



Dialogue Highlights from the LEPH2019 Panel on Police Mental Health and Well-Being

Katy Kamkar,* Grant Edwards,[†] Ian Hesketh,[‡] Dale McFee,[§] Konstantinos Papazoglou,[#] Paul Pedersen,^{||} Katrina Sanders,^{||} Tom Stamatakis,^{**} and Jeff Thompson^{††}

This article is related directly to the Law Enforcement & Public Health (LEPH) Conference in Edinburgh, Scotland, October 2019.

EDITOR'S INTRODUCTION

Dr. Katy Kamkar, Ph.D., C. Psych & LEPH
Session Convener

It has been a sincere honour and true pleasure to be on the program committee, as well as session convener, for the International Law Enforcement and Public Health (LEPH) conference held in October 2019 in Edinburgh, Scotland. During the recent conference, I was fortunate to work with eight esteemed colleagues from Canada, the United States, the United Kingdom, and Australia, sharing international perspectives on Police Mental Health and Well-Being. Police Organizations everywhere, it seems, are increasingly working on reducing stigma and addressing common mental health conditions such as depression, anxiety, and post-traumatic stress disorder as part of mental health education, prevention, early identification, and intervention. To this date, workplace interventions continue to be primarily reactive rather than preventive. One of the many pathways to build and optimize prevention involves interventions at both individual and organizational levels—creating a healthy positive organizational culture and improving workplace mental health promotion by reducing workplace risk factors and identifying and building individual as well organizational strengths and protective factors.

Together with these colleagues, all of whom contributed to the preparation and delivery of our panel session in Edinburgh, we are pleased to share some highlights from the important dialogue that resulted. The following segments each provide guidance on building awareness of police mental health; both organizational and individual level factors; ways to reduce stigma (personal stigma, self-stigma, and workplace stigma); optimizing interventions; and taking holistic approaches to care. I begin this paper, as I did during our session, by offering some of my own thoughts about a proactive approach to health at organizational and individual levels, as well as a discussion on psychological health and safety implementation strategies to help reduce risk factors

and promote individual and organizational resiliency. My co-authors then each share their own perspectives.

Police Mental Health and Well-Being—Psychological Health and Safety Strategies Addressing Moral Injury, Compassion Fatigue, and Burnout to Promote Individual and Organizational Resiliency

Police work does increase the risk of psychological work-related injuries. Police officers are exposed to a unique set of challenges in their day-to-day duties that can increase the risk of mental health concerns. Occupational burnout and exhaustion result in reduced motivation and care or passion for the work. For others, it can cause feelings of helplessness or powerlessness, resulting in emotional disengagement or numbness. Depression, anxiety, substance misuse, pain and physical injuries, and occupational stress injuries (OSI), which are persistent psychological difficulties resulting from operational or service-related duties are also common. Depression has been found to increase the risk of post-traumatic stress disorder (PTSD), anxiety disorders, and addiction. As well, PTSD has often been found to be accompanied by depression, and the two overlapping conditions further worsen overall functioning and quality of life and increase the risk of suicide. Thus, the promotion of good mental health and mental health education, prevention, and early intervention, as well as the promotion of a healthy and supportive organizational culture and work environments based on trust, support, and care, are essential to prevent complications resulting from concurrent issues. Ongoing work is needed to encourage a proactive approach to health. Workplace stigma remains prevalent, in addition to other barriers to care and recovery that deserve further attention and interventions, including moral injury, compassion fatigue, and burnout.

Although moral injury, compassion fatigue, and burnout are not mental health disorders, they represent significant mental health issues resulting from organizational and operational stressors, with long-lasting emotional and psychologi-

Correspondence to: Dr. Katy Kamkar, Ph.D., C. Psych., Clinical Psychologist, Centre for Addiction and Mental Health (CAMH) and Assistant Professor, Department of Psychiatry, University of Toronto, 455 Spadina Ave, Suite 200, Toronto, ON M5S 2G8, Canada.
E-mail: katy.kamkar@camh.ca ■ DOI: <http://dx.doi.org/10.35502/jcswb.123>

cal impact. They are associated with psychological disorders as part of Operational Stress Injuries, impaired personal, social, and occupational functioning, exhaustion, reduced work performance and productivity, reduced personal and professional accomplishment, suicidal ideation, interpersonal conflict, prolonged recovery, difficulty resuming daily activities or returning to employment, and self-isolation. There needs to be further education and early intervention around the emotional, cognitive/psychological and behavioural symptoms related to moral injury, compassion fatigue, and burnout in order to adopt psychological health and safety implementation strategies to help reduce the risk and promote individual and organizational resilience.

