Suicide Prevention for Police Officers

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Introductory Comments:

In 2006 there were 721 homicides in Pennsylvania, an average of one murder every 12 hours. That year there were 1372 suicides statewide, an average of one about every 6 hours. Police officers deal with twice as many suicides as they do homicides.

This booklet looks at why suicides happen. It takes a behavioral health perspective because police are often involved with suicide related to mental illness. Jail suicide, suicide among police officers, and "suicide by cop" are also addressed.

This material will be helpful to both new and experienced law enforcement personnel, especially if used as part of a mental health or crisis intervention training.

As you read on please keep these realities of suicide in mind:

- It is the outcome of an individual crisis and it causes crisis in others.
- It is produces trauma in all those who experience it in any way.
- It happens in families and not in a vacuum.
- It is the most abnormal form of death.
- It is always a premature death.
- It is preventable.

What follows is meant to aid you in your public safety role, not change your role. Learning about suicide prevention does not supersede your responsibility to protect yourself, other first responders, and the public if you find yourself on the scene of suicide in process.

If you have comments about this publication please call 610-279-6100 or send an e-mail to tsalvatore@mces.org. A bibliography is available on request. This booklet benefited from comments by many members of the Montgomery County, PA law enforcement community.

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September 2009

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1) What is the terminology?

These are some of the terms and phrases used in this booklet:

Lethal Means – The act, process, or instrument by which suicide is completed (e.g., guns, other weapons, pills, poisons, etc.)

Suicidal Behavior – Encompasses suicidal ideation, planning a suicide, acquiring lethal means, a suicide attempt, or a suicide completion.

Suicidal Ideation – Occasional or persistent thoughts of self-harm or completing suicide.

Suicidality – Any level of suicidal behavior from ideation to making a plan to an attempt

Suicide Attempt –Deliberate self-harm intended to be fatal that does not result in death.

Suicide Completion – A suicide attempt that results in death.

Suicide Plan – An individual determination of when and how suicide will be completed.

Suicide Postvention –Aid following a suicide attempt or a suicide loss.

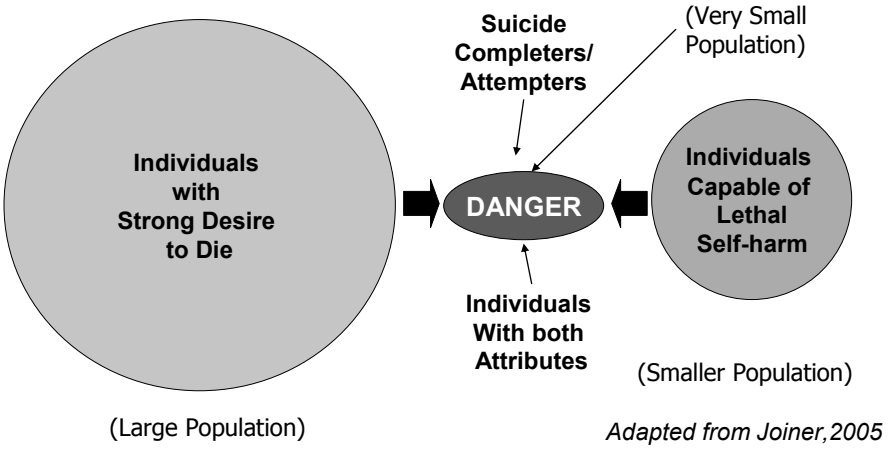
Suicide Prevention - Helping someone avoid the onset of suicide risk or to get help if suicide risk is present.

Herein suicide is presented as the outcome of a process (see p. 5) over which the victim has decreasing control as it proceeds. This is the increasingly accepted view in suicide prevention. Suicide is described as "completed" rather than "committed." The latter usage, though popular, is stigmatizing. It implies control and equates suicide with criminality or immorality.

2) Why do people die by suicide?

