

Final Summary Overview

THE IMPACT OF CORRECTION OFFICER SUICIDE ON THE INSTITUTIONAL ENVIRONMENT AND ON THE WELLBEING OF CORRECTIONAL EMPLOYEES

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Purpose

In 2016, we were awarded a National Institute of Justice grant to conduct the first comprehensive mixed methods study of suicide among correction officers and in 2017 we launched the correction officer wellbeing study with the central objective of developing a nuanced understanding of the context in which correction officer suicides occur. The project involved a partnership between the research team at Northeastern University, the Office of Strategic Planning and Research at the MADOC, the Massachusetts Correction Officers Federated Union (MCOFU) and clinical direct service providers at the Riverside Trauma Center (RTC), a program of Riverside Community Care (RCC).

The research was conducted in two overlapping phases, with findings from the first phase informing key elements of the second phase. In phase one, the Northeastern University research team conducted comprehensive qualitative case studies of the occupational and personal lives of the 20 correction officers and retirees who had died by suicide between 2010 and 2015.¹ The goal in phase one was to identify any patterns or themes across the occupational lives of those officers who had died by suicide and to identify risk factors for suicide. A community partner, Riverside Community Care, performed posthumous holistic assessments (psychological autopsies) of the circumstances surrounding the death for a selection of those cases (n=6). In phase two, we collected both qualitative and quantitative data to assess the impacts of the correction officer suicides on correction officers still working in the state's prisons. We conducted on-site and on-shift in-person interviews with 440 officers and administrators to assess the impacts of officer suicide on attitudinal, behavioral, and psychological well-being outcomes. The phase two officer interview opened with questions designed to collect egocentric social network data from each

¹ When we first proposed this study, we were only aware of 16 officer suicides. We learned of the other 4 over the course of our research.

officer and included assessments of behavioral, emotional, and psychological health using validated instruments. The phase one methodology, informed consent processes and instrumentation were approved by the Northeastern University IRB in February 2017 and phase one data collection commenced in May of 2017 and ended in October of 2019. The phase two methodology, informed consent processes and instruments were approved in February 2018 and phase two data collection began in July 2018 and was completed in December 2019.

Project Design and Methods – Phase One

The goal in phase one was to develop a rich understanding of the personal, occupational, and institutional factors that can lead to suicide by conducting comprehensive case studies of the 20 known suicide deaths occurring between 2010 and 2015. Accomplishing this goal required a multipronged approach involving data collection from three primary sources: (1) officer data from the department's administrative and personnel records, (2) focus groups with family members, close friends (and a subset of six psychological autopsies), and (3) focus groups with supervisors.

Administrative Data

We reviewed the complete administrative files for all 20 officers with a specific focus on the officer's background and personnel history. These data included each officer's background and criminal history checks, their personnel history, their records of attendance and absenteeism, their commendations and reprimands, as well as any data in the personnel file on workplace injuries sustained or incidents in which they were involved during their service. We also reviewed data referencing each of the 20 officers from the department's Inmate Management System (IMS) and identified 2,549 incident reports and 640 disciplinary (misconduct) reports that one of the deceased officers wrote or was referenced in prior to their death. We coded each narrative incident and disciplinary report for exposure to violence and trauma, and for whether the officer was involved in the incident as a witness or responding officer, and then created count variables for each type of

violence exposure. These incident and disciplinary reports gave us estimates of direct and vicarious trauma exposures experienced by each officer.

Family and Friend Interviews

The administrative data collected on the 20 deceased officers provided us with critical information regarding officers' professional experiences, however, these data provided a unidimensional view of the lives of correction officers. We learned from our previous work with correction officers that relatives and close friends would provide the most well-rounded profile that best captures the challenges facing correction officers. Identifying and recruiting relatives and friends for these case studies was complicated by the sensitive nature of the work and the risk of re-traumatizing those who were likely to be at different stages of the grieving process. We used the personnel files to identify immediate relatives and other personal contacts (references) who were named in the original job application and used published obituaries and funeral home guest books to identify other relatives and close friends. The university's institutional review board (IRB) would only allow us to make two attempts at contact, both times through a mailing explaining the nature and purpose of the research, and required an affirmative return response from the friend or family member. We eventually received correspondence from the families and friends of 17 of the 20 officers (85%). While some wrote to let us know that they would rather not participate or that participation would be too difficult, we ultimately interviewed a total of 42 family members and friends of 14 of the officers. Just over a third of the family members and close friends we interviewed for our case studies were also current or former officers with the MADOC (15 of 42, or 36%). The interviews, which provided us with the opportunity to hear firsthand accounts of the lives and careers of these officers from the spouses, former spouses, parents, siblings, children, and close friends of the officers, were typically conducted in the home of one of the interviewees and lasted between one and three hours. Our first family/friend interview