THE INSTITUTION, LEADERSHIP, AND CULTURE—THE MAJOR IMPEDIMENT TO BETTER HEALTH & WELL-BEING IN POLICE AND FIRST RESPONDERS

Grant Edwards, Head of Aspect Frontline; Australian Federal Police Commander (Retired)

Despite the best efforts of many to raise awareness, provide support, and promote well-being things aren't changing in any great way. In order for change to happen, a far-reaching institutional and leadership change program is required. Perhaps the biggest impediment to gaining traction for any mental health program is culture—a culture based on stoicism, that is the endurance of pain or hardship without a display of feelings and without complaint, separating yourself from feelings and emotions to get the job done. This culture breeds distrust, cynicism, and scepticism—all honed as a survival mechanism, physically, emotionally, and psychologically.

Australian Federal Police Commander Grant Edwards discussed a) the importance of understanding first-responder culture and, moreover, the variety of sub-cultural elements that impact and affect institutions and their members and how to use these to effect mental health change; b) the need to holistically address the issue of mental health cultural reform from four angles: underdeveloped human capital, weak and confused vocational capability, major leadership deficiencies, and dysfunctional institution practices; and c) the call to develop, plan, and engage a program for staff focusing on trust, commitment, overt actions, and communication to normalize the language of mental health within the workplace and institution; d) the need to reshape the law enforcement institution to be more accommodating and understanding of the impact mental health is having on the profession; and e) the importance of sharing a framework that can help law enforcement agencies, big and small, to implement subtle institutional and cultural change to build trust in staff, normalize the language of mental health in the workplace, and commence a strategy towards better employee wellness. Commander Grant Edwards also shared his personal lived experience of being diagnosed with Post Traumatic Stress Injury and the impact that had on his career as a senior officer in the Australian Federal Police. He has been working on sharing a framework that can assist law enforcement agencies of all sizes on how best to implement institutional and cultural change to build trust in staff, normalize the language of mental health in the workplace, and begin a strategy to better employee wellness.

THE THIN BLUE LINE IS OK: DELIVERING A NATIONAL WELLBEING SERVICE IN UK POLICING

Dr. Ian Hesketh, FCMi (CMgr), FRSA, MSET (QTLs), Wellbeing Lead UK College of Policing and SRO – National Police Wellbeing Service UK (Oscar Kilo)

In 2013, the National Police Chiefs Council (NPCC) Wellbeing and Engagement working group was established in the United Kingdom. Within this initiative, significant research was undertaken to understand the well-being landscape across policing, culminating in a well-being roadmap. This enabled UK policing to better understand the issues that challenge the police force in relation to employee well-being. Further, it identified and acknowledged a significant unmet need. A requirement for a whole systems approach to embed prevention into the system was recognized. In 2017, Oscar Kilo (OK) and the Blue Light Wellbeing Framework (BLWF) were launched.

Shortly after, on 11 July 2017 the UK Home Secretary announced that a grant of £7.5 million from the Police Transformation Fund (PTF) was being made available to the College of Policing. This grant would be provided over three years and used to address welfare provision within Policing across England and Wales.

A review of policing, known as Front Line Review, was carried out. This review proposed moving from a “blame” culture to one of “learning from failure” and highlighted a number of important implications for forces’ ability to learn from mistakes and for their long-term success. Dr. Les Graham, from Durham University, who reported to the review, noted that when there is an ability to view failure as a source of feedback for improvement in daily work and to create recognition of the need for change, negative consequences that arise from future failure will be reduced. He further commented that work systems, processes, and policies can be improved through discussion, analysis, and information-sharing on failure and near misses, and innovation and proactive improvement behaviour would be encouraged.

