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

Final Report submitted to the Massachusetts Department of Correction[1]

Natasha A. Frost, PhD, Northeastern University
Carlos E. Monteiro, PhD, Suffolk University

December 1, 2021

[1] The National Institute of Justice funded this research in 2016 (NIJ Grant #: 2016-MU-MU-0010). Much of what is reported here has previously been described in a series of articles (Frost, 2020; Frost and Monteiro, 2020; St. Louis, Frost, Monteiro, and Migliaccio, 2021; and Wills, Bates, Frost, and Monteiro, 2021) and presentations. As we continue to analyze the data collected through this work, we will provide copies of publications related to this work to the department and post them to our webpage dedicated to this ongoing work: https://cssh.northeastern.edu/sccj/co-wellbeing/

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With doctoral research assistants
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Dedication: All the work that we do extending from this research is dedicated to the memory of the officers who died by suicide and to their families, friends, and colleagues who live with the pain of that loss every day.

Acknowledgements: First and foremost, we express our sincere gratitude to all the officers, friends, and family members who participated in this research. We are also grateful for the support of the Massachusetts Department of Correction (MADOC) and the Massachusetts Correction Officers Federated Union (MCOFU). Dr. Rhiana Kohl, Nicholas Cannata, and Patricia Snow, in particular, have supported this research since its inception and we could not have accomplished this work without them.

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1. Introduction

In 2016, almost 43,000 Americans died by suicide (Peterson et al., 2018). Suicide, which is the 10th leading cause of death in the United States, claims more than twice as many lives each year as homicide and causes immeasurable pain, suffering, and loss to individuals, families, and communities (Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Suicide rates have been increasing nationally for at least the past two decades with the age-adjusted suicide rate in the United States increasing by 30 percent (from 10.4 to 13.5 per 100,000) between 2000 and 2016 alone (Hedegaard et al., 2018). Rates of suicide of males between age 25-44 and 45-64 were reported as among the highest at 26.2 and 29.1 per 100,000, respectively, in 2016. Moreover, Center for Disease Control and Prevention (CDC) research has demonstrated that suicide risk varies substantially by occupation with the protective service occupations, which includes corrections, consistently ranking among the ten occupations at highest risk for suicide (Peterson et al., 2018).

While the limited evidence suggests correction officers are vulnerable to adverse mental health outcomes and at higher risk for suicide, there have been no published studies examining suicide and suicidal ideation among correction officers specifically. This study is the first comprehensive mixed method assessment of the impact of correctional officer suicide on the institutional environment and on the wellbeing of correctional employees.

1.1 Study Background

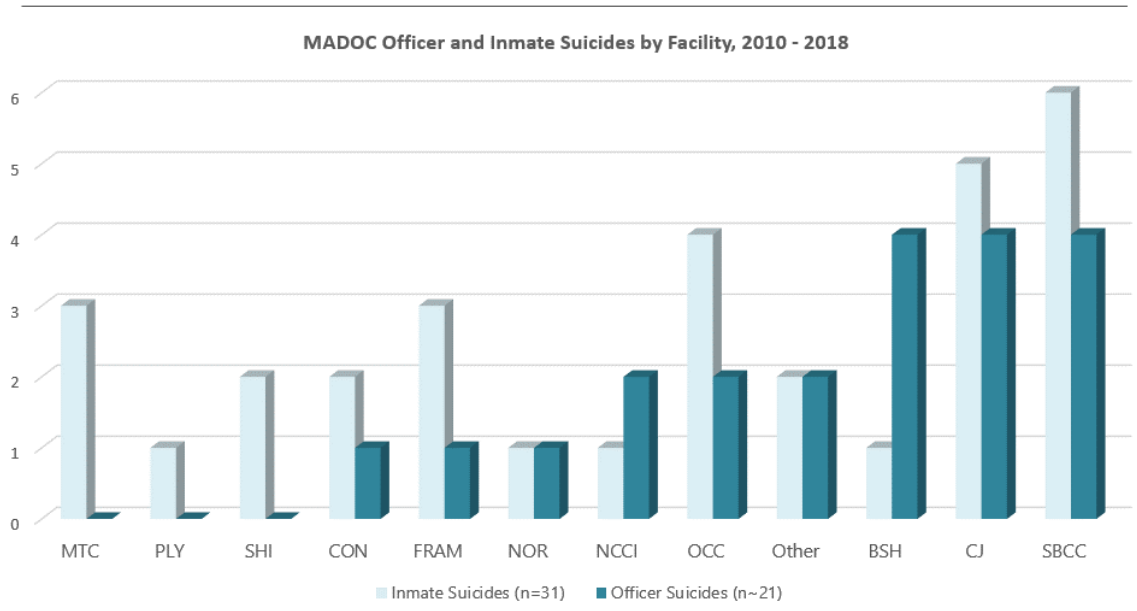
Between 2010 and 2015, at least 20 current or former correction officers working for the Massachusetts Department of Correction (MADOC) died by suicide. We initially learned of the suicides through interviews we were conducting with officers and sergeants who were taking part in an occupational stress study. During the interviews, a number of officers shared their concern about the recent suicides of colleagues, with several noting they themselves were only participating in the stress study out of concern about the suicides. Around the same time, a local Fox news station ran several stories about the increases in officer suicide at the MADOC, featuring some the families of officers who had died. As university researchers already working with the department, we asked the MADOC for more information.

The department provided a list of 16 names of officers who had died by suicide. We thought we might see an identifiable pattern among the data that they provided, and we were surprised when there really wasn't anything obvious. The officers who had died included both men and women, roughly proportional to their representation in the MADOC workforce. They ranged in age from 23 to 62 and had careers in corrections as short as 6 months to as long as 32 years. Fewer than half had military backgrounds. Among the ranks of those who died by suicide were officers, sergeants, lieutenants, and captains – several had served in the administration as a deputy superintendent or higher. Most of the prisons across the state had experienced at least one officer suicide, with a handful experiencing multiple suicides. In several of the years, there had been as many four to five suicides in a single year. The only obvious things these officers had in common

was that they all had currently or previously worked for the Massachusetts Department of Correction, and they had all died by suicide.[2]

We are often asked whether the suicide rate among MADOC over this period was in fact elevated. To that end, it's useful to think about the suicide in terms of the standardized rate. The suicide rate among current and former MADOC officers averaged 105 per 100,000 people over this six-year period. As a state, Massachusetts has one of the lowest suicide rates in the country at approximately 10 per 100,000. By that measure, the MADOC suicide rate is at least 10 times higher than you would expect in Massachusetts. The population of people who work for the MADOC department are mostly men who are between the ages of 25 and 64 and that's a demographic group at very high-risk group for suicide outside of corrections. Taking into account that men in this age group are high-risk, the rate among the officers in this department over this period was still four times higher than the rate you would expect. The rate of suicide among current and former MADOC officers was indeed exceptionally high between 2010 and 2015.

The first figure depicts MADOC officer suicide by facility. Between 2010 and 2018, there were 31 suicides among the incarcerated over that period and 21 officer suicides. Suicide rates are known to be high among incarcerated populations but in Massachusetts over this period officer suicides were rivaling the number of suicides among the incarcerated.

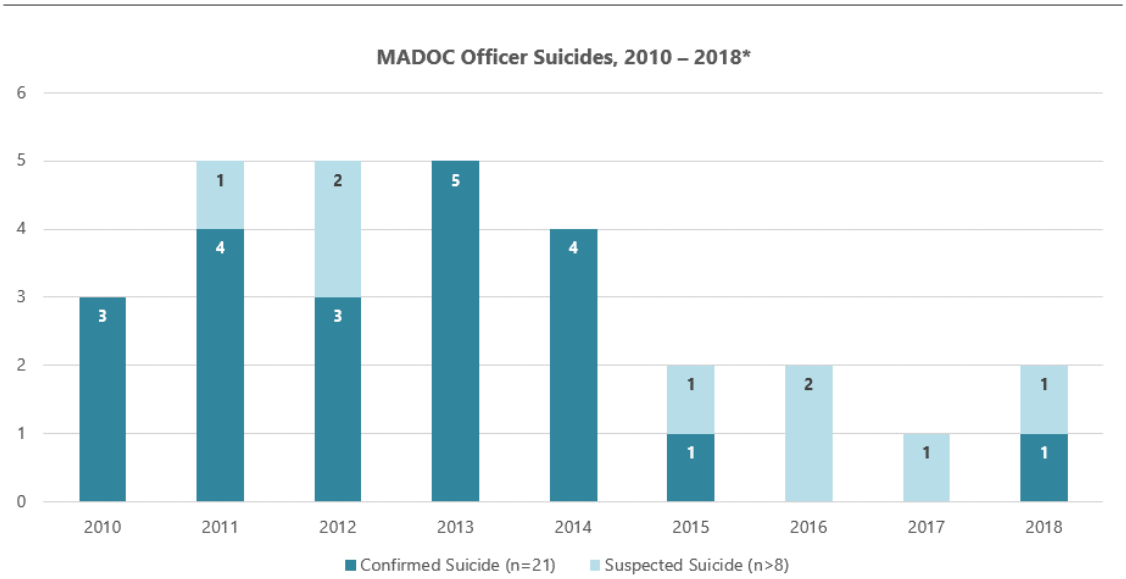


[2] Several of the MADOC officers who died by suicide had retired or resigned prior to their death. Among those who retired or resigned, all but one had done so within two years of their death by suicide.