In *Why People Die by Suicide* (2005), Thomas Joiner notes that two conditions must be present to overcome the instinct for self-preservation: (i) an intense desire to die caused by a lost sense of social belonging and the belief that one is a burden; and (ii) the capacity for lethal self-harm acquired by experience with abuse, pain, violence, past suicidality, and other factors. Both must be present for a completed suicide as shown below:

Joiner Model:



Cases of depression total in the millions and many of the individuals affected may experience thoughts of suicide, but few proceed further. The ability to complete suicide is far less common than suicidal intent. It is only when the two coincide that a suicide attempt may occur.

Interpersonal relationship losses can lead to a person feeling that he or she doesn't belong. Depression may cause someone to feel that they are a burden. Both may lead to thinking about death, one of the prerequisites for suicidal behavior.

Risk rises if there is a prior attempt, alcohol use, a history of trauma, violence, abuse, self-injury, severe physical or emotional pain, or access to firearms. These factors plus mentally practicing or rehearsing suicide lower inhibition to self-harm and increase "suicide competence."

Suicide is not an impulsive act. "…Individuals advance along a trajectory of advancing capability for self-injury by engaging in activities that foster fearlessness and competence for suicide."[1] Suicide is the outcome of a process and a plan.

[1] *Smith, A. et al. (2008) "Revisiting Impulsivity in Suicide"* ***Behavioral Science Law*** *26(6) 779-797.*

3) What are the victims' demographics?

Here is a breakdown of reported suicides in the Commonwealth for a recent 3-year period:

Suicides in Pennsylvania by Age, Gender, and Race, 2004-2006

Gender/Race	*Age 19/Under*	*Ages 20-64*	*Age 65/Over*	*Totals*
White Males	143	2421	577	3141
White Females	41	594	82	717
Black Males	9	188	20	217
Black Females	8	36	3	47
Other Males	5	86	8	99
Other Females	6	17	2	25
Totals	**212**	**3342**	**692**	**4246**

PA Department of Health

Highlights:

- There is an average of over 1400 suicides annually in Pennsylvania
- 91% of all victims in the state are white; less than 10% are nonwhite
- Over 81% of the victims were males
- White males made up almost 74% of the victims
- 57% of the victims were adult white males (20-64)
- Elder suicides (65/Over) outnumbered youth suicides (19/Under) 3 to 1
- Elders made up over 16% of the victims

These pronounced gender, age, and racial disparities are likely to persist well into the future. Elder suicides are expected to grow as this population increases and as "baby boomers age out. Also there has been an upward trend in females suicides (up 22% from 2000 to 2006). There is concern about high suicide rates among Latina teens and rising rates in Afro-American males.

4) How is suicide connected to mental illness?

Most people who complete suicide do not have a known mental illness. The National Violent Death Reporting System[2] compiled data on over 8000 suicides in 16 states in 2005. It found that just over 40% of the victims had a psychiatric diagnosis at the time of death.

Nonetheless most of the suicidal people that police deal with have serious mental illness and/or alcohol or substance abuse problems. They have police contact because they have frequent suicidal ideation, often experience suicidal intent, and make many suicide attempts. They have few supports. Police are their crisis safety net.

Some of these individuals are what has been called "chronic suiciders" (see p. 10). They use suicide threats or low lethality attempts to deal with problems. This may result in police involvement.

Mental illness has a very strong link to suicide. About 5% of all people with mental illness do complete suicide. Let's look at the role that mental illness plays in suicide.

In Joiner's theory (see above) a desire to die is a prerequisite for suicide and this state of mind is can be brought about by major depression, bipolar disorder, and schizophrenia. There is a high incidence of suicide in those with these disorders, but according to the theory they also needed to acquire the capability for lethal self-harm and that does not come from mental illness alone.

Mental illness contributes to suicidality in those that it afflicts but it is not a cause. Mental illness is a strong risk factor for suicide (see page 12). It plays a big part in acquiring multiple risk factors for suicide. This means that individuals with mental illness will usually have many problems that bear on their risk for suicide. One of the most common is co-occurring alcohol and drug use.