To support the findings from the review and the earlier roadmap research, the National Police Wellbeing Service launched eight “live” services that are now available to all 43 forces in England and Wales:

1. **Leadership for Well-Being:** developing executive leaders and line managers who can lead and manage their organisations in a way that facilitates well-being, and improves performance
2. **Individual Resilience:** building individual resilience of officers and staff by developing their understanding and use of positive psychology, and other techniques, to enhance personal well-being and improve their ability to support others
3. **Peer Support for Well-Being:** delivering a national peer support model and network in order to provide the best care and support to officers and staff
4. **Psychological Risk Management:** high-risk roles screened for potential psychological trauma, and well-being screening available for all
5. **Trauma Management:** providing a police-specific post-incident support and disaster management model of care for officers and staff that provides

clear strategic and tactical direction specific to well-being when dealing with major incidents – known as Emergency Services Intervention Programme (ESTIP)

6. **Well-Being at Work:** Occupational Health support and liaison; post-HMICFRS inspection peer support
7. **Mobile Well-Being Outreach Service:** providing access to well-being services at the place of work, in order to increase the opportunity to access well-being services
8. **Physical Well-Being:** Including fitness mentoring and initiatives with Police Sport UK and the University of Lincoln

To complement the live services on offer, a number of toolkits and resources have been developed. A program of marketing and workforce engagement has also been developed. The key messaging focused on the following:

1. **Standard of Excellence** – OK is a visible sign that your police force has made a commitment to your well-being.
2. **Education** – OK provides information and guidance about well-being.
3. **Guidance** – OK delivers practical support to help forces build their well-being offer.
4. **Promotion** is achieved by displaying the OK badge as a symbol of commitment after embedding the frameworks and using the resources and materials to enhance well-being.
5. **Practical support** – OK is not a tick box exercise; it is a bold commitment to well-being.
6. **Evidence-based practices** that are cost-effective are modelled.

The final aspect, evidence-based practice (EBP), is based on the work of Prof Rob Briner at University of Bath's Centre for Evidence-Based Management. It proposes, the conscious, explicit and judicious use of the best available evidence for decision-making, drawn from four sources:

1. Practitioner experience, expertise and judgement
2. The local social and organizational context
3. The best available research findings
4. Those affected by the decision

The National Police Wellbeing Service has proven popular with officers and staff from all UK forces and is heavily used. The Oscar Kilo web portal has all the information www.oscarkilo.org.uk.

MENTAL WELLNESS FOR OUR MEMBERS ON TWO STREAMS

Dale McFee, Chief of Police, Edmonton Police Service, Alberta, Canada

Having spent 34 years in policing, including 9.5 years as Chief of Police in Prince Albert, Saskatchewan; 6.5 years as Deputy Minister of Corrections and Policing in Edmonton, Alberta, and now currently serving as Chief of Police, also in Edmonton, I must say that my position on Mental Health

and Well-Being has grown significantly, largely due to the multiple perspectives that I have held.

The Edmonton Police Service has a progressive personnel-focused program that is divided into two streams:

- a short-term program to deal with serious incidents;
- a long-term program designed for re-integration/return to work.

While these are effective and crucially important pieces that have been successful in protecting our officers' well-being, we are now looking to go further.

It is not enough to just look internally at maintaining the health of our officers. With social issues growing in our communities and with trauma present in many of the people to whom police respond, we must also create treatment and partnerships in order to realize maximum impact in keeping our officers safe. This is a net sum program, and we must ensure that we are dealing with this issue at both ends of the spectrum.

As my colleagues, with a considerable amount of experience, have clearly stated in this chapter and articulated in volumes of prior literature, building resilience is critical early on in our people's careers. We are currently studying the best way to entrench trauma-informed practise in our training regime. There is without a doubt a need to have supports for police personnel to deal with the impacts of trauma on their mental health and well-being.

Extensive research has been done, but what has not happened fast enough is implementation and action! As this article is being written, news headlines make mention of another officer in a major police service within our country who has died by suicide. This again reminds us that we might not have all the answers, but that it is time to start implementing what we know. We don't need all the answers to start. We must continually be researching, implementing, and evaluating because this is about our people, and the status quo is not an option.