This figure also demonstrates that suicide among officers have concentrated at three of the department's facilities: Bridgewater State Hospital (BSH), MCI-Cedar Junction (MCI-CJ) and Souza-Baranowski Correctional Center (SBCC). Although some of the other department facilities had experienced at least one suicide, the majority of officer suicides occurred at one of those three facilities. There are only three facilities where there had been no confirmed officer suicides.

The next figure similarly shows the number of confirmed suicides among current and former MADOC officers and suspected officer suicides. With regard to the suspected suicides, we were not able to independently confirm that those officer deaths were suicides. These were names provided by officers when asked if they knew anyone in the department who had died by suicide. Each of these was a suspicious death and the person typically died of an overdose. Unless an official deemed an overdose to be intentional, we did not conclude it was a suicide. In other words, in each of the cases that we included as suicides, the death was confirmed to be a suicide via either a medical examiner or a police report.

Although we didn't include these suspected suicides in the case studies, they were perceived to be suicides by officers that we interviewed. Given our findings related to knowing officers who have died by suicide, these suspected suicides could have potentially been as impactful as the confirmed suicides.



* Includes current and former officers (among those who retired all but one had retired in the previous two years).

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1.2 Study Overview

In 2016, we were awarded a National Institute of Justice grant to conduct the first mixed methods study of suicide among correction officers. 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 Massachusetts Department of Correction (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).

Since suicide is not caused by a single event but rather a complex interplay of life events, we sought to identify patterns and trends in the life and work histories of the officers who died that would help us better understand the fatalities and would allow us to talk about the officers as people.

In this research, we undertook comprehensive, intensive qualitative work to develop a more nuanced understanding of the complex lives of correction officers and to assess the extent to which there might be an interaction between family- and work-life factors that lead to crisis level distress and suicidal ideation or risk. We sought to identify any key transition or turning points across correction officers' lives and careers.

We had five primary objectives in this work:

1. To develop a nuanced understanding of the **context** within which CO suicide occurs.
2. To better understand the many **impacts** of correction officer suicide.
3. To assess the **effects** of fatalities on the institutional environment and on the wellbeing of the correctional staff working in correctional facilities.
4. To identify **risk factors** for anxiety, depression, PTSD, and suicidal ideation.
5. To understand how the structure, function, and composition of officers' **social networks** might be related to suicide ideation and indicators of wellbeing.

To better understand the impacts of the officer suicides on the institution, we supplemented comprehensive case studies with sophisticated quantitative analyses of data collected from correction officers still working in facilities to identify some of the key correlates of psychological wellbeing in this context. Our findings, triangulated across methods, have allowed us to begin to identify risk factors for crisis-level distress and suicidal ideation. We hope that the research will help identify potential intervention points.

This research was conducted in two phases. In the first phase, we worked with official records and those who knew the officers who died by suicide to better understand the context within which correction officer suicide occurred. In phase two, we examined the impact of correction officer suicide on the behavioral, emotional, and psychosocial wellbeing of officers who still work for the department of correction.

1.3 Research Partners

We could not have done this work without the assistance and cooperation of the Massachusetts Department of Correction (MADOC) which has allowed us to do our correction officer research without any interference since 2015. The MADOC has allowed us to do our interviews on-site and on-shift, which makes it possible for us to interview large numbers of officers and represents a substantial commitment of staff resources. There have been three different commissioners of correction since we started this work in 2016, and each of those commissioners has offered the research team unfettered access to the documentation and data that we needed to conduct the most comprehensive study possible. Each of the commissioners has also encouraged us to present our findings directly to multiple audiences, including to the officers themselves.

The Massachusetts Correction Officers Federated Union (MCOFU) has always supported our work and has helped us spread the word about the importance of this research to those who are most affected by it. The union stewards, in particular, played a crucial role in helping us maintain exceptional participation rates.

We are also indebted to Bryanna Mellen, and the On Guard Initiative, a nonprofit that she started with a friend when her father (a retired captain with the MADOC) died by suicide. The OnGuard Initiative helped us connect with some of the families of the officers who had died by suicide in the first part of the study.

Riverside Community Care (RCC) is a suicide prevention and postvention nonprofit that works with suicide survivors. Riverside provided consultation as we developed the interview and helped ensure that our interview materials were trauma-informed and would not cause secondary trauma. We also contracted with RCC to provide services to any study participant who was experiencing distress as a result of our interviews.

2. Officer Suicide Case Studies

2.1 Overview

The case studies were conducted between May 2017 and August 2019. To include an officer death in our sample, we relied on external validation of suicide as the cause of death of the officer. Although that validation typically came via a medical examiner's determination on a death certificate in the officer's personnel file, we also requested police reports for each of the cases and some of those reports indicated that the death was clearly a suicide.

Our case study methodology involved conducting comprehensive reviews of officer's occupational history (reviewing entire personnel files and coding administrative data on violence exposures) to better understand the occupational lives of the officers and conducting interviews with family members and friends, including fellow officers to better understand the personal lives

of the officers. We used the data triangulated across methods to develop an understanding of suicide among correction officers.

2.2 Administrative Records

We began our research with comprehensive reviews of the administrative and personnel data from the MA DOC for all 20 officers who died by suicide between 2010-2015. These data included background and employment records including information about 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.

As we launched the case studies, we were interested in whether these officers had been experiencing problems at work that might help explain their suicide. We relied on data provided by the department of correction to develop an understanding of the occupational lives of the officers and to potentially identify any common factors across the careers of the officers.

For each case, we began the case study by thoroughly reviewing the entire personnel file of each of the 20 officers who had died by suicide between 2010 and 2015. In some cases, these personnel files spanned decades – in others, mere months. Within the personnel files, we reviewed all the pre-employment background investigation documents, each of the annual performance reviews, all commendations and reprimands, and any department disciplinary actions taken. We had access to formal correspondence between the department and the officer. We noted any leaves of absence, including for family medical (FMLA) and industrial accident (IA) leaves, and the reasons for those leaves. Where they existed, we reviewed inmate grievances filed against the officers.

We also requested incident and disciplinary reports for all of the officers who died by suicide between 2010 and 2015 and coded them for direct and vicarious exposure to violence. The disciplinary and incident reports are narrative reports filed by responding and/or witnessing officers. In total, we received 2,549 incident reports and 640 disciplinary reports across the 20 officers. We read the narrative of each incident and coded it for the following exposures to violence: (1) inmate on inmate fights, (2) verbal assaults/threats on staff, (3) physical assaults on staff, (4) physical assaults on staff with injury, (5) cell extractions and/or inmate restraints, (6) biohazard incidents (throwing substances), (7) inmate self-harm, and (8) suicide attempts or completions. We then coded for whether the officer was involved in the incident as a responding officer or whether they witnessed the incident.

To our knowledge, the only files that we were not given access to were those related to departmental internal affairs investigations. The Massachusetts Department of Correction did, however, provide information regarding the internal investigation status of each of the officers indicating whether each of the officers had: (1) ever been investigated by internal affairs and (2) whether they had been under active investigation in the year immediately preceding their death. We also learned about some of these investigations from our family and friend interviews.

Beyond the department, we requested police reports from the jurisdictions that responded to the initial call for service at the time of each of the suicides and retrieved each officer's criminal history from the state's Division of Criminal Justice Information Services (DCJIS).

We meticulously reviewed the materials gathered through the administrative files and used them to develop a narrative summary describing each officer's career. Although the administrative file reviews allowed us to understand the officers as employees, they told us little about the officers as people.

As we began the case studies, we were particularly concerned that we represent the correction officers who had died by suicide as more than just statistics. Given the stigma unfortunately still associated with suicide, we wanted to capture the officers' lives as comprehensively as possible. To convey the stories of these officers and to better understand the personal and professional circumstances surrounding their suicides, we sought to find and interview the family members and close friends of each of the officers who had died by suicide. With the exception of MADOC facilities, all names of persons and places referenced in interviews, presentations, and reports are pseudonyms.[3]

2.3 Case Study Interviews – Family and Friends

The administrative data collected on the 20 officers who had died by suicide provided us with important information regarding officers' professional experiences, however, these data offered a one-dimensional view of the lives of the officers. We learned from our previous work with correction officers that family members and close friends would provide a well-rounded profile that best captures the challenges facing correction officers. To accomplish this, we completed a series of individual or group interviews with relatives, close friends, coworkers, supervisors, and administrators, with the ultimate objective of identifying turning points in the careers of their loved ones from their perspective and to discuss collectively how they felt the work environment affected their loved one.

We identified surviving family members and close friends who we identified through various sources including background and employment records. The process of identifying and recruiting relatives and close friends for these case studies was complex given the sensitive nature of the work and the fear of possibly retraumatizing loved ones who were likely in different stages of the grieving process. The Northeastern University Institutional Review Board (IRB) provided a set of stringent recruitment guidelines to lower the potential for adversely affecting and retraumatizing relatives and close friends who would be contacted. The research team could only contact friends and relatives via mail, making no more than two attempts for each relative identified from the personnel files or through online obituaries and public record searches.