occurred in August of 2017 and the last in October of 2019. Most of the interviews were audio-recorded and transcribed, and for those that were not, research assistants took detailed notes.

Focus Groups and Interviews with Supervisors

In addition to the in-depth qualitative interviews with friends and relatives, we also conducted a total of 22 administrator and supervisor interviews and focus groups with between 1 and 7 people participating in each. The purpose of the focus groups was to better understand the impacts of the officer suicides on the institutional environment and the challenge of responding to officer suicides as supervisors. A total of 59 people participated in phase 1 focus group/interviews (32 were MADOC administrators and 27 were Captains and Lieutenants). Individuals who worked in the department's Employee Assistance Services Unit (EASU), which responds to traumatic events such as officer suicides, or as members of the department's Trauma Informed Committee at the time of interview are included as administrators. 36 of the 59 supervisor interview and focus groups participants (61%) also completed a phase two interview, though these are not linked due to the risk of compromising confidentiality.

Project Design and Methods - Phase Two

Participants in phase two were sworn correction officers and administrators working for the MADOC between May 2017 and December 2019. We drew a random sample of 500 officers (~15% of the population) from a list of all sworn officers (N=3,298) in May 2018 with the goal of interviewing at least 300 randomly selected officers from across the department. Of the 500 officers initially sampled, 451 were available to be interviewed at the time we reached their facility (49 had retired, resigned, or been terminated). Of the 451 randomly selected officers eligible for interviews, 319 completed the interview (71%) and 132 declined to participate (29%). Although the original random sample was representative of the population of officers, there were several

significant differences between those who agreed to participate and those who declined. Those who declined interviews were significantly older, were more likely to be male, and had worked for the department longer than those who agreed to participate.

In June 2018, as we began preparing to interview officers at the MADOC, the department ran an academy (N=147). Given the fortuitous timing of this academy, we randomly selected and then conducted interviews with a group of new recruits (n=50) so that we could establish baseline levels of outcome variables (e.g. anxiety, depression, posttraumatic stress, suicidal ideation etc.) among those just entering the field and compare the outcomes for the randomly selected new recruits to those of the randomly selected officers at all ranks from across the department.

In addition to the random samples of officers and recruits, we conducted an additional 76 purposive interviews were completed with administrators, supervisors, and officers who had either participated in phase one focus groups or had been identified as someone who was a colleague or supervisor of one of the officers who died by suicide. The total number of officer interviews completed in phase two was 440 with interviews broken down by group: (1) random sample of all sworn officers (n=319); (2) random sample of new recruits (n=45); (3) supervisors (e.g. Administrators/Captains/Lieutenants) (n=42); and purposive known friends of officers who had died (n=34).

DATASETS PRODUCED

The project produced seven distinct but related datasets. Administrative data related to the careers of the officers who died by suicide were collected, coded, summarized, and tracked in an officer file (SPSS). The interviews with families and friends were audio-recorded and transcribed with permission and extensive notes were taken during those interviews that were not recorded. Focus groups and interviews with MADOC administrators and supervisors (including captain and

lieutenants) were not recorded but extensive notes were taken and these comprise the third phase one dataset. Phase one psychological autopsies were conducted for a subset of six of the officer suicides and these comprise a fourth qualitative data set.

The phase two interviews with 440 officers resulted in three distinct datasets that can be linked via the study ID. A master interview datafile contains all of the data from the officer interviews, including the assessments and the egocentric social network outcome measures (SPSS). An egocentric social network analysis (SNA) datafile contains the social network data used to generate the SNA outcomes (STATA), and the open-ended questions asked at the end of the interview (known as Section 14s) were all entered into Word documents and coded in NVivo.