COMPASSION FATIGUE IN THE UNIQUE NATURE OF POLICE WORK

Dr. Konstantinos Papazoglou, Ph.D., Postdoctoral Scholar, Yale School of Medicine

Officers routinely face critical incidents that can involve violent offenders, hostage negotiations, intense crime scenes, and irate civilians (Cross & Ashley, 2004; Karlsson & Christianson, 2003). In addition, police officers often provide care and support for victims of crimes (Rudofossi, 2009). For instance, police officers were the first responders at the mass shooting in Newtown, Connecticut, providing, among other things, support for wounded children until medical help arrived (Draznin, 2013). Gilmartin (2002), a veteran police officer and police well-being author, coined the phrase "the hypervigilance biological rollercoaster" (p. 91) to describe the extreme physiological states that officers experience while on-duty (e.g., hypervigilance to threat) and the inevitable physiological exhaustion after each shift (Gilmartin, 2002). These extreme physiological states, combined with organizational stressors and frequent exposure to public disapproval or condescension, are a particularly potent set of risk factors for compassion fatigue (Violanti & Gehrke, 2004; Gilmartin, 2002).

Over time, efforts to alleviate victims' suffering may come with a cost. Figley (1995) coined the term "compassion fatigue" to describe this "cost of caring for those who suffer" (p. 9). Compassion fatigue has multiple negative effects on caregiving professionals' well-being and occupational performance, including behavioural (e.g., irritation, hypervigilance), cognitive (e.g., concentration problems, depersonalization), and emotional (e.g., negativity, helplessness, and hopelessness) detriments (Bride *et al.*, 2007; Figley, 2002). Ultimately, compassion fatigue may render officers susceptible to other serious mental health issues, such as anxiety and depression, as well as failure to perform as expected on the job (Conrad & Kellar-Guenther, 2006). Covey and colleagues (2013) found that police officers with symptoms of anxiety were more likely to shoot inappropriately in simulated critical incidents. On the other hand, some care providers experience "compassion satisfaction" (p. 108), which refers to feelings of increased motivation and satisfaction gained from helping those who suffer. Compassion satisfaction is associated with enhanced job commitment, performance, and quality of life (Stamm, 2002), and may buffer or prevent compassion fatigue.

Once compassion fatigue is present, emotions such as hostility or apathy may prevent feelings of compassion satisfaction, leading to a further lack of commitment to occupational duties. In principle, individuals with higher levels of compassion satisfaction may find more meaning in their jobs despite the emotional weight of caring for victims (Radey & Figley, 2007). This author's (Papazoglou, 2017) doctoral dissertation research (study #1) with officers from the United States and Canada, revealed that of the total participants ($n=1,351$), 23% reported high or extreme compassion fatigue and 31.7% reported high or extreme compassion satisfaction. As expected, compassion fatigue was also negatively correlated with compassion satisfaction. Similar results to these were found in study #2 of the same project, with officers recruited from the National Police of Finland ($n=1,173$) (Papazoglou, 2017). Further research into police traumatization is imperative, as the findings will support the development of evidence-based training curricula and workplace policy programs that will promote compassion satisfaction and reduce traumatization among police officers. The development of such programs would yield results that will benefit not only the officers' mental health and well-being, but also their families and the communities they serve.

MEMBER WELLNESS: AN INTERWOVEN SUITE OF SERVICES IS REQUIRED

Paul Pedersen, M.P.A., DipEd, M.O.M., SBSSt, C.M.M.III, Chief of Police – Greater Sudbury Police Service; President – Ontario Association of Chiefs of Police 2019-2020

Police work is a people business. Community safety is not brought about by buildings or equipment; it is brought about by dedicated people who are regularly being pulled in multiple directions often to an unrealistic standard of perfection.

At the Greater Sudbury Police Service, Ontario, we have a robust, interwoven, suite of services that includes: an employee assistance program (EAP), Peer Support, our Health & Wellness Committee, a Chaplaincy Program, Service Psychologists, Road

to Mental Readiness Training, an Income Protection Program, a Peer Support Program Coordinator, a Critical Incident Team, and more. We also work in a province where presumptive legislation is in place to assist those suffering with PTSD to access services without some of the barriers that used to exist.