[3] Because there were only two women, we use male pronouns throughout, and we refer to current and former spouses as simply "spouses.'

Although we expected that the IRB restrictions might limit the reach of our family interviews, we eventually heard from the families and friends of 17 of the 20 officers (85%). A few families wrote to let us know that participation would be too difficult as the experience was still too painful to recount. Ultimately, we conducted 29 individual or group interviews, interviewing a total of 42 family members and friends. It is important to note that 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 department of correction (15 of 42, or 36%).

The interviews allowed us to hear firsthand accounts of the lives and careers of these officers from the officers' spouses, former spouses, parents, siblings, children, and close friends. Family and friend interviews were typically conducted in the home of one of the interviewees, at their workplace, or at a private location reserved to conduct an interview. Interviews were led by the lead researchers and were conducted individually or in groups based on the participants' preference (ranging from 1-6 participants). The interviews with were semi-structured and guided by a series of questions that had been developed in advance to progressively follow the officer's life and career in more or less sequential order. With the permission of the participants, we recorded the interviews and transcribed the conversations. 28 of the 42 interviews (67%) were audio-recorded. For the 14 interviews that were not audio recorded, one or more research assistants took comprehensive notes as the conversation proceeded. Through these individual and group interviews, the family members, close friends, and colleagues provided rich descriptions of the officers' lives. For the nine cases where we conducted interviews with multiple friends and family members of a single officer, there was a high level of agreement across participants around the personal and professional circumstances leading up to the officer's suicide.

2.3 Holistic Assessments

The project design included a key partnership with direct service providers at the Riverside Trauma Center (Riverside), a program of Riverside Community Care to conduct holistic posthumous assessments that anchored these case studies and augmented our understanding of the different pathways to suicide. Phase one holistic assessments were conducted for a subset of six of the officer suicides and these comprise a fourth qualitative data set. These holistic assessments, known in suicidology as psychological autopsies, allowed us to obtain important data surrounding the context in which the suicides occurred and helped us identify some common risk factors across the cases. Although the goal of a single assessment is to determine the proximate causation and better understand the pathways to suicide, the goal of studying multiple suicide deaths is to define common risk factors and to identify points of entry for prevention.

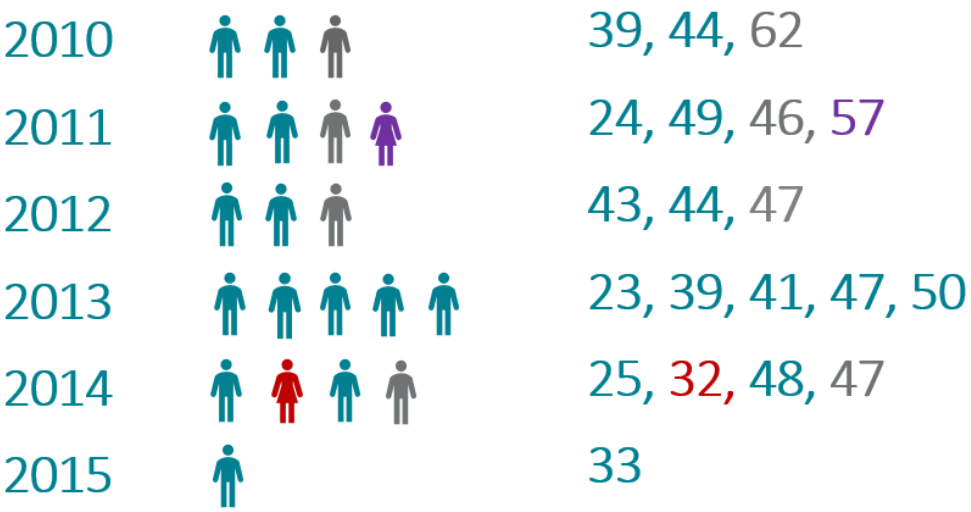
We expected that some of the families of the deceased officers would choose not to participate in the holistic assessments. Riverside clinicians ultimately completed six psychological assessments with families who consented to the more comprehensive assessment of the nature and circumstances surrounding their loved one's death.

2.4 Findings from the Case Studies

Among the MADOC officers who had been confirmed to have died by suicide between 2010 and 2015, there were 18 men and 2 women. The officers ranged in age from 23 to 61 and the average age was 41. Half of the officers who died were between 40 and 49 years of age.

In the figure below, the teal male icons represent men who were actively employed by the department at a time that they died by suicide, the gray male icons were men who had previously worked for the department but had retired prior to their death (again most had retired or resigned within two years of their death by suicide). The red female icon represents a female who was currently employed by the department and the purple female icon represents a woman who had retired or resigned prior to her death. In the right on the figure are the ages at which each died by suicide. Although the officers ranged from very young at 23 to 62, there's a concentration of officers in their the 40s (as might be expected based on highest-risk age group for suicide in the general population).

Figure 1. MADOC Officer Suicides, 2010-2015



Demographic and Occupational Profiles

Table 1 expands upon these demographics and adds occupational profiles for the twenty officers who had died by suicide. 85% of the officers who died were white, reflecting the race/ethnicity profile of MADOC officers more generally (who are also 85% white). 90% of the officers had been hired before the age of 30, and 85% died before their 50th birthday.

Table 1. Demographic and Occupational Profiles of MADOC Correction Officers who Died by Suicide, 2010 – 2015

	f (n=20)	%
Gender		
Male	18	90%
Female	2	10%
Race/Ethnicity		
White	17	85%
Black	1	5%
Hispanic	1	5%
Mixed Race	1	5%
Age at Hire		
20 – 24	9	45%
25 – 29	9	45%
30 or above	2	10%
Military Veteran		
Yes	9	45%
Criminal History		
Yes	14	70%
Highest Rank Achieved		
Officer	14	70%
Sergeant	3	15%
Lieutenant	1	5%
Captain	2	10%
Evaluated for Fitness for Duty		
Yes	4	20%
Subject of Internal Affairs Investigation		
Ever	10	50%
Within a year of suicide	7	35%
Age at Death		
20 – 29	3	15%
30 – 39	4	20%
40 – 49	10	50%
50 or above	3	15%
Employment Status at Death		
Current Employee	13	65%
Detached with Pay	2	10%
Retired	5	25%
Cause of Death		
Self-Inflicted Gunshot Wound	14	70%
Intentional Overdose	4	20%
Asphyxiation by Hanging	2	10%

At the time that they died, 15 were still employed by the department (although two of those officers had been detached with pay) and 5 (or 25%) had resigned or retired prior to their death. Given the known elevated risk for suicide among military veterans, we are often asked about the overlap between veteran suicide and officer suicide. Among the 20 officers who died between 2010 and 2015, 9 of the officers (45% or slightly fewer than half) were veterans.

As previously mentioned, the officer suicides occurred across all ranks: 14 were officers, 3 were sergeants, 1 was a lieutenant, and 2 were captains. Two had served as administrators within the department. The average years of service among the officers was 15 years, but it's crucial to note that the years of service ranged from less than 1 year all the way to 32 years. In terms of facility, 14 had worked at a single facility for their whole career while 6 had worked at multiple facilities.

In our interviews with families, we learned that several of the officers had been arrested and decided to retrieve the criminal histories of each of the officers who had died by suicide from the Division of Criminal Justice Information Services (DCJIS). 70% of the officers who had died by suicide had criminal histories, but it is important to note that these were primarily arraignments for misdemeanors. There were very few convictions and some of these incidents preceded the officer's employment with the department. There were a handful of arraignments on more serious charges, including DUIs and assaults, but none of these arraignments resulted in a conviction.

Crucially, half of the officers (50%) who died by suicide had been the subject of an internal affairs investigation and 35% were under investigation at the time of their death. As previously noted, the department didn't share the details of internal affairs records with the research team, although families often talked about the stress of department investigations and sometimes knew a little bit about the reason for an Internal Affairs investigation.

It is perhaps crucial that half of the officers who died had faced internal affairs investigations because in the second phase, where we interviewed current officers, we find that facing departmental discipline is an acute stressor and is associated with adverse mental health outcomes. In at least four of the officer suicides, an ongoing department investigation was perceived to be a contributing factor in the suicide death. 20% of the officers who died, so one in five, had been evaluated for fitness for duty at some point in their career. Again, we did not have access to department investigations, but given documentation in personnel files and obtained through our family/friend interviews, it appears that these officers were likely evaluated for fitness for duty based on either mental health and/or substance abuse issues.

Given access to firearms is a key risk factor for suicide, it is notable that 14 of the officers died of gunshot wounds, 2 died by hanging, and 3 died by drug overdoses that were deemed intentional. It is also notable that within our time frame (2010-2015), there was one homicide-suicide and one attempted homicide-suicide, in both instances, the officer died by suicide.

Risk Factors for Suicide

There were known risk factors for suicide across most, but not all, of the officer suicides. These included: 1) access to firearms; 2) deteriorating mental health; 3) relationship problems; 4) excessive alcohol and/or drug use; and 5) chronic pain. Most of the officers had access to firearms and as previously noted, firearms were used in 70% of the officer suicides.

