He didn't want to be labeled as 'soft.' He didn't want to be labeled . . . And something along the lines of if he had a mental illness, obviously, that has to be documented with work and then that jeopardizes his job. So, it's kind of like a whole trickle effect."

-Excerpts from interviews with family members of correctional officers who died by suicide[15]

Reluctant help-seeking

Seeking mental health support is not the norm among correctional officers. In fact, help-seeking behavior is often stigmatized in correctional settings due to the same workplace cultural factors that perpetuate stigma against mental illness. In the first in-depth study of correctional officer suicides, which followed a cluster of 20 suicides in a single department, occupational factors—including mental health stigma and institutional barriers to help-seeking—were found to interact with other suicide risk factors (e.g., anxiety, depression, and suicidal ideation) as factors precipitating the suicides.[15] The same study found that, although correctional officers were reluctant to seek help for themselves, they expressed a willingness to seek help for other correctional officers.[15,34]

Structural barriers

While some jurisdictions have programs or initiatives to address stigmas around mental illness and suicide and promote correctional officer help-seeking, there remain numerous structural barriers to suicide prevention in correctional settings.[35]

"It's just that sometimes, um, it gets to the point where you can't function. That's the thing, everyone has their ups and downs, but it's when it impacts your ability to function, and it started to impact his. He was withdrawing himself, isolating, calling out of work. Those are the signs and I really believe when it comes to his case, I really believe the biggest regret that we have is that I think we could've been more aggressive, in fact, we probably should've committed him, because he wasn't willing, he couldn't see it, he wasn't, everybody was so worried about his job . . . and I remember [him] saying, 'I don't want to lose my job.' That came out of his mouth so many times. 'I just don't want to lose my job, I can't, I can't lose my job.' That's what bothered me when I really thought about it . . . I remember that day [that he died by suicide] thinking, 'We need to do something. We need to probably admit him,' but some of the conversation was - 'we can't - his job, his job' - and that's the truth. I'm just being honest."

-Excerpt from interviews with family members of correctional officers who died by suicide[15]

One key barrier is a lack of systematic approaches to identifying correctional officers who are at risk of suicide or in distress. In a profession where high levels of stress and exposure to potentially traumatic events are common, mental health problems or symptoms may accumulate over time and be normalized as "part of the job."[36] Organizationally, prisons systems face human resource constraints or policies that may unintentionally deter help-seeking or access to clinical interventions for suicide prevention. For example, overtime requirements due to staffing shortages and irregular shift hours may constrain correctional officers' opportunities to seek mental health care. Coworkers or administrators may frown on those who miss work time due to a mental health issue; any absence may be perceived as exacerbating staffing shortages. Officers have reported that breaches of confidentiality occur and bullying and ridicule can follow.[34] Further, in some correctional institutions a correctional officer who expresses a need for mental health care may be evaluated for fitness for duty. Among those who do seek care, access can be limited due to long wait times for appointments, inadequate numbers of qualified professionals, or lack of provider experience or familiarity with corrections and correctional officers' work environments.[5]

OPPORTUNITIES TO ADVANCE MENTAL HEALTH AND SUICIDE PREVENTION AMONG CORRECTIONAL OFFICERS

There are many ways that mental health clinicians can support suicide prevention in correctional environments, including when working with correctional officers. The following sections describe three ways clinicians can support suicide prevention and suicide care among correctional officers.

1. **Promoting resilience**
2. **Suicide risk identification**
3. **Clinical intervention**

DID YOU KNOW?

Effective suicide prevention is comprehensive. It requires a combination of efforts that work together to address different aspects of the problem.

Learn more by reading about the Suicide Prevention Resource Center's Comprehensive Approach to Suicide Prevention.

The Comprehensive Framework for Law Enforcement Suicide Prevention, created by the National Consortium on Preventing Law Enforcement Suicide, is a general suicide prevention framework developed for law enforcement professions, including corrections.

Promoting Resilience

Resilience is a protective factor against suicide, and building resilience is an essential strategy for addressing the problem of suicide among correctional officers. Enhancing resilience is one of the key strategies in the Suicide Prevention Resource Center's (SPRC) Comprehensive Approach to Suicide Prevention. While resilience is variously defined in the literature, it can be generally characterized as the ability to cope with stress or adversity. The American Psychological Association defines it as "the ability to adapt to challenging life experiences through mental, emotional, and behavioral flexibility."[37] Due to the inherent challenges of working in corrections, correctional officers need to be equipped with skills to adapt to difficult work environments and circumstances. Mental health clinicians working in correctional settings are ideally positioned to promote resilience initiatives and help the individual correctional officers they support develop and enhance their resilience.

Previous research has identified a need for problem-focused interventions that take a strengths-based approach to reducing self-harm and promoting protection against mental health problems among correctional officers.[20,38] Efforts to promote psychological resilience can form part of a strengths-based approach (as opposed to

a deficit-focused one) that emphasizes positive problem-focused coping strategies and adaptability. Providing individuals with strategies to promote resilience can help them find and use healthy solutions to challenging situations, which can reduce mental health problems or symptoms.[39] In a study of 245 correctional officers in California, positive problem-focused coping strategies (e.g., planning) and emotion-focused coping strategies (e.g., positive growth) were both associated with lower levels of PTSD symptoms, whereas negative emotion-focused coping strategies (e.g., denial) were associated with higher levels of symptoms.[40] Additional resilience-focused strategies have emerged in the broader literature on suicide prevention. These strategies include developing a social support system, identifying personal coping strategies, enhancing psychological capital (hope, efficacy, optimism, and resiliency), and understanding one's sense of purpose and responsibility on the job.[41,42]