And yet, we struggle with staffing levels due to absenteeism, with morale problems, and with occupational stress that didn't seem to be present years ago. As Chiefs of Police, we are charged with running a public business that can only perform at its peak levels with sufficient staffing levels.

While legislation that enables access to treatment more efficiently is important, it is equally important that the treatment be effective and sufficiently efficient to return people to work to maintain workforce levels. Moreover, funding is required to support both the treatment and replacement staff during absences.

As leaders and change-agents, we must set the stage to reduce stigma and to change traditional autocratic, leader-focused styles to leadership that is understanding, accepting, supportive, and involved but that also holds to the tenets of individual and organizational accountability to professionalism and fiscal responsibility.

A BIOPSYCHOSOCIAL APPROACH TO MENTAL HEALTH AND WELL-BEING IN POLICE

Dr. Katrina Sanders, MBBS FRACGP MPH, Chief Medical Officer, Australian Federal Police

The prevalence of mental illness amongst law enforcement officers is increasing despite genuine intent by leaders, policy makers and practitioners to combat this public health epidemic. Police jurisdictions typically rely on psychological interventions such as psychological screening, mental health first aid training, investment in psychologists, and psychological education as a means to protect the mental health of the workforce. The over-reliance on purely psychological workplace initiatives demonstrates a lack of understanding of the biopsychosocial model of healthcare.

Historically, the practice of medicine involved diagnosis and treatment of the biological causation, with little attention given to psychological or social aspects of health that also contribute to ill-health. Good medicine has evolved over the last few decades to incorporate a biopsychosocial model of health. This model recognizes that there are multiple inputs to ill-health: biological, psychological, and social elements, all of which can cause adverse biological changes to the human body (Inerney, 2002).

This is highly relevant to police, who have higher rates of hypertension, dyslipidemia (disordered cholesterol profile), obesity, diabetes, and sedentary lifestyles than the average adult (Zimmerman, 2011). These risk factors combine to a reported incidence of cardiovascular disease in police at 31.4% versus 18.4% in the general population (Han, 2018). Exercise reduces the risk of cardiovascular risk in addition to improving mental health (Rosenbaum, 2014). Furthermore, approximately 40.4% of police report a sleep disorder, which directly impacts police officer health, safety, performance, and risk of burnout (Garbarino, 2019).

Police jurisdictions must adopt a biopsychosocial approach to health and well-being, as part of a holistic health program. Exercise, a balanced diet and quality sleep can improve

psychological health and overall well-being and should be considered as critical components of prevention programs and treatment plans in police with mental illness. Adopting a biopsychosocial model of health protection in police jurisdictions is good practice and good medicine.

TOWARDS IMPROVED WELLNESS OUTCOMES FOR OUR MEMBERS: RESOLVING THREE VITAL ISSUES

Tom Stamatakis, President of the Canadian Police Association; President, International Council of Police Representative Associations

With respect to police mental health, the following three yet-to-be resolved issues need to be addressed or considered so that we might change our culture in such a way as to truly become organizations that prioritize mental health and wellness.

We have very little program evaluation to help us determine what kinds of treatments are effective and which are not, and we still have very little access to appropriate and qualified persons for assistance, particularly in more rural and remote areas. That said, access is a very real issue in urban centres as well.

There is currently a tremendous amount of emphasis on recruiting diversity, including more gender equity or balance, into our police services, yet very few services (in my estimation) have shown that they are able to build capacity in this regard. The messages and direction from the Police Boards, City Councils and more senior levels of government have likely contributed to the urgency and pressure around this particular initiative or priority. To be clear, no one disagrees that diversity and gender equity/balance should be prioritized; however, it is unrealistic to expect to turn what has historically been a predominantly homogenous male-dominated industry into something completely different overnight, particularly when our industry attrition rates are generally quite low. This is important because our organizational construct is based on this type of organizational make-up, in terms of both shifting and deployment, for instance. We have not created capacity to manage the needs or demands that come along with more ethnic, cultural, and religious diversity and we have definitely not built the capacity to manage the needs and demands that having more female officers create for an organization. Just one very important example of this is our maternity and paternity benefits and how much they lag behind what is available federally and in other sectors. In addition, we do not seem to “backfill” for maternity or paternity leaves, which has a negative impact organizationally in a number of ways, including on employees who have to cover or work harder to pick up the gap created by the vacancy, as well as for the person taking the leave, who potentially has to deal with the “stigma” attached to taking time off and leaving co-workers to pick up the slack. That is just one example. A related example is when a parent, most often our female members, needs an accommodation for childcare or for family reasons; we have not created a culture where this is widely accepted or where people feel these requests or accommodations are managed equitably. A further example is found in expectations for those on leave to manage work-related demands, including court, even though they are effectively off work on leave without pay.