FINDINGS

Based on preliminary analyses of the different qualitative and quantitative original data collected over the course of this project, we have several key findings. *While well-known risk factors for suicide were prevalent across the officer suicide case studies, in the correctional context, the interaction between these individual-level risk factors and organizational level occupational factors emerged as potentially uniquely important to explaining the cluster of officer suicides occurring between 2010 and 2015.* Most notably, by virtue of their occupation and the associated exposures to trauma and violence, officers experience elevated levels of anxiety, depression and post-traumatic stress and acquire a capability for suicide that leading suicidologists view as critical to explaining why some people die by suicide and others (who have suicidal ideation and are otherwise at risk) do not (Joiner, 2005; Van Orden et al., 2010). Officers work in an occupational cultural context that at best discourages help-seeking, and at worst denigrates those who do need help, so officers struggling through mental health, substance abuse, and interpersonal crises are reluctant to seek help even when they know they need it. The acquired

capability for suicide through violence exposures coupled with a cultural context that discourages talking about or seeking help for problems - appear to interact in ways that might begin explain the elevated risk for suicide among officers (Frost and Monteiro, 2020, forthcoming).

To assess the impacts of the officer suicides on officers still working for the department, we administered a series of assessments during the in person interviews with officers. Given the relative paucity of research we were particularly interested in the mental health outcomes. At the time of the interview, *20-25% of the officers who were randomly selected for interviews as part of the larger officer suicide study were exhibiting either problematic or clinically elevated levels of psychological distress as measured by anger, anxious arousal (anxiety and hyperarousal), and post-traumatic stress. Moreover, at the time of the interview at least 12 of the 319 officers interviewed (4%) were at clinically elevated risk for suicide* (two additional officers refused to answer only those questions related to suicidality). By contrast, through our random sample of new recruits, we were able to establish that those recruits started their careers relatively free of psychological distress symptomology. *At the outset of their careers, new recruits did not exhibit clinically elevated levels of psychological distress and they were not at risk for suicide.*

Additionally, we ran a series of regressions predicting a variety of outcomes for the randomly selected officers currently working at the department. The preliminary multivariate analyses introduced nine separate indicators of health and wellbeing as dependent variables, each of which fell in one of three broad categories: (1) mental health outcomes (anger, anxiety, depression, PTSD, suicidality), (2) behavioral outcomes (alcohol use and insomnia), and (3) concern about wellbeing and willingness to seek help. All regression equations were estimated using an array of independent variables, including individual demographic factors (7), work related indicators (10), as well as important features of an officer's social network (4). Across the results

from the preliminary regression analyses, several independent variables emerged as consistently significant predictors across outcome domains. Having faced disciplinary action, for example, appears to adversely affect mental health outcomes, as does job satisfaction (or dissatisfaction), but other work-related conditions, such as facility-level characteristics (security level, non-fatal injuries) and responding to inmate suicides do not emerge as strong predictors of any of the dependent variables.

Particularly noteworthy in terms of understanding the impacts of officer suicides we find that having known an officer who died by suicide consistently predicted adverse psychological health outcomes. *Those officers who personally knew officers who died by suicide are significantly more likely to report experiencing psychological distress symptomology themselves.* Our preliminary analyses of the egocentric social network data we collected suggests some encouraging results regarding the aspects of social networks. Network size (e.g. degree) and Blau's index of racial/ethnic heterogeneity of the social network emerged as predictive of behavioral outcomes (alcohol use in particular). These data are cross-sectional but we anticipate that egocentric social network data that can assess changes in the composition of social networks over time, which we will collect as we continue this work, will emerge as pivotal to understanding long term impacts of correctional work on officer health and wellbeing.

We presently have four papers in preparation at various stages of development. The first, based on the qualitative case studies with the families and friends of officers who have died by suicide has been accepted for publication and will appear in a forthcoming issue of *Justice Quarterly*, one of the premiere peer review journals in the discipline (expected publication date of December 2020). The lead paper from the quantitative officer interview data focuses on the factors that predict officer mental health outcomes (anxiety, depression, post-traumatic stress, and suicidal

ideation) and underscores the pivotal role of suicide exposure (particularly in terms of having known an officer who died). We anticipate at least one additional officer wellbeing papers focused on emotional and behavioral health outcomes (absenteeism, alcohol use and abuse, insomnia, etc.). A third paper focuses on the findings from focus groups with superintendents, captains, and lieutenants highlighting the organizational and supervisory challenges officer suicide presents and the ways in which this department has sought to address it. A fourth paper is focused on the impacts of officer suicide on officers working across the department, with specific foci on officer health, wellbeing, and suicide in the aftermath of a cluster of officer suicides, and on officer willingness to seek help for self and others in times of emotional distress. Given our findings on risk factors for officer suicide from the case studies, we see the concern and help-seeking paper as pivotal.