Lived Experience Perspective on Promoting Resilience

Rick Field, a career correctional officer, administrator, and public speaker with three decades of experience in the profession, says that a common barrier he has observed to correctional officers' wellness and resilience is officers' perception that their mental health is the responsibility of others, such as supervisors, managers, and headquarters personnel. Although organizational factors and leadership play a part in promoting the resilience of correctional staff, Field emphasizes that officers can also learn strategies to manage their own mental health. Reflecting on his long career in corrections, Field shares that one of his most liberating experiences while working in corrections was realizing that he did not have to wake up angry every day and that he could learn strategies to better regulate his thoughts, emotions, and behaviors. Based on his personal experiences and extensive outreach to promote wellness in the correctional community, Field identifies several resilience-building strategies for consideration.[5]

- **Developing life skills:** Life skills training has been shown to help first responders, including law enforcement officers, learn to control negative emotions, manage stress, and build resilience.[5,43] Life skills training can help correctional officers recognize that difficulties are temporary and that they can meet challenges with effective coping strategies, such as positive thinking, emotional regulation, working toward goals, and the use of distraction or other behavior-based techniques, such as "powering down" from a difficult workday through music, breathing exercises, or practicing mindfulness meditation.

- **Enhancing social support:** Social support enhances resilience and may come from a variety of sources, such as a spiritual leader, life coach, peer mentor, supervisor, or coworker. Some correctional officers may benefit from more formal sources of interpersonal support, such as support from a mental health provider.

- **Enjoying life outside of work:** While corrections is a demanding profession, Field emphasizes the importance of recognizing that the job is just one part of life. Enjoying life outside of work could entail hobbies, social connections with people outside the institutional setting, or other sources of personal fulfillment that are not work-related. In Field's experience, correctional officers can learn how to leave the job at the worksite and focus on other parts of life when not at work.

Suicide Risk Identification

Identifying risk, such as through suicide screening and assessment, is an essential clinical skill and an important part of suicide prevention in correctional settings. Clinicians can conduct screenings to identify correctional officers who may be thinking about suicide or engaging in suicidal behavior. Clinicians working in a correctional setting may also be asked to support risk identification efforts through suicide risk assessments.

While screening and assessment tools specific to correctional officers do not exist, there are evidence-based tools that have been developed for general adult populations. One such tool is the Columbia-Suicide Severity Rating Scale (C-SSRS), also known as the Columbia Protocol. A simple, efficient, and evidence-based tool,

the C-SSRS has been used by some law enforcement agencies and first responders to identify risk among individuals they serve and members of their departments.[44] Using a screening tool such as the C-SSRS assists clinicians in asking direct questions about suicidal thoughts and behaviors. The C-SSRS provides a risk indicator based on an individual's responses to the questions, which gives the clinician further information about the individual's potential level of suicide risk.

Many correctional officers have a military background, so clinicians working with correctional officers may also consider the appropriateness and potential utility of suicide screening and assessment tools that have been tested in military populations. Similar to correctional officers, members of military populations may have a high level of trauma exposure relative to other occupations.[45,46] In its suicide screening guidance for clinicians, the U.S. Department of Veterans Affairs (VA) recommends the C-SSRS as well as the Comprehensive Suicide Risk Evaluation (CSRE), which provides a more detailed assessment of chronic and acute risk levels.[47] The CSRE may be appropriate for correctional officers who are veterans and seeking care through a VA provider.

Clinical Interventions

Not all correctional officers will need or want mental health interventions, but having access to quality clinical mental health services is fundamental to preventing suicide and supporting correctional officers' mental health and well-being. Correctional institutions need clinicians who are trained to deliver clinical interventions that address mental health problems, including suicidal ideation and behaviors, among correctional officers. Whether working in correctional settings or in private practice, clinicians who work with correctional officers should be prepared to provide evidence-based mental health care, including suicide-specific care. At a minimum, clinicians should be prepared to facilitate timely referrals to providers who can deliver such care.

When correctional officers are assessed to be at risk of suicide, clinicians can deliver a range of interventions to address the risk, including brief, single-session interventions, such as suicide safety planning and lethal means counseling, as well as other evidence-based treatments, such as cognitive-behavioral therapies that directly address suicide risk (e.g., dialectical behavior therapy or cognitive therapy for suicide prevention).[48,49] Clinicians can also work with consultants who have experience working with correctional officers to provide mental health services.

Correctional officers are at high risk for exposure to stressful incidents and trauma on the job, so clinicians providing care to correctional officers may wish to consider becoming trained in trauma-informed clinical interventions.[50] While there is limited research on clinical mental health interventions that address PTSD symptoms among correctional officers specifically, several trauma-focused interventions have been shown to be effective in similar populations, such as the military and some law enforcement communities.[51] Examples of these evidence-based interventions include cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), and prolonged exposure therapy (PET).[39,52-54] These psychotherapeutic interventions have demonstrated efficacy in addressing PTSD in numerous studies.[49,54] A less robust but growing body of evidence indicates that other interventions show promise for supporting the mental health of law enforcement officers, including motivational interviewing (MI), disconnected values model (DVM), mindfulness-based resilience training (MBRT), and problem-solving therapy (PST).[39,49,51,52,54-57]