Second, we talk about police personnel seeking assistance, “taking a knee” or a break, when necessary to manage their mental health and wellness. However, we have not built the capacity to allow for that. Generally speaking, most if not all services are under-resourced right across Canada. Most don’t have the capacity to ensure members regularly take the breaks and time off they are contractually entitled to, let alone additional time off because of unexpected events or the cumulative effect of exposure to trauma—or just too much work. Our typical response to managing any crisis is to schedule mandatory overtime with little consideration for what impact that might have on an employee or the employee’s family. It is easy to say that mental health is important, and it’s great that we are having a conversation about it. However, there is little evidence that Police Services are able to provide opportunities for time off where the vacancy is backfilled so that the “stigma” issue can be better managed and so that the vacancy does not have an aggravating effect on those who continue to have to respond to calls or manage files. Furthermore, until we change how we reflect on these issues when we select people for assignments or promotion, we will not create the kind of environment that emphasizes positive mental health and overall wellness.

Finally, I can provide numerous examples, including where a mental health/PTSD/Operational Stress Injury (OSI) diagnosis has been made, where this is not at all taken into account when it comes to police misconduct and discipline. There is often very little consideration of any underlying issues when misconduct occurs, and I find this particularly troubling and disappointing when it involves long-term employees with many years of exemplary service. Rather than taking an approach that seeks to be supportive and corrective, the common approach appears to be one that emphasizes discipline and punishment. Often, investigations take far too long and include re-assigning a member, which is not only stigmatizing but also often removes the member from the place where they typically get the most support. One of the key recommendations that came out of the Oppal Commission of Inquiry into Policing in British Columbia in the 1990s was the need to normalize police labour relations and discipline. In a labour context, all of the case law, research, and best practices around misconduct including discipline is that the response needs to be progressive, proportionate, and timely in order to be effective. These are concepts that are either nonexistent in or foreign to policing. As part of prioritizing employee mental health and wellness, any misconduct involving a sudden change in behaviour, where there has not previously been any misconduct, should trigger a response that seeks to look beyond the misconduct.

THE LAW ENFORCEMENT PSYCHOLOGICAL AUTOPSY: UNDERSTANDING SUICIDE IN POLICING

Jeff Thompson, PhD, Adjunct Associate Research Scientist, Columbia University Medical Center

According to the Blue HELP, more law enforcement officers in the United States have died by suicide than been killed in the line of duty in the last three consecutive years. In order to prevent suicide, law enforcement outreach and prevention efforts must be developed by understanding, to the extent

possible, why it happens. An effective and scientific way to understand why officers die by suicide on a case-by-case basis is by conducting a psychological autopsy.

The psychological autopsy (PA), which was created in the 1950s, is a scientific, investigative procedure designed to explore what happened in a person's life that resulted in their death by suicide. A Law Enforcement Psychological Autopsy (LE-PA) has been developed to meet the specific needs of the law enforcement community.

More often than not, a death by suicide is the result of numerous factors. Further, a common feeling expressed by a suicidal person is having a deep sense of helplessness and hopelessness. They feel as if no one is able to help them and things will never get better. The emotional, psychological, and physical pain becomes unbearable, resulting in the person feeling that there is only one option to get rid of that pain (also referred to as psychache): taking their own life.

The LE-PA cannot change what has happened, but it can provide a greater understanding of why it happened. The LE-PA seeks to answer the following questions for an individual officer's death by suicide: why suicide, why the particular method was used, why that particular day, and what, if anything, could have been done to prevent it.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest. The editor and co-author K. Kamkar serves as a Section Editor for the Journal of CSWB.