It was difficult to identify risk factors for suicide in administrative and personnel records, so most of what we learned about these risk factors were drawn from our interviews with family members and friends (n=14).

Table 2. Presence of Known Risk Factors for Suicide

Risk Factor	%
Mental Health Concerns	**86%**
Relationship Issues (Separations/Divorces/Child Custody)	**79%**
Substance Abuse Issues	**79%**
Serious Injuries / Chronic Pain	**57%**
Known Previous Suicide Attempts	**36%**

Family members and friends were concerned about the officer's mental health across most of the cases (86%). Although there was evidence of anger, anxiety, and PTSD across the cases, the families perceived the officer to have been suffering from depression, usually severe depression, in the months (and sometimes years) preceding their deaths.

As a family member of one of the officers explained:

> *"I think he was depressed. I mean because he was… he was so bothered by the whole [relationship] situation… He just wasn't himself. He just seemed always preoccupied, even when he was with us. You know the last time I had seen him of course was Christmas time… And I remember him picking us up… you know we're driving… and you know I am asking… I am like 'What's going on with you? How are you doing? How are you managing?' and ummm he was… he was different."*

A family member of another officer said,

"I'm pretty sure that he had depression. He wasn't treated for it, but I do know that he had wanted to go to the doctor and talk about getting medications or something for depression. And when he went, the doctor was too young. He felt like he couldn't talk to him."

In some of the cases, the officer had struggled with mental illness for decades. In five of the cases, family members and friends told us of prior suicide attempts. But in other cases, the officers were described as struggling only in recent months and years, and the families tied their mental health problems to things going on in their personal or professional lives. One of the officers had been demoted following a departmental investigation, which the family clearly identified as directly connected to his death. Others were going through relationship problems that included infidelities, separations, divorces, and child custody battles.

More than three-quarters of the officers who died had been struggling with addiction, most commonly mounting problems with alcohol abuse. Several were reported to have been using prescription pain medications. Many of the family members and friends tied the substance abuse problems directly to correctional work and an occupational culture in which going out after work for drinks is the norm. As one spouse described:

"They'd always go out to a bar or something, or wherever, and they'd all be there, after shift... Even towards the end of our relationship that's where he'd go all the time… be like "Yeah, I'm going out to the bar" and everyone was there, all the time, um yeah so that was mostly his group. Yeah, and I can't speak for anyone else, but I know that he did a lot of drinking to cope, and all of his friends did, so you know, there's something wrong there."

Family members and close friends described the social networks of the officers and how frequently those were based on drinking buddies from work. The drinking culture within the department came up again and again, and it seemed to the research team that the social circles of the officers were comprised largely of other officers:

"So you just hang out with the people that you work with, because that's all you have. you know so I think that was what it turned out to… so you know he'd go out drinking on Tuesday night, because that was, you know fifteen people went out, it was all work people, so that was, you know… I don't think there were a lot of true, true friends."

An officer who was a close friend of one of the officers who died by suicide explained:

"I was trying to get him to stop drinking too cause… every single night we were out until 2, 3 o'clock in the morning. Drinking. And, uh. I didn't want to… I didn't feel like I needed to go to AA. I still to this day don't feel like I needed to be there. So, I knew if I told him, 'hey why don't you go to a meeting?'—he would never go. So, I said "Hey, I need you to come with me tonight, I'm going to a meeting, but I don't want to go alone. I need you to come with me." So he'd go with me. For me. And I was trying to get it to sink in. It didn't for him. And, uh. We were at a meeting Tuesday night, of the week that he killed himself."

A number of the family members and friends indicated that the officer was changed by the work and directly or indirectly connected correctional work with the officer's growing problems with substance abuse and mental health. As one mother explained:

> *"I think he was suffering from depression most likely from drinking so much, but he was not a depressed child, he had never been a depressed person his entire life, he got out of bed wanted to run. He woke up every day with so much enthusiasm, he was not depressed. And the depression he was undoubtedly now, in hindsight, experiencing I am sure was from drinking too much, which he hadn't done to my knowledge prior to that and the DOC… I think it just haunted him."*

As another spouse explained:

> *"So he had some major paranoia… and again, I firmly believe it was working in corrections, he was very paranoid about inmates knowing where he lived, we couldn't put anything in the paper, no names in the paper, no pictures in the paper. If we went out somewhere he would have specific places he would not go. Obviously when you went somewhere your back was to the wall, you hear that all the time, but that is the god's honest truth. truly always scoping out wherever we were, he was highly paranoid to the point where at the end of his life he was sleeping with a gun under his pillow, not under the bed, under his pillow."*

More than half of the officers who had died by suicide suffered serious injuries at some point in their lives. Several of those had been work-related injuries, and some families indicated that the officer was using alcohol or drugs to offset problems with chronic pain:

> *"Plus the back. Plus his back… Hurting. That's one of the biggest things. Self-medicating cause… Cause he wasn't taking drugs. He wasn't using anything off the street or anything like that. I…I do think the drinking was helping with numbing the pain in his back. Cause that's when it, it really…that's when it seemed to get much worse."*

Another spouse noted:

> *"I didn't realize it, but he had a drinking problem. I didn't realize until [later] because there would be times that I come home… and he would be passed out in the living room, and I'd help him upstairs to bed. And then later on, it kind of clicked that he was using narcotics too. It was more of… He got Percocets for his injury - when he was attacked by an inmate - and then it moved to Vicodin and then Oxycodone. And then I'm not sure where it went after that."*

There were just a couple of officer suicides where there did not appear to be a combination of the known risk factors.

Through our family and friend interviews, it became clear that there were at least three distinct categories of officer suicides among the 20 cases: (1) officer deaths where there were extensive histories of risk factors for suicide; (2) officer deaths following acute risk factors for suicide, without

an extensive history; and (3) officer deaths with a precipitating event, but few other identifiable risk factors for suicide.

To be clear, the suicide of the officer was shocking and devastating to every single family we spent time with; however, for some of the officers who died by suicide, the family explained that there had been a relatively lengthy history of anxiety and/or depression. In several of the cases, there were previous suicide attempts – for at least a couple of the officers the attempts dated back to adolescence. In these cases, the family was generally very aware that the officer was struggling and was actively doing everything they could to intervene. Even in these families, the officer suicide was unpredicted and unpredictable.

In a related set of cases, there was less of a known history of mental health struggles, but the officers were known to be experiencing particularly acute personal or professional challenges at the time that they died. These officers tended to have been perceived as emotionally and behaviorally stable until relatively recently when they had confronted a particularly significant life challenge. Although these challenges were sometimes very clearly work related, with several of the officers facing imminent (or recent) discipline, demotion, or dismissal, they were more often personal. That said, we have learned that for almost all the officers, personal and occupational struggles were inextricably intertwined.

Many of the officers were experiencing significant relationship strain, and several were going through difficult divorces and acrimonious child custody disputes; most were battling growing problems with substance use and abuse. Some were fighting chronic pain from injuries, often sustained at work. Several were fighting with the department to have the lingering effects of those workplace injuries recognized. In these cases, which were about equal to the number with known mental health histories, there were a series of clear precipitating events. These officers were facing ongoing existential or ontological crises and their families were concerned, but typically not about the potential for suicide. Frequently these were officers who had recently retired or were hoping to retire.

Then there were the handful of cases where there quite literally seem to have been no signs of any preexisting risk factors that family or friends could identify. To the family, these suicides seemed to come out of nowhere and were possibly triggered by a single precipitating event. We describe these as impulsive suicides – these officers seem to have simply lost perspective in a moment, making a snap decision with devastating and lasting consequences. In these cases, there was a triggering event, but none of the precursors for elevated suicide risk. These officers tended to be among the youngest officers and, given the lack of risk factors, their deaths were among the most difficult to comprehend.

As we have noted elsewhere, across the officers who died by suicide, very few had dreamed of being a corrections officer, but most had been excited for the opportunity when they first took the job. For some, that initial excitement faded only over time, while others seemed to struggle with the realities of the work almost immediately. While there were certainly those officers that

seemed to like their jobs and rarely complained about the work, we walked away from a handful of our family interviews feeling like the person just should have never pursued work in corrections.

The Occupational Context

While known risk factors for suicide were prevalent, features of the occupational context emerged as equally important.

Across many of the officer suicides studied, extensive exposures to violence and expectations that officers should be tough and 'suck it up' together with the stigma associated with both mental illness and help-seeking in the occupational culture in corrections interacted with those known individual-level risk factors for suicide.

Although not all of the officers who died by suicide worked in positions where they would have been routinely exposed to violence, those who worked in facilities – and especially those who worked in the three facilities where officer suicides had concentrated – experienced extensive exposures to violence.