At work, correctional officers must be action-orientated, vigilant, aware of power differences, and authoritarian.[3,5,52] While these qualities help correctional officers in their jobs, they may also lead to a distrust of outsiders, particularly those seeking to influence the workplace environment.[38] Clinicians will be more successful in their efforts to offer and implement clinical interventions if they develop rapport and a strong therapeutic alliance, which must acknowledge officers' concerns about safety and their need to remain in control of the correctional environment in their area of responsibility. Clinicians should address officers' concerns about pursuing mental health support and inquire about officers' hopes, expectations, desired treatment outcomes, and potential barriers to treatment. In addition, clinicians should be attentive to issues of confidentiality and privacy in correctional settings. These considerations are fundamental to establishing and sustaining a healthy and transparent therapeutic relationship with the client; such a therapeutic relationship increases the likelihood of a good therapeutic outcome.[5,58] Taking these steps to create a trusting relationship provides a critical foundation for successfully working with correctional officers.[59]

ADDITIONAL CONSIDERATIONS FOR RESEARCH AND PRACTICE

Recent research on suicide in corrections has focused on quantifying the occurrence of suicide in correctional populations or comparing suicide estimates between correctional officers and other public safety professionals, such as police. Only a handful of research studies have directly examined suicide risk among correctional officers.[15] To advance research in suicide prevention among correctional officers, attention should be directed toward three critical issues:

1. **Expanding the base of evidence on risk and protective factors for suicide among correctional officers. This will help inform risk prediction and identify factors that can be modified to reduce risk.**

2. **Developing reliable and valid screening and assessment tools that can help clinicians identify and assess suicide risk among correctional officers.**

3. **Testing the effectiveness of evidence-based, trauma-informed suicide prevention interventions that have shown promise with military personnel and police to examine their usefulness and appropriateness for correctional officers.**

Clinicians who work with correctional officers need not wait for more research before taking action to address suicide among this population. Many people who work in the correctional field now recognize that a cultural change is needed. The occupational culture of correctional institutions, with its intensely hierarchical structure and strict adherence to rules and regulations, promotes an organizational rigidity that resists change and flexibility. In such a culture, mental health clinicians can serve as important change agents, drawing on their skills and training to educate the workforce about mental illness and suicide warning signs while challenging misconceptions, stigma, and reluctance to seek mental health support and suicide care. Destigmatizing mental illness and breaking down some of the barriers to help-seeking in correctional occupational culture will be essential to future systemic improvements in wellness and suicide prevention.

Correctional officer suicide risk often goes unrecognized. Thus, a key area for advancing suicide prevention among correctional officers is improving the detection of officer suicide risk through screening and assessment. Clinicians who provide mental health services in correctional settings are well-positioned to improve risk identification and offer guidance to institutional administrators about identifying risk in an effective and appropriate manner.

For many reasons, officer suicides often go unreported or underreported. Some cases are misclassified as accidents. Some institutions are concerned that disclosing suicide as the manner of death will prevent an officer's family from receiving death benefits (which is true in some jurisdictions). In other cases, correctional institutions may be (understandably) concerned about suicide contagion, whereby the suicide of one officer might contribute to the suicide of others.

Correctional agencies often do not know how to respond in the aftermath of an officer suicide. Acknowledging suicide losses and having an adequate institutional response can open the door for conversations that can support the prevention of future suicides. Clinicians working in correctional settings should be involved in these conversations at the administrative level to ensure that the institutional response to an officer suicide is helpful and not unintentionally harmful. Clinicians can also plan to bolster clinical support services for correctional officers during the period immediately following an officer suicide. For example, clinicians can anticipate offering increased consultation availability and prepare outreach materials in advance. These steps can help mitigate potential negative impacts on the institutional workforce after an officer's suicide and reduce the potential for suicide contagion.[16]

There is growing evidence that peer-to-peer support programs, which involve trained colleagues providing support services, can help officers effectively manage the stress associated with correctional work.[3,20,60,61] Peer-to-peer support programs, which build on or enhance existing camaraderie among those working in corrections, can be effective for helping officers respond to stress. These programs are not, however, an appropriate substitute for mental health care.[62] Although peers can relate to other officers in a way that traditional service providers often cannot, they are not equipped with the training needed to provide clinical services. Clinicians can coordinate with peer-to-peer support programs to augment formal clinical support services (employee assistance programs, mental health treatment, direct referrals to external clinical providers, etc.).[63]

MOVING FORWARD

Correctional officers provide an essential public safety service. However, working in these settings is difficult, and the risk of suicide among correctional officers is higher than among the general population. Mental health clinicians play an important role in correctional officer suicide prevention. Clinicians can help prevent suicide among correctional officers in three ways:

1. **Promoting resilience**
2. **Identifying risk**
3. **Providing clinical intervention**

A resource list is provided in the appendix of this issue brief for clinicians who would like to learn more about this topic. Clinicians desiring formal training are advised to seek out opportunities for targeted skill development, such as training to improve risk identification skills using specific, evidence-based screeners as well as training in providing life skills programs and evidence-based treatments that address the mental health problems frequently observed in the correctional workforce.

DEFINITIONS

Corrections: Corrections refers to the supervision of persons arrested for, convicted of, or sentenced for criminal offenses. Correctional populations fall into two general categories: institutional corrections and community corrections.[64]

> **Institutional Corrections:** Secure correctional facilities (prisons, jails, and correctional facilities). There are many different types of correctional facilities.[65]
>
> **Community Corrections:** The supervision of convicted individuals in the general population as opposed to confining them in secure correctional facilities. The two main types of community corrections are probation and parole. Community corrections is also referred to as community supervision.[66]

Correctional Officer: Correctional officers are law enforcement personnel responsible for the care and custody of people in penal institutions and in transit between jail, courtroom, prison, or other points.[1]

Correctional Staff: Correctional employees who are not correctional officers.[5]

Custody: Prisoners held in the physical custody of state or federal prisons or local jails, regardless of sentence length or authority that has jurisdiction.[66]

Held Over/Hold Over: When a correctional institution requires an employee to work an additional shift after the shift they have already worked.[5]