AUTHOR AFFILIATIONS

*Clinical Psychologist, Centre for Addiction and Mental Health (CAMH) and Assistant Professor, Department of Psychiatry, University of Toronto, Toronto, ON, Canada

†Head of Aspect Frontline; Australian Federal Police Commander (Retired), Gold Coast, Queensland, Australia

*Wellbeing Lead UK College of Policing and SRO – National Police Wellbeing Service UK (Oscar Kilo), Westminster, London, England, UK

§Chief of Police, Edmonton Police Service, Edmonton, AB, Canada

Yale School of Medicine, Yale School of Medicine, New Haven, Connecticut, USA

¶Chief of Police – Greater Sudbury Police Service; President – Ontario Association of Chiefs of Police 2019–2020, Sudbury, ON, Canada

|| Chief Medical Officer, Australian Federal Police, Canberra, Australian Capital Territory, Australia

**President of the Canadian Police Association; President, International Council of Police Representative Associations, Ottawa, Ontario, Canada

††Adjunct Associate Research Scientist, Columbia University Medical Center, New York City, New York, United States

REFERENCES

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, 35, 155–163.

Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout,

and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect*, 30(10), 1071–1080.

Covey, T. J., Shucard, J. L., Violanti, J. M., Lee, J., & Shucard, D. W. (2013). The effects of exposure to traumatic stressors on inhibitory control in police officers: a dense electrode array study using a Go/NoGo continuous performance task. *International Journal of Psychophysiology*, 87(3), 363–375.

Cross, L. C., & Ashley, L. (2004). Police trauma and addiction: coping with the dangers of the job. *FBI Law Enforcement Bulletin*, 73(10), 24–32.

Draznin, H. (2013, December 6). Report supports police report time to Newtown shooting. *CNN Justice*. Retrieved from: <http://www.cnn.com/2013/12/06/justice/newtown-police-response-school-shooting/>

Figley, C. R. (1995). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Bruner/Mazel.

Figley, C. R. (2002). *Coping with secondary traumatic stress disorder in those who treat the traumatized*. London, UK: Brunner-Routledge.

Garbarino, G. P. (2019). Sleep quality among police officers: implications and insights from a systematic review and meta-analysis of the literature. *International Journal of Environmental Research and Public Health*, 16(5), pii: E885.

Gilmartin, K. M. (2002). *Emotional survival for law enforcement: A guide for officers and their families*. Tucson, AZ: E-S Press.

Han, M., Park, S., Park, J. H., Hwang, S. S., & Kim, I. (2018). Do police officers and firefighters have a higher risk of disease than other public officers? A 13-year nationwide cohort study in South Korea. *BMJ Open*, 1–7.

Inerney, M. (2002). What is a good doctor and how can we make one? *BMJ*, 324, 1537.

Karlsson, I., & Christianson, S-A. (2003). The phenomenology of traumatic experiences in police work. *Policing: An International Journal of Police Strategies & Management*, 26, 419–438.

Papazoglou, K. (2017). The examination of different pathways leading towards police traumatization: exploring the role of moral injury and personality in police compassion fatigue. *Dissertation Abstracts International*, 77.

Radey, M., & Figley, C. R. (2007). The social psychology of compassion. *Clinical Social Work Journal*, 35, 207–214.

Rosenbaum, T. S. (2014). Physical activity interventions for people with mental illness: a systematic review and meta-analysis. *Journal of Clinical Psychiatry*, 964–974.

Rudofossi, D. (2009). *A Cop Doc's Guide to Public Safety Complex Trauma Syndrome: Using Five Police Personality Styles (Death, Value, and Meaning)*. Amityville, NY: Baywood Publishing Company.

Stamm, B. M. (2002). Measuring compassion satisfaction as well as fatigue: developmental history of the compassion satisfaction and fatigue test. In Figley, C.R. (Ed.) *Treating Compassion Fatigue* (pp. 107–119). New York, NY: Brunner-Routledge.

Violanti, J. M., & Gerhke, A. (2004). Police trauma encounters: precursors of compassion fatigue. *International Journal of Emergency Mental Health*, 6(2), 75–80.

Zimmerman, F. (2011). Cardiovascular disease and risk factors in law enforcement personnel: a comprehensive review. *Cardiology in Review*, 159–166.