As previously described, we retrieved all of the incident and disciplinary reports that involved or referenced one of the officers in our case studies. Across the incident reports reviewed, together, BSH, MCI-CJ, and SBCC (where many officers had worked) accounted for:

- 91% of the physical assaults on staff (90% of threats on staff)
- 91% of the bio-hazard incidents
- 90% of the inmate-on-inmate fights
- 87% of the cell extractions and inmate restraints
- 83% of the uses of chemical agents
- 82% of the assaults on staff with injury
- 70% of the incidents of inmate self-harm
- 63% of the suicide attempts or suicides

Incident reports can only capture exposures to suicide within the prison walls. Beyond the incident reports, we also learned of exposures to suicide outside of the prisons through the interviews. Members of one officer's family, for example, described how he had lost his closest colleague (another correction officer who died prior to our study period) and a godson to suicide in the years leading up to his own suicide.

When asked about exposure to violence specifically, a number of the family members and friends, particularly those who were also officers themselves, directly referenced the role of vicarious trauma through exposure to suicide.

'Kevin,' an officer who admitted to having had suicidal thoughts himself, talked at length about exposures to violence within the prisons. He was particularly aware of, and forthcoming about, the cumulative nature of the impacts of these exposures:

> *We deal with cutups all the time. We deal with suicides, hangings and stuff. It becomes kind of normal… But he could [pointing to an interviewer], he could deal with a thousand of them and it not bother him one bit. You [pointing to the other interviewer] could deal with 50 and it not bother you. And her [pointing to a research assistant] and I could – our first one and, and it bothers us. And then your 51st one – and his 1,001st – and it bothers you. And the stuff that I've seen people do to themselves is just – it's mind boggling. Inserting stuff into their bodies. Places that [phew], I just – it's just not normal. And I can recall, I can recall two incidents in my head with inmates where I still see that body like it was yesterday. And then doing CPR. They had died. Cause— they k— they killed themselves and harmed themselves. I remember seeing them, doing CPR on them, and its still… in my head I guess.*

When asked whether the officer who died by suicide had also experienced these exposures, 'Kevin' responded *"Oh, God yeah. He did… he was in the can a lot, so he did a lot of that. He was involved in a lot of uses of force, a lot of staff assaults."* Similarly in another case, when asked whether that officer had been physically assaulted, 'Ron' said: *"Yeah, most of us, yeah most of us have all been… Nobody escapes that place without getting assaulted."*

Cumulative exposures to incidents involving violence, injury and death can result in elevated risk for anxiety, depression and post-traumatic stress symptomology (Spinaris et al., 2012), each of which have been associated with elevated risk for suicidal ideation and suicidal behavior (Franklin et al., 2017). These occupational exposures to violence also may have contributed to the development of an acquired capacity for suicide in these (and presumably other) officers (Joiner, 2005).

These are also the three facilities where family members and friends of the officers were most likely to talk about the ways in which the institution changes the individual. As one family member, who himself has over 20 years in the department at one of the three facilities, explained:

> *"It changes you as a person, you know, through time it changes you as a person. You're not the same person, you know, going in as you are coming out of that. It… it definitely does some damage inside."*

The finding that working in prisons changes a person has been described in work of other researchers who have closely examined the impacts of prison work (Crawley, 2004; Arnold, 2005).

The occupational context of corrections, e.g., the 'working culture,' was identified as problematic in at least three specific ways. In the first article that we published from the case studies, we refer to these as (1) an expectation that the officer "deal with it" no matter what they were experiencing or going through, (2) that they avoid the stigma of both struggling with a mental illness and of seeking help, and (3) that they hang on to the job until retirement.

No matter what the officers experienced at work, families and friends reported that they sensed the officers felt that they should be able to deal with it – and an inability to handle what they were experiencing was evidence of weakness.

One mother described her horror after hearing what her son was bring exposed to at work.

> *[He] said "I've learned to embrace the suck." And I had such a visceral response to that, I said "Whoa, what do you mean you've embraced the suck? What does that term mean?" And he said "Well that's what the officers say. That's the mantra, you know you suck it up, you deal with it."*

The theme of maintaining a façade of toughness, no matter what, was a recurrent theme particularly among the officers who were struggling through personal or professional challenges. A spouse explained that *"[He] always felt like pride was more important than showing weakness. That's definitely it, I mean if I've said anything that has hit the nail on the head, that felt right."* Another of the interviewees perceived that the bravado required of officers in corrections is even greater than in other law enforcement occupations:

> *"They'll talk for someone else, but it's not about them. It's the same way in the police, and the same way in the army, you know it's part of the code, it's part of the code. If you are going to be a man or you're going to be a warrior, then you can't show weakness and I get that the DOC is the worst. It is the worst."*

Families described officers' fears that if their problems were exposed, they would be perceived as weak by their colleagues and supervisors (and potentially those that the incarcerated population that they supervised). Time and again, we heard examples of an officer's personal struggles becoming widely known within the department. Some of the officers were apparently taunted and bullied as rumors about their struggles with depression, relationships, or substance abuse spread throughout the workplace.

When they were willing to admit they had a problem, families reported that the officers were reluctant to seek help because any attempt to seek help might also become public and help-seeking itself was evidence of weakness.

> *"I think in that environment it's especially not, it's not a help-seeking environment, obviously, to work in. And there is the fear of the job, and you know, like 'what if I show that I have depression.' You know, suddenly, they see it as 'mental illness'… depression as being mental illness, that being stigmatized… I think what he was afraid of is… [long pause] … I don't think he wanted anyone to look at him differently like if he had to get meds."*

This family member even admitted that the family was complicit in not seeking help for the officer because they too feared the occupational consequences:

> *"That's what bothered me when I really thought about it… I remember that day thinking 'We need to do something. We need to probably admit him,' but everybody – some of the conversation, this is the truth, I'm just being honest - some of the conversation was 'we can't - his job, his job' - and that's the truth. I'm just being honest."*

Families also described a desire to hang on to the job until retirement no matter what the consequences might be for the officer's own wellbeing

> *"The last 10 years of his career he was not happy, not happy at all. He just hated his job. He hated going to work every day… I feel like what happens with correction officers a lot of the time is that, after a while they are doing time. You know what I mean? They are doing their time, they're counting their days… 'I got 5 years, 2 months, 10 days left.' They are counting, every one of them is. I was just talking to someone the other day about it. I think that [he] felt so trapped in it because he had a family, he had a house, we had bills, and he had to be with this job, with the great benefits and the good pay. He had to stay there, you know he really didn't have anything else to do."*

As we interviewed family members and close friends who were also current or former officers themselves, this tendency to countdown to retirement was pronounced.

When we interviewed one officer about the death of his friend, we asked how long he himself had worked for the department and he replied: *"17 and a half years. I have 2 years, 5 months, 26 days and I'm out."*

The family member of another officer also described the tendency to hang on and its effects on officers:

> *"Ummm at, at that point he knew that he was going to get out in 20 years, you know? He just wanted to get his pension… Yeah I think he had had it at that point…. once you get to like 15 years in the department, it's kind of a crazy thing, you just want to be done with it, you just don't want to do it anymore. So you just struggle the last 5 years, you know?"*

When we later went back into the department and interviewed officers who currently work for the department, it became even more clear that the perceived benefit of making it to retirement is so substantial that officers will hang on to the job no matter what the consequences might be for their own wellbeing.

In the interviews, family members and friends who were also officers themselves were much more likely to discuss the impacts of correctional work, though they too emphasized that the problems the officers were experiencing in the months leading up to their suicides were primarily personal in nature.

Nonetheless, these officers argued that the work environment in corrections can be a very unforgiving place when an officer is struggling personally.

We conclude the case studies with a comment from an officer who worked alongside one of the officers who died by suicide. He articulated some of the specific ways in which personal and occupational pressures can interact to make an already bad situation worse for officers who are struggling:

"A lot of people go to work to get away from problems. It's a stress relief. As crazy as it sounds, a lot of people go to get away. But, when you go to work and you're not quite 100 percent yourself, and people kick you while your down - they put you through hell - the administration is playing stupid games. So, now you come to work miserable and you leave even worse. Now, you go home and the problems at home are getting worse cause you are aggravated. It keeps snowballing and snowballing and snowballing. That's where I feel the problem is. Instead of trying to help somebody, let's make things worse. [sigh] And when you work in a negative environment like that everyday [long pause], the job's hard enough alone without the BS."

Very few of the families that we interviewed suggested working in prisons ***by itself*** led to the suicide of their loved one, but many emphasized that ***features of the work environment made it exceptionally difficult*** for the officers to admit that they were struggling or to reach out for help even when they knew they desperately needed it.

3. Administrator and Supervisor Focus Groups and Interviews

3.1 Overview

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. Focus groups provide an effective and useful approach to gleaning insights from multiple stakeholder groups who collectively, in interaction, can identify issues, patterns, causes, and effects that individuals by themselves may be less likely to identify. 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.

3.2 Focus Group Data

A total of 59 people participated in phase one focus group/interviews (32 were MADOC administrators and 27 were captains and lieutenants). We led separate sets of focus groups for supervisors (lieutenants and captains) and administrators (superintendents and deputy superintendents). 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 are included as administrators. Of the 59 supervisor interview and focus groups participants, 36 (61%) also completed a phase two interview.

3.3 Findings from the Focus Groups

Qualitative data from 22 focus group discussions with a total of 59 participants were reviewed for emergent themes. Individual field notes from each session were read and then analyzed using NVivo to detect themes across participant responses.