Implications or Policy and Practice

Despite a collaborative effort to better understand the problem of correction officer suicide, the problem of officer suicide continues to plague the department. Over just the past three months (June – August 2020), at least three more officers who were working for the department have died by suicide. We have learned over these past four years that the cluster of officer suicides in Massachusetts that we had hoped might be an anomaly was probably not an anomaly at all. We anticipate that the findings we have described here, and the implications that flow from them, will likely be applicable across local, state and federal correctional contexts.

Through this research, we have demonstrated that many of the prominent risk factors for suicide (prior suicide attempts, substance abuse, mood disorders, access to lethal means, exposure to suicide and trauma, depression), were also factors across our case studies of the suicide deaths of correction officers. Most of the officers who died had been struggling in the days and months leading up to their deaths. Particularly relevant in the correctional context, however, are the

heightened risk of suicide following exposure to suicide and trauma in prisons and a heightened risk in cultures that discourage talking about or seeking help for problems. The correctional occupational context is in many ways a uniquely difficult environment for those struggling with mental illness or facing particularly challenging personal or professional circumstances. Both risk factors and protective factors provide direction for systemic suicide prevention efforts. Generally, good suicide prevention strategies include trying to reduce risk factors (e.g. – treatment for mood disorders and/or substance abuse, removing firearms from the residence during a depressive or suicidal crisis, etc.) while enhancing protective factors (e.g. – providing easy access to mental health and substance abuse services, restoring personal connections to family, friends, colleagues, etc.) (Centers for Disease Control and Prevention, n.d.; Suicide Prevention Resource Center & Rodgers, 2011).

Our most actionable recommendations came directly from the officers who participated in the research. Through the open-ended questions, which focused on what the department had, had not, and could, or should, be doing about correction officer health, wellbeing and suicide, we learned that the officers are incredibly adept at articulating the aspects of the occupational environment that make the work difficult and particularly taxing to their emotional, mental, and physical health and wellbeing. Notably, relatively few officers complained about the incarcerated population. Officers across all ranks and across all facilities, on the other hand, complained about the organizational stressors (management and supervision) that make their work more difficult and the work schedules (shifts, mandatory overtime) that negatively impact time with family and friends outside of work. The officers seemed keenly aware of the impacts of correctional work on the social networks that can prove crucial to overall health and wellbeing particularly in times of personal difficulties (Perry, Pescosolido, & Borgatti, 2018). They also offered suggestions for

actionable steps the department could take to reduce these impacts on their personal and professional lives.

We look forward to working with the MADOC, the officers' union (MCOFU), and Riverside Community Care to develop an evidence-based trauma services model and skill-based trainings for officers. These trainings will help correction officers understand and cope with the stresses and violence exposure and to support officers and supervisors specifically with the traumatic injury to or loss of a colleague and fellow correction officer. The trainings will focus on shifting the narrative from the idea that stress *causes* suicide, to understanding that suicide is multi-factorial and that simplistic explanations of causes have been shown to increase the risk of contagion. By "shifting the narrative" we are referring to evidence from the National Action Alliance for Suicide Prevention that suicide prevention efforts are made stronger by "normalizing" or de-stigmatizing issues such as depression, seeking help, and discussing stressful situations (U.S. Department of Health and Human Services (HHS) Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012).

As we continue our work with the MADOC and MCOFU, we will work with them to develop resources for correction officers and supervisors that would train all to recognize the psycho-social indicators of depression and suicidality before it reaches crisis-levels, that teaches strategies for managing stress and trauma, and that attempts to create a culture where it is acceptable to ask for help and to offer support to one another. We approach this recognizing that changing the correctional occupational culture is likely a formidable challenge, but we intend to work with the department to effect policy changes that might allow for some of those cultural shifts to begin to manifest.

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