Incarcerated individuals/persons: People who are confined in short-term or long-term facilities run by the state or federal government or private agencies. Persons awaiting trial and who receive short-term sentences (less than one year) are typically held in local or county jails, while those who have received a longer-term sentence (one year or more) are typically held in state or federal prisons. Sentence length may vary by state because few states have one integrated prison and jail system.[64]

Inservice Training: A training program that provides ongoing job specific training in a correctional institution to address institutional, individual, and staff needs. Institutionally focused training seeks to support the accomplishment of the institution's mission through the established legal and procedural framework; individual and staff training aim to increase job proficiency and self-confidence.[67]

Jurisdiction: The official authority to make decisions and judgments, especially legal ones.[68]

Resilience: Resilience is the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands.[37]

Secondary Trauma: Secondary trauma is the phenomenon in which an individual is indirectly yet severely affected by learning about another person's direct experience with a traumatic event. It is especially common among professionals who work with people who have experienced trauma, including physicians, psychotherapists, human services workers, correctional officers, and first responders.[69]

Sworn/Non-Sworn Officers: Sworn officers have full arrest powers granted by a state or local government. Non-sworn officers serve in the capacity of security officer and do not have the authority to arrest.[70]

Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[71]

RESOURCE LIST

Crisis Lines

988 Suicide & Crisis Lifeline
A national network of local crisis centers that provides free and confidential support to people in suicidal crisis or emotional distress (available 24/7).

COPLINE
1-800-267-5463 (1-800-COPLINE)
COPLINE is a non-profit organization that offers confidential and anonymous peer support to active and retired law enforcement officers and their families.

Crisis Text Line
Text *HOME* to 741741
Crisis Text Line offers live, trained crisis counselors who respond to texts on a secure online platform. The crisis counselors are volunteers who help individuals experiencing a crisis. Text HOME to 741741 from anywhere in the United States, anytime.

Screening Tools

Suicide-Specific Screening Tools

Ask Suicide-Screening Questions (ASQ)
The Ask Suicide-Screening Questions tool is a set of four brief suicide screening questions. Additional materials to help with suicide risk screening implementation are available in The ASQ Toolkit, a free resource for use by providers in various settings.

Columbia-Suicide Severity Rating Scale (C-SSRS) - Triage and Risk Identification Version
The Columbia-Suicide Severity Rating Scale (C-SSRS) provides risk screening through a series of simple questions. The answers help users identify whether someone is at risk for suicide, determine the severity of symptoms, the immediacy of that risk, and assess the level of support that the person needs.

Patient Safety Screener (PSS-3)

The Patient Safety Screener (PSS-3) a tool for identifying patients in the acute care setting who may be at risk of suicide. The PSS-3 can be administered to all patients who come to the acute care setting, not just those presenting with psychiatric issues.

Other Screening Tools

Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 is a validated, 9-item instrument for screening for depression. The ninth item ("Thoughts that you would be better off dead or of hurting yourself in some way") is sometimes used to identify patients who have suicide ideation or may be at risk of suicide.

Trauma Symptom Inventory, Revised (TSI-2)

The TSI-2 is a 136-item adult self-report measure of posttraumatic stress and other psychological sequelae of traumatic and stressful events. The TSI-2 has been updated to assess sequelae of a wide range of adversities, including trauma as defined in the DSM-5 and other stressful experiences, such as emotional neglect and experiences of loss. The TSI-2 assesses PTSD symptoms as well as other symptoms, including suicidality. Symptom responses are not tied to a particular event or timespan.

Suicide Assessment Tools

Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)

This suicide assessment can be used by mental health professionals during their first contact with an individual at risk of suicidal behavior or suicide. The five-step assessment includes identification of risk and protective factors; conducting an inquiry about suicide risk; determining level of risk and selecting an appropriate intervention; and documenting the process, including a follow-up plan.

Columbia-Suicide Severity Rating Scale (C-SSRS)
A scale commonly used in suicide risk assessment. A checklist of risk and protective factors can be used along with any version of the C-SSRS. The Columbia Lighthouse Project addresses the use of the C-SSRS in correctional settings.

Resources and Training on Clinical Interventions

Safety Planning Interventions and Tools

Stanley-Brown Safety Planning Intervention
A brief intervention that offers those experiencing self-harm and suicidal thoughts a concrete way to mitigate risk and increase safety.

Stanley-Brown Suicide Safety Plan
The form used in the Stanley-Brown Safety Planning Intervention.

CAMS Stabilization Plan
The Suicide Status Form (SSF) is a unique, multipurpose, clinical tool that guides the CAMS Framework®. It functions as a clinical roadmap in CAMS for assessments, treatment planning, tracking of patient stability, and, ultimately, clinical outcomes.

Crisis Response Planning (CRP)
The CRP is a short process drawn from brief cognitive behavioral therapy that is intended to reduce suicidal ideation and risk of suicide attempts when used as a stand-alone intervention.

Lethal Means Counseling

SPRC Online Course: Counseling on Access to Lethal Means (CALM)
Reducing access to lethal means, such as firearms and medication, can determine whether a person at risk for suicide lives or dies. This free online course focuses on how to reduce access to the methods people use to kill themselves. It covers how to: (1) identify people who could benefit from lethal means counseling, (2) ask about their access to lethal methods, and (3) work with them—and their families—to reduce access.

Evidence-Based Clinical Treatments for Trauma-Affected Populations

Cognitive Processing Therapy (CPT)
CPT is a cognitive-behavioral treatment for PTSD. CPT was developed in the late 1980s and has been shown to be effective in reducing PTSD symptoms related to a variety of traumatic events including child abuse, combat, rape, and natural disasters.