Throughout these discussions, participants repeatedly described specific challenges in their area of work including staffing shortages, mandatory overtime, absenteeism, staff training issues and a host of other recurring concerns involved with correctional work. Generational differences emerged as the most common theme, illustrated by quotes such as "older equals thicker skin; younger equals thinner skin". Focus group participants characterized younger and incoming officers as complex, entitled, and defiant of the command structure; noting they "come in with a degree and are attracted to the job because of the pay, but younger people don't want to do this job because they can't text all day; millennials don't want this job."

In addition to generational differences, our analysis identified five other themes and subthemes including: (1) opposition to help-seeking and confidentiality, (2) promotion stress and unclear department policies, (3) management style differences, (4) inadequate training and resources, and (5) a call for more proactive approach to addressing officer wellbeing.

Opposition to help-seeking and concern about confidentiality emerged in all the focus groups as participants described the correctional culture within the department as unsympathetic to issues involving mental health or help seeking. One focus group participant captured this theme perfectly stating, "*if you had compassion coming into this job, you had to put it in your pocket*".

Promotion stress emerged as another important theme highlighting the conflict officers face when considering a promotion with a participant noting "someone with less tenure than any of us (three) was taken for a higher position because he was willing to move up."

The two different sets of focus groups (administrators vs. supervisors (captains/lieutenants)) identified many of the same issues, however, there were some clear differences particularly in concern about management styles. Supervisors (captains and lieutenants), for example, expressed concerns over having their hands tied and not being able to identify or help struggling officers mainly due to policies set by their administrators. Some of the captains explained that *captains used to have open door policies to inspire openness among COs, however, now people are afraid to speak up when something happens for fear of repercussions; everyone has become afraid of their fellow employees.* Captains and lieutenants also lamented that policies are being set by individuals with little correctional experience.

Although there were some clear differences between the two types of supervisors that participated in focus groups (administrators versus command staff), both agreed that changes in recruitment, quality of training, and resource shortages are tied to the health and wellbeing of correction officers.

4. Correction Officer Interviews

4.1 Overview

As we completed the phase one case studies, we went back into the prisons and completed 440 one-on-one interviews with employees of the department. While we interviewed three distinct groups, most of the findings here focus on our interviews with the 319 sworn officers at all ranks who were randomly selected. Because these officers were randomly selected, they are representative of all the officers in the department, and what we find related to their outcomes is generalizable to the population of officers working for the department.

In addition to the interviews with the randomly selected sworn officers from around the department, we also interviewed a group of 45 randomly selected new recruits. The department graduated an academy just as we were beginning our phase two interviews, so we took that opportunity to interview a random sample of those new recruits primarily because we knew whatever we found regarding officer outcomes someone would say, "Well, how do you know that they didn't come in like that? How do you know that this career doesn't attract people with high levels of anger, anxiety, depression, or PTSD?" Although it doesn't definitively answer those questions, we knew that if we at least had some baseline measures among new recruits, we'd be able to speak to that question specifically a little bit better than we would be able to without the new recruits.

We also interviewed 76 volunteers: the focus group participants, employees of the department who simply came forward and volunteered, and friends of the officers who had died by suicide who we identified through conversations with family members and friends. Most, but not all, of these volunteers were sworn officers.

During the phase two interviews, which were conducted on-site and on-shift, we focused on the impacts of the suicides on the health and wellbeing of the officers who still work for the department.

4.2 Officer Interviews

In Table 3, we present the demographics of the total population of officers who worked for the Massachusetts Department of Correction in May 2018 when the department provided the population list. We contrast those population statistics with the random sample of 451 officers who were approached for interviews, and with the 319 randomly sampled officers who agreed to be interviewed.

The table demonstrates that this random sample is a representative sample. What we find among the randomly selected officers who we interviewed can speak to the population of officers currently working for the department.

Table 3. Population, Sample and Participant Demographics

	Population		Random Sample		Interview Participants	
	%	N	%	n	%	n
Gender						
Male	88%	2918	87%	391	85%	271
Female	12%	380	13%	60	15%	48
Race/ethnicity						
White	84%	2785	85%	383	86%	274
Black/African American	8%	259	6%	29	6%	18
Hispanic	6%	200	6%	27	5%	17
Other	1%	60	3%	12	3%	10
CO grade						
COI – Officers	76%	2519	80%	359	82%	260
COII – Lieutenants	15%	485	12%	55	10%	32
COIII – Sergeants	7%	215	7%	31	7%	23
Captains	2%	79	1%	6	1%	4
	Mean	Median	Mean	Median	Mean	Median
Age	42	43	42	42	41	40
Years on job	14	12	14	11	13	11
Total		**3298**		**451**		**319**

4.3 Findings from the Officer Interviews

Suicide Exposure

We begin the presentation of phase two findings by noting that ***suicide exposures across the department are substantial***. This might be expected given that there were so many officer suicides in such a short period of time, but those exposures to suicide ended up being important to officer wellbeing outcomes.

Two thirds of the officers who we interviewed in the random sample who are currently working for the department reported having personally known at least one officer who died by suicide. In other words, two thirds of all the employees who work for the department personally knew one of the officers who had died. Again, this will become important when we look at the impact on officers' own mental health and wellbeing.

The officers who worked with department are also incredibly concerned about this issue. They're concerned both about the mental health and wellbeing of their colleagues generally and they are very specifically concerned about the risk for suicide.

Concern about Officer Suicide

We asked each of the officers interviewed to rate their level of concern on a scale of 1 to 10 asking first "On a scale of 1-10, how concerned are you about the emotional and psychological health of the other officers you work with?" On average, the officers rated their concern about other officers' health and wellbeing as almost 8 out of 10. In other words, the officers we interviewed were generally very concerned. Fully one-third of the officers we interview indicated that their level of concern was a '10'.

We then asked officers "On a scale of 1-10, how concerned are you about officer suicide?" The officers expressed even more concern (the average level of concern was 8.3 out of 10). *More than half of the officers who currently work for the department reported that their level of concern about officer suicide was a 10*.

Not only are officers working in the department exposed to suicide, but they're also concerned about suicide and officer wellbeing more generally.

We then asked "for what percentage of the people who you work with are you concerned about: (1) their emotional health (such as anxiety, depression, etc.); (2) their interpersonal wellbeing in terms of their relationships; and (3) also their behavioral wellbeing (in terms of their substance use, insomnia, etc.). On average, the officers reported being concerned about almost half of the people they work with so 44%, 44%, and 48% respectively. Not only are officers concerned about wellbeing and suicide, but they reported that they were concerned that almost half of the people that they work with are experiencing the types of problems that we saw as important in the officer suicides that formed our case studies.

Crucially, about a third of the officers we interviewed indicated that another correction officer ***had talked to them about suicide in a way that made them concerned for the officer's safety***. So, in other words, one third of the officers interviewed felt someone they work with was acutely at risk for suicide.

Mental Health Outcomes

In addition to asking officers about their concern about health and wellbeing, we also assessed each of the officers that we interviewed using a series of validated assessment tools. We measured the psychological outcomes that are the focus here using licensed subscales from the Trauma Symptom Inventory-2 (TSI-2).[4]

[4] The TSI-2 was reproduced by special permission of the Publisher, Psychological Assessment Resources, Inc. (PAR), 16204 North Florida Avenue, Lutz, Florida 33549, from the Trauma Symptom Inventory-2 by John Briere, PhD, Copyright 2011 by PAR. Further reproduction is prohibited without permission from PAR.

The TSI-2 is a validated tool for assessing the presence of symptoms that has been normed on age and sex. We used officers' normed scores across each of the subscales (anger, anxious arousal, depression, PTSD, and suicidality) to identify scores in the 'normal', 'problematic' or 'clinically elevated' ranges.[5] Each of the latter two categories indicates an officer who is self-reporting symptoms associated with the mental health outcome.

Table 4. Psychological Distress Symptomology (TSI-2)

	In the Normal Range		Problematic or Clinically Elevated	
Anger	232	73%	**87**	**27%**
Anxious Arousal	244	77%	**75**	**23%**
Posttraumatic Stress	260	82%	**59**	**18%**
Depression	300	94%	**19**	**6%**
Suicidality	304	95%	**14**	**4%**

Among the 319 officers in the random sample, there were relatively high percentages who self-reported experiencing symptoms of each of the psychological distress outcomes.

As we review the findings related to mental health outcomes, it is important to note that these are very likely undercounts of the prevalence of these problems, because, as we discussed in the context of the case studies, not just officers, but people in general, are not always willing to admit their own mental health issues (especially in the context of interviews with people they don't know).

About a quarter (or one in every four) of the officers who work for the department self-reported symptoms consistent with at least one psychological distress outcome, whether that was anxiety, anger, PTSD, or depression.

Crucially, almost 5% of the officers who we interviewed in the department had been at risk for suicide within the past six months.

In addition to the 14 officers who self-reported suicidal ideation or behaviors in the previous six months, two of the officers we interviewed refused to answer only the questions related to suicide. These two officers self-reported clinically elevated symptoms on at least two of the other mental health outcomes, so were equally concerned about their risk for suicide.