[2] *www.cdc.gov/ncipc/profiles/nvdrs/publications.htm*

5) What about alcohol, drugs, and suicide?

Suicide is a leading cause of death among people who abuse alcohol, drugs, and other substances. Alcohol and drug use disorders elevate risk for suicide ideation and attempts, which in turn drives up the odds of suicide:

- Those treated for alcohol dependence have 10 times higher risk of completing suicide
- IV drug users are at 14 times higher risk of eventually completing suicide
- Misuse of alcohol and street or prescription drugs yields 40 times greater risk of suicide
- Alcohol and prescription drugs misusers have a 39 times higher risk of suicide
- Attempts are more likely in alcohol misusers with depression

Here are some aspects of alcohol and drug use that increase suicide risk:

- Mood instability and chronic state of hopelessness
- Impulsiveness and disinhibition
- Poor self image; low self-esteem; loss of support system
- Less likelihood of seeking/getting help and intervention.
- Low sensitivity to negative consequences of actions
- Limited temporal outlook; little future orientation; "all or nothing thinking"
- High exposure to abuse, violence, suicide loss, and other trauma
- High criminal justice system contact and incarcerations (jail suicide risk)

Alcohol is involved in 20%-25% of all US suicides. It is estimated that 7% of alcohol dependent persons will complete suicide. Alcohol misuse raises stress levels and induces myopic thinking (a lessened range of perception, reduced inferential thought, and decreased awareness of optional problem solutions). This creates a "slippery slope" towards an attempt if suicidality occurs.

Co-occurrence of mental illness and substance abuse increases suicide risk far beyond that which accompanies either disorder alone. It increases exposure to more suicide risk factors and weakens protective factors.

6) What about suicide attempts?

An attempted suicide is the closest thing to a completed suicide:

- The intent to die was present.
- A doable plan was present
- Lethal means were present.
- The ability to lethally harm one's self was present.
- The warning signs were missed or ignored.

A suicide attempt is highly traumatizing and many who have made a suicide attempt experience post-traumatic stress disorder (which is often overlooked). Suicide attempters may be re-traumatized if they again become suicidal.

Suicide attempts create a life-long risk of suicide. About half of all suicide victims made at least one previous attempt. Greatest risk is within 3 months of the first attempt. 10% of attempters complete suicide within 10 years of the first attempt. 40% of these deaths occur within one year.

Individuals with psychiatric disorders have significantly higher rates of attempts compared to the general community. Alcohol users are at high risk of attempting suicide:

- 65% of all attempters have used alcohol
- 67% of attempters in acute psych units abused alcohol
- 50% used alcohol just prior to attempt

There are more attempts among young people than adults and elders. Teen girls make more attempts than boys. Greater access to guns by adults and elders turns attempts to completions.

A study of attempt survivors in ERs has found that 40% spent less than 5 minutes contemplating their decision. Another study found that only 21% felt suicidal 12 hours after the attempt. Some attempts may be impulsive responses to short-term ideation whereas completions are the outcome of a longer process in which impulsiveness is less a factor.

7) What about people who are always talking about suicide?

One of the most frustrating suicidal behaviors is when someone frequently threatens suicide or voices suicide intent. This is called "chronic suicidality" because of its repetitive nature and because it tends to go on for a long time.

Individuals who do this are known as "chronic suiciders." Their suicide threats are usually contingent in nature (e.g., "I'll kill myself if I don't get into rehab tonight") and may have a manipulative or control element. The threats can be dramatic and often involve "setting terms."

People who make these kinds of suicide threats have been found to use suicide threats to evade pending legal or criminal justice issues or as a way to get shelter. Most cases seem to involve a low intent to die and are limited to vague or non-specific threats.

Chronically suicidal persons seem to be troubled by hopelessness, emptiness, and a need for control. This behavior is a coping strategy. Chronic suiciders learn that suicide threats get attention, open doors, and compel others to care.