Eye Movement Desensitization and Reprocessing (EMDR) Therapy
The EMDR Institute™, founded by Dr. Francine Shapiro in 1990, offers training in the EMDR™ therapy methodology, a treatment approach that has been empirically validated in over 30 randomized studies of trauma victims.

Prolonged Exposure (PE) Therapy
The Center for the Treatment and Study of Anxiety at the University of Pennsylvania provides instruction in the use of PE therapy with survivors of trauma; it covers the basics of all components of PE and ways to tailor PE procedures to the client's response to exposure.

Resilience Trainings Focused on Correctional Officers and Law Enforcement

Desert Waters Correctional Outreach Staff Wellness Trainings
Desert Waters offers trauma-specific wellness trainings and other resources for correctional staff and their families.

Shield of Resilience Training Course
Shield of Resilience is a one-hour training course from the Substance Abuse and Mental Health Services Administration (SAMHSA) that helps law enforcement officers learn to recognize signs and symptoms of stress, depression, PTSD, and suicidal thoughts and actions.

Struggle Well
The Struggle Well First Responder Initiative is a prevention-based program for law enforcement agencies, including correctional agencies, that uses a comprehensive posttraumatic growth-based strategy. Struggle Well offers 1-, 2-, and 5-day programs.

Promoting Wellness and Resiliency in Correctional Staff

This one-hour webinar from the National Institute of Corrections presents research on officer wellness and relevant practices. It incorporates practitioner expertise on valuable resources and support for correctional officers and staff. The webinar moves from preventive to reactive strategies and builds on new approaches to increase resiliency.

The Peace Officer Wellness, Empathy & Resilience (POWER) Training Program

This nationally certified intensive and interactive curriculum for police and correctional officers uses mindfulness practices, compassion-based communication exercises, and training in wellness-related areas such as stress management and self-care.

Law Enforcement Agency and Officer Resilience Training Program

This training is part of the Bureau of Justice Assistance's effort to improve officers' resilience and mental wellness. It offers skills to help officers improve their ability to handle occupational stress.

Resilient Minds on the Frontlines

An initiative intended to help participants shift organizational culture around behavioral health issues among frontline workers, including correctional officers. This three-day training program helps organizations understand the stress and trauma of working on the frontlines and ways to create resiliency among correctional staff.

Advocacy and Peer Support Resources

Desert Waters Peer Support Training (PST)

This five-day, 40-hour course trains correctional staff to offer social support to peers who may be experiencing distress due to critical incidents or other life stressors on or off the job.

American Correctional Chaplains Association (ACCA)
This organization provides information and support for correctional chaplains who serve the needs of incarcerated individuals, correctional staff, and their families. Correctional chaplains counsel spouses, serve as community liaisons, advise correctional staff and administration, and assist incarcerated individuals in transitioning back in to society.

Blue H.E.L.P.
This nonprofit organization is focused on raising awareness about suicide in law enforcement (including among correctional officers) and honoring those who have died by suicide. Blue H.E.L.P.'s mission is to "Honor. Educate. Lead. Prevent." The organization offers trainings for responders, supervisors, families, and service providers, as well as train-the-trainer workshops, and other online trainings.

Developing a Critical Incident Peer Support Program
This guide, created by the U.S. Department of Justice's Community Oriented Policing Services, supports law enforcement agencies in creating a peer support program and responding appropriately after an officer suicide. The guide promotes effective peer leadership and confidentiality and provides examples of relevant activities.

Mobile Apps

Suicide Safe
Free app that helps providers integrate suicide prevention strategies into their practice and address suicide risk among their patients.

Virtual Hope Box
Free app that provides coping tools, relaxation exercises, distraction content, and positive thinking support. It can also store photos and recorded messages from loved ones.

*Note: SPRC has not evaluated these apps and does not endorse any specific app.

REFERENCES

[1] *Occupational employment and wage statistics*. (2022). U.S. Bureau of Labor Statistics. Retrieved April 25. 2023, from https://www.bls.gov/oes/current/oes333012.htm

[2] Carson, A. E., Kluckow, Rich. (2023). *Correctional populations in the United States, 2021, statistical tables*. https://bjs.ojp.gov/library/publications/correctional-populations-united-states-2021-statistical-tables

[3] Ferdik, F. V., & Smith, H. P. (2017). *Correctional officer safety and wellness literature synthesis.* Department of Justice, National Institute of Justice. https://www.ojp.gov/pdffiles1/nij/250484.pdf

[4] Denhof, M. D. (2014). *Occupational stressors in corrections organizations: Types, effects and solutions*. U.S. Department of Justice, National Institute of Corrections. https://info.nicic.gov/nicrp/system/files/028299.pdf

[5] R. Field. Personal communications (September-December 2023).

[6] Spinaris, C. G., Denhof, M. D., & Kellaway, J. A. (2012). *Posttraumatic stress disorder in United States corrections professionals: Prevalence and impact on health and functioning*. U.S. Department of Justice. https://www.ojp.gov/ncjrs/virtual-library/abstracts/posttraumatic-stress-disorder-united-states-corrections

[7] Konda, S., Reichard, A. A., & Tiesman, H. M. (2012). Occupational injuries among U.S. correctional officers, 1999-2008. *Journal of Safety Research*, *43*(3), 181-186. https://doi.org/10.1016/j.jsr.2012.06.002

[8] Bureau of Labor Statistics. (2016). *Nonfatal occupational injuries and illnesses requiring days away from work, 2015* (Vol. USDL-16-2130). U.S. Department of Labor. https://www.bls.gov/news.release/pdf/osh2.pdf