[5] Briere, J. (2011). TSI-2: Trauma Symptom Inventory-2 Professional Manual. Lutz, FL, PAR Inc.

About 25% of officers (or 1 out of every 4) in the department self-reported symptoms consistent with at least one psychological distress outcome (anger, anxiety, ptsd, and depression)

Almost 5% of officers (or 5 out of every 100) in the department were at risk for suicide within the past six months (at the time of interview)

Those officers who personally knew officers who died by suicide are significantly more likely to experience psychological distress symptomology (including suicidality) themselves

When we controlled for other potential explanatory variables, three variables were important predictors across the psychological distress outcomes.

1. **Suicide proximity**, or how well officers knew an officer who had died by suicide, was a significant predictor of psychological distress. Those officers who reported that they personally knew at least one of the officers who died by suicide were significantly more likely to experience psychological distress themselves (exhibiting symptoms of anxiety, depression, and PTSD). Having personally known someone who had died by suicide was a key predictor of each of the psychological distress outcomes and the measure of suicidality.
2. **Work-family conflict** was also a significant predictor across all four mental health outcomes, so those who reported experiencing more work-family conflict in their lives were significantly more likely to exhibit symptoms of anger, anxiety, depression, and PTSD. These findings are crucial because, as we mentioned in our discussion of the case studies, the interaction between work and family was often described in the cases of the officers who died. This interaction is also very prevalent in predicting mental health outcomes for officers who work in this department.
3. **Departmental discipline** (defined as discipline that goes beyond the immediate supervisor) was a key predictor across three of the four psychological outcomes. Those who reported having faced departmental discipline were significantly more likely to exhibit symptoms of anger, depression, and PTSD. This is crucial as well because departmental discipline similarly emerged as important in the case studies. Departmental discipline was referenced as a precipitating factor by family and friends in several of the officer suicides. Moreover, as we mentioned, half of the officers who died by suicide had been under investigation at some point in their careers and 35% had been under active investigation in the year preceding their death. Officers have described the department's disciplinary processes as acutely stressful, and our results indicate that it is a key predictor of mental health outcomes for the officers that we interviewed.

Suicide proximity is a key predictor across all four mental health outcomes: Those who personally knew an officer who had died were **significantly more likely** to exhibit symptoms of **anger**, **anxiety**, **depression**, and **PTSD**.

Work-Family Conflict is also a key predictor across all four mental health outcomes: Those who reported experiencing more work-family conflict were **significantly more likely** to exhibit symptoms of **anger**, **anxiety**, **depression**, and **PTSD**.

Departmental Discipline is a key predictor across three of the four mental health outcomes: Those who reported having faced departmental discipline were **significantly more likely** to exhibit symptoms of **anger**, **depression**, and **PTSD**.

It is important to emphasize that these predictors of psychological distress outcomes were significant even when controlling for demographic variables (age, race/ethnicity, tenure, etc.). Findings related to psychological distress outcomes are covered extensively in a forthcoming article. We anticipate additional findings related to behavioral health (alcohol and substance use, insomnia, and burnout) as we continue to analyze the data.

Help-seeking

We also asked specifically about help seeking. Having learned from the families about the reluctance of officers to seek help, we asked current officers about help-seeking behaviors. As we anticipated, there was a reluctance to seek help, even when people desperately needed it. Here we explicitly asked:

"How likely are you to seek help if you were severely depressed or suicidal?"

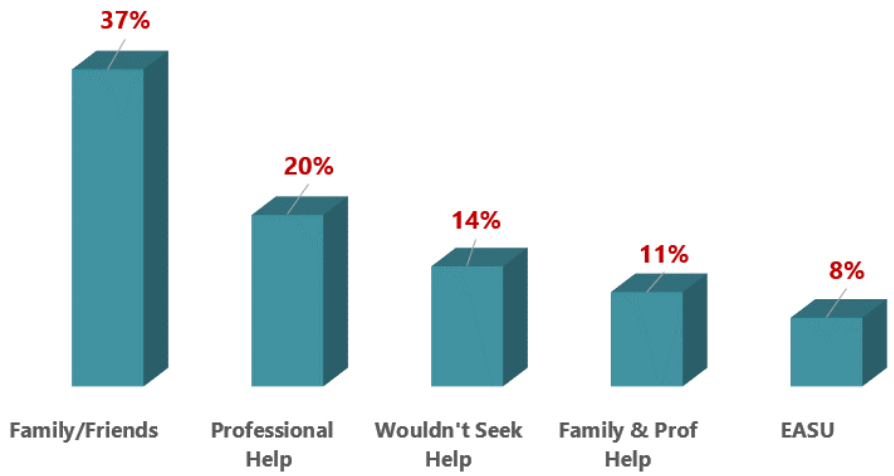
16% admitted that they were not at all likely to seek help, even if they were severely depressed or suicidal, 29% indicated that they were somewhat likely to seek help, and just over half (55%) said that they were very likely to seek help.

Although it is easy to focus on the 55% who said they would seek help, it is important to emphasize that, even in the extreme case of extreme depression and suicidal ideation, almost half of the officers interviewed expressed some reluctance to seek help even when desperately needed.

We then asked more specifically about types of help they might seek. In terms of seeking help for themselves, officers reported that they were very unlikely to go to the EASU if they needed help themselves. Only 8% of the officers that we interviewed identified the EASU as a resource that they would be willing to reach out to if they needed help.

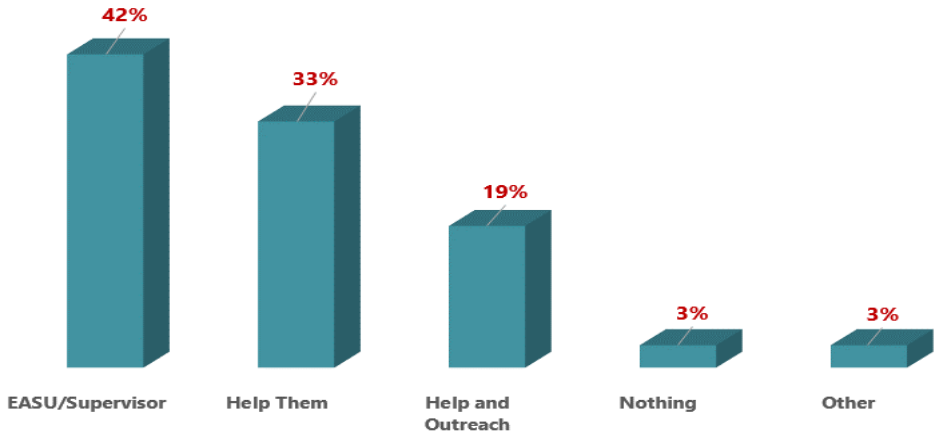
Those willing to seek help would most likely turn to their family or friends (37%), about 20% reported they would seek professional help outside of the department, 11% indicated that they would both talk to their family and seek professional help outside of the department, and 14% acknowledged that they wouldn't seek help of any kind, *even if they desperately needed it*.

Figure 3. Help-Seeking for Self



Crucially, this actually inverts when the officers are asked about seeking help for others. We asked ***"What would you do if you were to seek help for others?"*** Almost all (97%) of the officers indicated that they were willing to do something to help another officer. In terms of seeking help for others, the officers were most likely to reach out to the EASU or a supervisor (42%), along with helping the struggling officer themselves (33%). Almost one in five (19%) said that they would do whatever it took, trying to help them themselves and also reaching out to others on behalf of the officer. Finally, about 3% reported they would do something else, such as helping them find a spiritual advisor, and 3% said they would do nothing at all because it wasn't their business. The department could capitalize on this willingness of officers to seek help for others.

Figure 4. Help-Seeking for Others



Psychological Distress Across the Samples

Once we had these findings related to psychological distress outcomes, we compared the outcomes among the randomly sampled officers to the outcomes for the randomly sampled new recruits (and then later to those officers known to have known at least one officer who had died by suicide).

As previously noted, one in four of the randomly sampled officers reported symptoms associated with problematic or clinically elevated levels of anger, anxiety, depression, PTSD, or suicidality but as indicated in Table 5, the numbers were much lower among new recruits. It wasn't that none of new recruits had these problems, but far fewer self-reported symptoms.

Table 5. Psychological Distress Symptomology (TSI-2): Officers and New Recruits

	Normal		Problematic or Clinically Elevated	
Anger				
Officers	232	73%	**87**	**27%**
New Recruits	44	98%	1	2%
Anxious Arousal				
Officers	244	77%	**75**	**24%**
New Recruits	39	87%	6	13%
Posttraumatic Stress				
Officers	260	82%	**58**	**18%**
New Recruits	41	91%	4	9%
Depression				
Officers	300	94%	**19**	**6%**
New Recruits	44	98%	1	2%
Suicidality				
Officers	302	95%	**14**	**4%**
New Recruits	45	100%	0	0%

While 27% and 24% of the officers interviewed reported symptoms consistent with problematic or clinically elevated anger or anxious arousal respectively, only 2% and 13% of the new recruits had these symptoms. Rates of PTSD symptomology among officers were double those among new recruits. Moreover, there were very low levels of depression and suicidality among new recruits.