[9] Grupe, D. W., Stoller, J. L., Alonso, C., McGehee, C., Smith, C., Mumford, J. A., Rosenkranz, M. A., & Davidson, R. J. (2021). The impact of mindfulness training on police officer stress, mental health, and salivary cortisol levels. *Frontiers in Psychology*, *12*, 720753-720753. https://doi.org/10.3389/fpsyg.2021.720753

[10] Neylan, T. C., Brunet, A., Pole, N., Best, S. R., Metzler, T. J., Yehuda, R., & Marmar, C. R. (2005). Ptsd symptoms predict waking salivary cortisol levels in police officers. *Psychoneuroendocrinology*, *30*(4), 373-381. https://doi.org/10.1016/j.psyneuen.2004.10.005

[11] Yehuda, R. (1995). Dose-response changes in plasma cortisol and lymphocyte glucocorticoid receptors following dexamethasone administration in combat veterans with and without posttraumatic stress disorder. *Archives of General Psychiatry*, *52*(7), 583-593. https://doi.org/doi:10.1001/archpsyc.1995.03950190065010

[12] Konyk, K., & Ricciardelli, R. (2023). Tough lessons: Pathways toward correctional officer resilience and growth. *Traumatology 29*(3), 340-351.

[13] Denhof, M. D., & Spinaris, C. G. (2016). *Prevalence of trauma-related health conditions in correctional officers: A profile of Michigan corrections organization members*. Desert Waters Correctional Outreach. https://www.mco-seiu.org/files/2016/05/MCO-Paper_FINAL.pdf

[14] Harrell, E. (2011). *Workplace violence, 1993-2009: National crime victimization survey and the census of fatal occupational injuries* [Special report]. U.S. Department of Justice. https://bjs.ojp.gov/content/pub/pdf/wv09.pdf

[15] Frost, N. A., & Monteiro, C. E. (2020). The interaction of personal and occupational factors in the suicide deaths of correction officers. *Justice Quarterly*, *37*(7), 1277-1302. https://www.tandfonline.com/doi/full/10.1080/07418825.2020.1839538

[16] St. Louis, S., Frost, N. A., Monteiro, C. E., & Trapassi Migliaccio, J. (2023). Occupational hazards in corrections: The impact of violence and suicide exposures on officers' emotional and psychological health. *Criminal Justice and Behavior*, *50*(9), 1361-1379. https://doi.org/10.1177/00938548231177710

[17] Xu JQ, M. S., Kochanek K. D., & Arias E. (2021). *Mortality in the United States, 2021* (Report No. 456). https://www.cdc.gov/nchs/data/databriefs/db456.pdf

[18] Glazer, S., & Torres, C. V. (2022). Human values differentially motivate police actions. *Industrial and Organizational Psychology*, *15*(4), 592-598. https://doi.org/10.1017/iop.2022.75

[19] James, L., & Todak, N. (2018). Prison employment and post-traumatic stress disorder: Risk and protective factors. *American Journal of Industrial Medicine*, *61*(9), 725-732. https://doi.org/10.1002/ajim.22869

[20] Ferdik, F., & Pica, E. (2023). Correctional officer turnover intentions and mental illness symptom: Testing the potential confounding effects of resilience. *Psychology, Public Policy, and Law*. https://psycnet.apa.org/fulltext/2023-60261-001.html

[21] Jaegers, L. A., Matthieu, M. M., Werth, P., Ahmad, S. O., Barnidge, E., & Vaughn, M. G. (2020). Stressed out: Predictors of depression among jail officers and deputies. *The Prison Journal*, *100*(2), 240-261. https://doi.org/10.1177/0032885519894658

[22] Obidoa, C., Reeves, D., Warren, N., Reisine, S., & Cherniack, M. (2011). Depression and work family conflict among corrections officers. *Journal of Occupational and Environmental Medicine*, *53*(11), 1294-1301. https://doi.org/10.1097/JOM.0b013e3182307888

[23] Magaletta, P. R., Hom, M. A., Stanley, I. H., & Joiner, T. E. (2020). Strategies and solutions to address the mental health needs of protective service workers: An introduction. *Psychological Services*, *17*(2), 127-128. https://doi.org/10.1037/ser0000371

[24] Schaufeli, W. B., & Peeters, M. C. W. (2000). Job stress and burnout among correctional officers: A literature review. *International Journal of Stress Management*, *7*(1), 19-48. https://doi.org/10.1023/A:1009514731657

[25] Jaegers, L. A., Matthieu, M. M., Vaughn, M. G., Werth, P., Katz, I. M., & Ahmad, S. O. (2019). Posttraumatic stress disorder and job burnout among jail officers. *Journal of Occupational and Environmental Medicine*, *61*(6), 505-510. https://doi.org/10.1097/jom.0000000000001600

[26] Carleton, R. N., Afifi, T. O., Taillieu, T., Turner, S., Krakauer, R., Anderson, G. S., MacPhee, R. S., Ricciardelli, R., Cramm, H. A., Groll, D., & McCreary, D. R. (2019). Exposures to potentially traumatic events among public safety personnel in Canada. *Canadian Journal of Behavioural Science*, *51*(1), 37-52. https://doi.org/10.1037/cbs0000115

[27] National Academies of Sciences, Engineering, & Medicine. (2023). *Measuring law enforcement suicide. Challenges and opportunities: Proceedings of a workshop*. The National Academies Press. https://doi.org/doi:10.17226/27216

[28] Violanti, J. M. (2017). Suicide behind the wall: A national analysis of corrections officer suicide. *Suicidology Online*, *8*, 138-144. http://www.suicidology-online.com/pdf/SOL-2017-8-138-144.pdf

[29] Stack, S. J., & Tsoudis, O. (1997). Suicide risk among correctional officers: A logistic regression analysis. *Archives of Suicide Research*, *3*(3), 183-186. https://doi.org/10.1080/13811119708258270

[30] Zimmerman, G. M., Fridel, E. E., & Frost, N. A. (2023). Examining differences in the individual and contextual risk factors for police officer, correctional officer, and non-protective service suicides. *Justice Quarterly*, 1-28. https://doi.org/10.1080/07418825.2023.2188063

[31] Violanti, J. M., & Steege, A. (2021). Law enforcement worker suicide: An updated national assessment. *Policing*, *44*(1), 18-31. https://doi.org/10.1108/pijpsm-09-2019-0157

[32] Crime Data Exporter. (2022). *Law*, *enforcement*, *suicide*, *data*, *collection*, *(LESDC)* [Data set]. Federal Bureau of Investigation. Retrieved February 28, 2024, from https://cde.ucr.cjis.gov/LATEST/webapp/#/pages/le/lesdc

[33] National Action Alliance for Suicide Prevention, American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2022). *2022 public perception survey results - executive summary*. https://theactionalliance.org/resource/2022-public-perception-survey-results-executive-summary

[34] Wills, C., Bates, K., Frost, N. A., & Monteiro, C. E. (2021). Barriers to help-seeking among correction officers: Examining the influence of institutional culture and structure. *Criminal Justice Studies*, *34*(4), 423-440. https://www.tandfonline.com/doi/full/10.1080/1478601X.2021.1997276

[35] Brower, J. (2013). *Correctional officer wellness and safety literature review*. U.S. Department of Justice. https://www.ojp.gov/library/publications/correctional-officer-wellness-and-safety-literature-review

[36] Johnston, M. S., Ricciardelli, R., & McKendy, L. (2022). Improving the mental health of correctional workers: Perspectives from the field. *Criminal Justice and Behavior*, *49*(7), 951-970. https://doi.org/10.1177/00938548221081468

[37] *Resilience*. (n.d.). American Psychological Association. (2018). Retrieved February 29, 2024, from https://dictionary.apa.org/resilience

[38] Cassidy, T., & Bruce, S. (2019). Dealing with death in custody: Psychosocial consequences for correctional staff. *Journal of Correctional Health Care*, *25*(4), 304-312. https://doi.org/10.1177/1078345819879752

[39] Rodriguez, S., Ferrell, B., Cipriano, R. J., Jr., Van Hasselt, V. B., Falzone, L., Kuhlman, K., Acosta, W., & Miller, M. V. (2023). Law enforcement mental health: Strategies and issues in prevention and treatment. *Practice Innovations*. Advance online publication. https://doi.org/10.1037/pri0000210

[40] Taylor, K. H., & Swartz, K. (2021). Stress doesn't kill us, it's our reaction: Exploring the relationship between coping mechanisms and correctional officer ptsd. *Criminal Justice Studies*, *34*(4), 380-396. https://doi.org/10.1080/1478601X.2021.1999116

[41] Wang, X., Lu, Z., & Dong, C. (2022). Suicide resilience: A concept analysis. *Frontiers in Psychiatry*, *13*, 984922-984922. https://doi.org/10.3389/fpsyt.2022.984922

[42] American Psychological Association. (2023, August 21). *Psychological capital: What it is and why employers need it now.* https://www.apa.org/topics/healthy-workplaces/psychological-capital

[43] Antony, J., Brar, R., Khan, P. A., Ghassemi, M., Nincic, V., Sharpe, J. P., Straus, S. E., & Tricco, A. C. (2020). Interventions for the prevention and management of occupational stress injury in first responders: A rapid overview of reviews. *Systematic Reviews*, *9*(1), 121. https://doi.org/10.1186/s13643-020-01367-w

[44] The Columbia Lighthouse Project. (n.d.). *Asking about suicide is vital for first responders and the public they serve*. https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/first-responders/

[45] Burton, A. L., Lero Jonson, C., Miller, W. T., Petrich, D. M., & Burton, J. V. S. (2024). Understanding who is hired to work in U.S. prisons and why it matters: A call for research. *Corrections*, *9*(2), 287-308. https://doi.org/10.1080/23774657.2022.2101161

[46] Burton, A. L., Lux, J. L., Cullen, F. T., Miller, W. T., & Burton, V. S. (2018). Creating a model correctional officer training academy: Implications from a national survey. *Federal Probation Journal*, *82*(1), 26-60. https://www.uscourts.gov/sites/default/files/82_1_4_0.pdf

[47] Wells, D., L., Popish, S. J., & Himstreet, J. (2021). *Suicide prevention clinician's guide: Continuing our mission to prevent suicide*. U.S. Department of Veterans Affairs. https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/IB_1525_Provider_SuicidePrevention_CG.pdf

[48] Psychological Health Center of Excellence. (2020). *Lethal means counseling: Recommendations for providers*. https://www.healthquality.va.gov/guidelines/MH/srb/LethalMeansProviders20200527508.pdf

[49] Collazo, J. (2022). Adapting trauma-focused cognitive behavioral therapy to treat complex trauma in police officers. *Clinical Social Work Journal*, *50*(2), 160-169. https://doi.org/10.1007/s10615-020-00770-z

[50] Johnston, M. S., Ricciardelli, R., & McKendy, L. (2022). Fight or flight? Exploring suicide thoughts, experiences, and behaviours among correctional workers and their interventions of agency. *Sociology of Health and Illness*, *44*(9), 1500-1516. https://doi.org/10.1111/1467-9566.13526