We used these comparisons to make the case for funding of our newest study with the MADOC in which we will be following the careers of officers in an effort to identify the turning points in their careers at which assessments detect symptoms of psychological distress developing. That study was funded by the National Institute of Justice in 2020 (NIJ Grant #: 2020-R2-CX-0007).

The next table compares the random sample of officers to the purposive sample of 34 officers who reported being close friends with at least one of the officers who died. Given our finding that knowing one or more of the officers who had died by suicide predicted psychological distress, we wanted to compare outcomes across these two groups of officers.

The table illustrates how ***much more prevalent*** these symptoms were among these officers. In other words, psychological distress symptomology is quite prevalent among the random sample, but it is even more prevalent among those who were close friends of officers who died by suicide. Those who we interviewed because they were known friends of the officers who had died by suicide were particularly more likely to self-report symptoms of PTSD, depression, and suicidality.

Table 6. Psychological Distress Symptomology (TSI-2): Random and Purposive Sample

	Normal		Problematic or Clinically Elevated	
Anger				
Random Sample	232	73%	87	27%
Purposive	**27**	**79%**	**7**	**21%**
Anxious Arousal				
Random Sample	244	77%	75	24%
Purposive	**24**	**71%**	**10**	**29%**
Posttraumatic Stress				
Random	260	82%	58	18%
Purposive	**23**	**68%**	**11**	**32%**
Depression				
Random	300	94%	19	6%
Purposive	**29**	**85%**	**5**	**15%**
Suicidality				
Random	302	95%	14	4%
Purposive	**28**	**82%**	**6**	**19%**

As mentioned at the outset, this critical finding that those who are closest to officers who have died by suicide are significantly more likely to experience distress themselves. This will have important implications for the department moving forward.

5. Recommendations for the MA Department of Correction

In the final section of this report, we use our findings across both parts of the study to make recommendations to the department.

Transform the Occupational Culture

Before turning to the specific recommendations, our overarching recommendation is that the department work to transform the occupational culture by increasing workforce diversity and confronting institutional barriers to culture change. It is imperative that the department work to address the occupational culture in corrections that stigmatizes mental illness and reinforces barriers to help-seeking. The department will continue to confront substantial problems of officer health and wellbeing, including officer suicide, until it breaks down these barriers.

From our perspective, the most significant barriers to cultural change within the department are the lack of diversity in the workforce and the promotion structure that disincentivizes even the best employees from seeking promotions. Talent atrophies in such an environment. While we agree that there seems to be a new generation of officers who fundamentally differ from the previous generation, both demographically and in their collective orientation to the work, we disagree that this is necessarily a problem.

Simply stated, in 2021, a department simply cannot maintain a workforce that is 88% male and 85% white. There are some promising signs that the department will look more diverse in the future with the more recent academies including more women and more persons from traditionally under-represented groups. The work to create a more diverse and inclusive workplace must be a priority of the leadership in order to accomplish institutional and cultural change.

As the department works to transform the department, we recommend that they *engage the officers in that process*. The officers themselves have many of the best ideas for changing the occupational culture. Engage them in frank and open discussions about addressing aspects of the work environment that are particularly challenging. Not only will engaging officers in working together to address the occupational culture potentially improve the lives of the officers who work for the department, but improving the working conditions for officers will also potentially positively benefit the lives of the incarcerated populations that they work with.

Occupational health is now a priority for most industries and departments of correction should similarly prioritize health and wellness. Administrators should revisit their wellness curriculum annually, incentivize wellness across the department, adopt best practices and consider collaborative efforts with other states or departments.

The specific recommendations that follow largely reflect the final part of the officer interviews where we asked officers what they think the department can or should be doing about officer suicide and wellbeing.

Proactively address officer wellness. Department administrators should proactively adopt programs and services to continuously address the ongoing effects of correctional work. The focus needs to be on identifying early indicators of psychological distress and developing a network of supportive services. Moreover, the department should contract with third party licensed mental health professionals to supplement the work of the EASU and to provide an external and confidential resource for officers struggling in their occupational or personal lives.

Prioritize critical incident aftercare and reduce the stigma of needing and seeking help. The department should contract to routinely provide external services to officers following acute violence exposures and offer bereavement time to officers who are known to have been close to an officer who has died. Although shifting the occupational culture of corrections is likely going to be challenging, there appears to be a will to change things, particularly among the more recently hired officers. The department should work with officers to break down some of the stigma related to mental health and help-seeking. Providing for critical incident aftercare in itself would signal that these experiences can be traumatic and that there is nothing wrong with needing or receiving help in the aftermath a violence or suicide exposure.

Attend to the organizational stressors. Differences in management styles (and the difficulties that can follow) also emerged as a prominent them across the focus groups with command staff and department administrators. Officers similarly reported that supervisors can make the work more difficult than it needs to be. Forced overtime was identified as a keen organizational stressor for officers as we conducted these interviews. Department policies should be revised to ensure they are clear and consistent.

Adopt a rotating schedule for all new officers. Officers and supervisors at all levels recognized that the current work schedules negatively impact time and relationships with family and friends outside of work. We therefore strongly recommend moving to a rotating schedule. We realize that those who have worked long and hard for seniority will not want to convert to a rotating schedule, so here we specifically recommend that the department consider moving to a rotating schedule for all incoming officers. Over time this will phase out the current scheduling system. While we have been told that the officers' union (MCOFU) will resist any efforts to disrupt the seniority system that is in place, we are optimistic that they will do what is necessary to ensure that the department's scheduling process reflects the interests and health and wellbeing of its members.

Reform the department's disciplinary processes. Department discipline emerged as a recurring theme across the officer suicides and as an acute stressor for officers still working in the department. Frequently officers expressed frustration about the department's perceived failure to support its officers. Moreover, investigations can apparently drag on for weeks and months. Officers reported that they sometimes learn that they are under investigation from other officers and sometimes don't even know the reasons for an investigation. Given our findings related to impacts on health and wellbeing, we recommend that the department work with the officers to promote fairness, consistency, transparency, and expedience in the disciplinary process.

In Their Own Words

The officers themselves are their own best advocates. 398 of the 440 officers we interviewed answered open-ended questions about what the department should be doing to address officer wellbeing and suicide (and those who did not typically did not have an opportunity because the interview had run too long). Almost all of the officers offered reasonable and actionable suggestions in response. We therefore conclude with a series of quotes from officers that support these recommendations.

When we asked, "In your opinion, what can (or should) be done to address correction officer wellbeing within the MA DOC?", the officers' responses coalesced around five main themes: (1) supporting the officers; (2) addressing inequities in staffing and scheduling, (3) reducing the stigma of seeking help, enhancing confidentiality through providing access to external resources, and proactively addressing the problem of officer wellbeing and suicide.

Supporting the Officers

"There should be some time dedicated to the issues and complaints of officers and what we have to say – guys are disgruntled and don't feel enough attention is being paid to these critical issues officers are having."

"We don't feel like any time is dedicated to us – dedicating that time would mean a lot to a lot of officers."

"Just be kind – It's not easy. We get paid decently but it comes at a price. It would be easier if we were respected. It should also be easier to get time off because you miss so much of your family life that you start to get resentful."

"We should be able to express our concerns and suggest things we can do to improve the culture. Sometimes on the front lines, they [admins] don't understand the aggravations and problems we can deal with at times."

"Just treat officers as people, as human beings. It is important to talk to people and ask them how they're doing – management doesn't talk to staff unless they're yelling, berating, or disciplining."

Addressing staffing and scheduling

"Morale is terrible right now… people are spending so much time here… it's destroying their lives at home."

"[give us a] rotating schedule like the police have"

"A lot should be done, swaps are great but department-wide we should go to a four-days on, two-days off so that way you could have a weekend every once in a while - that's something the union would have to do."

"I think it would help morale and staff to have a rotating schedule. Let the young guys off at least a weekend a month. It can wreck relationships, this schedule. Give the young [officers] a week off in the summer if they could figure out a way to do it."

Culture change: Reducing the stigma of help-seeking and enhancing confidentiality

"The department needs to address the rate of suicide and come up with solutions to decrease it… the department is reactive, not proactive; they need to acknowledge they had a suicide rate increase and figure out the common denominators."

"The stigma has to go away because it's a real thing—you can't always be rough and tough. Have a little more care and compassion towards one another. You don't have to like the people you work with, but you have to respect them and respect that we're all doing the same job. We all want to go home."

"More stuff like this [interview], I think just allowing guys to talk about it where they feel like they're not going to be judged – [with an] outside 3rd party. If guys go to the department for help, they're worried about the possible repercussions. If the department came to us and said something was confidential, we wouldn't believe them – there is a bit of a trust issue between us COs and the department."

Future Directions

As we finished collecting the data for this study of the many impacts of officer suicide, we learned that our next project had been funded by the National Institute of Justice. The new funding provides for the first five years of a longitudinal study of occupational stress, trauma exposure, psychological distress, and suicide risk among correction officers. As we continue our work with the officers of the Massachusetts Department of Correction, we hope to begin to identify some of the underlying causes of psychological distress and suicide and to improve our understanding of the interaction between personal and occupational factors in the lives of correction officers.

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