[51] U.S. Department of Veterans Affairs. (2023). *VA/DOD clinicial practice guidelines: Management of posttraumatic stress disorder and acute stress disorder* (Version 4.0). https://www.healthquality.va.gov/guidelines/MH/ptsd/VA-DoD-CPG-PTSD-Provider-Summary.pdf

[52] Steinkopf, B. L., Hakala, K. A., & Van Hasselt, V. B. (2015). Motivational interviewing: Improving the delivery of psychological services to law enforcement. *Professional Psychology: Research and Practice*, *46*(5), 348-354. https://doi.org/10.1037/pro0000042

[53] Malik, N., Facer-Irwin, E., Dickson, H., Bird, A., & MacManus, D. (2023). The effectiveness of trauma-focused interventions in prison settings: A systematic review and meta-analysis. *Trauma, Violence, & Abuse*, *24*(2), 844-857. https://doi.org/10.1177/15248380211043890

[54] Jones, C., Miguel-Cruz, A., Smith-MacDonald, L., Cruikshank, E., Baghoori, D., Kaur Chohan, A., Laidlaw, A., White, A., Cao, B., Agyapong, V., Burback, L., Winkler, O., Sevigny, P. R., Dennett, L., Ferguson-Pell, M., Greenshaw, A., & Brémault-Phillips, S. (2020). Virtual trauma-focused therapy for military members, veterans, and public safety personnel with posttraumatic stress injury: Systematic scoping review. *JMIR Mhealth Uhealth*, *8*(9), e22079. https://doi.org/10.2196/22079

[55] Decker, S. E., Adams, L., Watkins, L. E., Sippel, L. M., Presnall-Shvorin, J., Sofuoglu, M., & Martino, S. (2019). Feasibility and preliminary efficacy of dialectical behaviour therapy skills groups for veterans with suicidal ideation: Pilot. *Behavioural and Cognitive Psychotherapy*, *47*(5), 616-621. https://doi.org/10.1017/S1352465819000122

[56] Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *The American Psychologist*, *59*(1), 20-28. https://doi.org/10.1037/0003-066X.59.1.20

[57] Galovski, T. E., P., Norman, S.B., & Hamblen, J.L. (2016). *Cognitive processing therapy for PTSD*. PTSD: National Center for PTSD., U.S. Department of Veterans Affairs. https://www.ptsd.va.gov/professional/treat/txessentials/cpt_for_ptsd_pro.asp

[58] Stubbe, D. E. (2018). The therapeutic alliance: The fundamental element of psychotherapy. *Focus: The Journal of Lifelong Learning in Psychiatry*, *16*(4), 402-403. https://doi.org/10.1176/appi.focus.20180022

[59] Nedelcea, C., Ciorbea, I. D., Vasile, D. L., Ionescu, Ș., Papasteri, C., Letzner, R. D., Cosmoiu, A., & Georgescu, T. (2022). The structure of ptsd. Development of the post traumatic symptom scale from a clinician-based perspective. *European Journal of Psychotraumatology*, *13*(1), 2066455. https://doi.org/10.1080/20008198.2022.2066455

[60] Gist, J. T. A., Ferdik, F., & Smith, H. P. (2023). A qualitative inquiry into the sources of resilience found among maximum security correctional officers. *Criminal Justice Policy Review*, *34*(3), 291-315. https://doi.org/10.1177/08874034221143750

[61] Butler, H. D., Tasca, M., Zhang, Y., & Carpenter, C. (2019). A systematic and meta-analytic review of the literature on correctional officers: Identifying new avenues for research. *Journal of Criminal Justice*, *60*, 84-92. https://doi.org/10.1016/j.jcrimjus.2018.12.002

[62] International Association of Chiefs of Police. (2023). *Implementing peer support services in small and rural law enforcement agencies*. Office of Community Oriented Policing Services. https://portal.cops.usdoj.gov/resourcecenter/content.ashx/cops-w0987-pub.pdf

[63] International Association of Chiefs of Police. (2021). *National consortium on preventing law enforcement suicide toolkit*. https://www.theiacp.org/sites/default/files/2021-04/_Toolkit_Combo_Final.pdf

[64] Bureau of Justice Statistics. (2021, February 18). *Corrections*. Retrieved February 29, 2024, from https://bjs.ojp.gov/topics/corrections

[65] Bureau of Justice Statistics. *Correctional institutions*. Retrieved February 29, 2024, from https://bjs.ojp.gov/topics/corrections/correctional-institutions

[66] Bureau of Justice Statistics. (2021, February 18). *Terms & definitions: State and federal prison facility characteristics*. Retrieved February 29, 2024, from https://bjs.ojp.gov/topics/corrections

[67] McKeen, R. B. (1983). In-service training and staff development for correctional educators. *Journal of Correctional Education (1974)*, *34*(1), 12-14. https://www.jstor.org/stable/41970687

[68] Cambridge Dictionary. (2023). Jurisdiction. In *Cambridge Dictionary.* Retrieved December 27, 2023, from https://dictionary.cambridge.org/dictionary/english/jurisdiction

[69] Levine, A. (2024, January 18). *Secondary trauma: How to build resilience and heal*. Psychology Today. Retrieved February 29, 2024, from https://www.psychologytoday.com/us/blog/things-to-consider/202401/secondary-trauma-learn-how-to-build-resilience-and-heal

[70] Bureau of Justice Statistics. (n.d.). *What is the difference between sworn and nonsworn officers?* Retrieved February 29, 2024, from https://bjs.ojp.gov/node/38626#0-0

[71] Substance Abuse and Mental Health Services Administration. (2014). *Concept of trauma and guidance for a trauma-informed approach* [HHS Publication No. (SMA) 14-4884]. https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884?referer=from_search_result

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