There is an inherent problem with this tactic. Overtime "chronic suiciders" may raise their threat level while they are getting more used to the idea of suicide. Despite their low desire to die they may have many some very real risk factors for suicide and a weakening set of protective factors.

Repeated threats can increase suicide capability by lowering resistance to self-harm over time. Those with a history of chronic suicidality are very vulnerable when this happens. Family and friends may not see that a change in risk level that has taken place. They may be less vigilant because of many "false alarms" in the past. "Chronic suiciders" often become suicide victims.

"Suicidality always has to be taken seriously. That is because suicidal thoughts and actions communicate profound suffering and hopelessness. This is a message that has to be received, understood, and acknowledged."[3]

[3] *Paris, J. (2007)* ***Half in Love with Death****. Mahwah, NJ: Lawrence Erlbaum Associates*

8) How are people who experience a suicide affected?

Every suicide leaves 6 – 8 people severely affected. Losing someone you love to suicide is utterly devastating. It is the worst loss of all.

Suicide loss upsets psychological and physical well-being, overrides coping mechanisms, and causes extreme distress[4]. It alters functioning, changes the quality of life, brings on anxiety, depression, and panic, and has significant affective and behavioral consequences. It generates severe emotional pain and shatters feelings of control and safety.

Worst of all it creates a sense of vulnerability to suicide and can even lead to suicidality. Complicated grief and depressive symptoms may occur and further heighten the risk for suicidal ideation, which may pose a risk for subsequent increased suicidality in suicide survivors.

Guilt may arise because the bereaved individual didn't see the danger or do anything to prevent it. There may be intense anger towards the deceased for abandoning those left behind. Suicide leaves a numbing and disabling shock because of the suddenness, unexpectedness, and violence involved. Fear, stigma, shame, and a lack of understanding may spur denial and helplessness.

There are other factors that can worsen the effects of a suicide. These include witnessing the suicide or finding the body, losing a child (at any age), being estranged from the victim, being away from where the death occurred, or being unable to travel to the services.

In some cases, those close to the victim may experience relief after the death. It may be an issue when the victim frequently threatened suicide or made many attempts. Relief usually gives way to guilt or it may be overcome by the gravity of the loss.

Police involvement after a suicide can be distressing. Investigating every unnatural death as a homicide until determined to be otherwise does not mean there can be no sensitivity to those at the scene. Similarly, acts like cutting down a body, throwing away pills, or starting to clean up must be seen in the context of the family's loss.

Everything said above also applies when the victim is a fellow officer.

[4] *See "What Emergency Responders Need to Know about Suicide Loss: A Suicide Postvention Handbook" (2005) at www.co.delaware.pa.us/intercommunity/SuicideBooklet.pdf.*

9) What are the risk factors for suicide?

Risk factors are variables strongly associated with suicide and found in victims. Risk factors do not *cause* suicide. Some risk factors (e.g., a past attempt or abuse) are permanent. Others may be eliminated or reduced (e.g., removing firearms). Some may be managed (e.g., maintaining treatment).

Several conditions act as short-term risk factors: a sense of being a burden, helpless, not belonging, instability, agitation, panic, anxiety; relational conflict, aggression, and violence. Impulsivity is linked to suicide risk because it makes it more likely that individuals will take on behaviors that increase the capability for lethal self-harm.

A past suicide attempt and alcohol use are such strong risk factors that they almost qualify as "predictors" of suicide. They are present in many victims. Other common risk factors are:

- Adult/elder white male, Native American, veteran, Latina teen
- Poor coping, problem-solving, help-seeking
- Intimate partner conflict, social isolation
- Family history of suicide, mental disorder or substance abuse
- Family violence, including physical or sexual abuse
- Firearms in the home or otherwise accessible
- Legal charges, financial problems, incarceration
- Physical illness and disability

Bisexual and homosexual men are at elevated risk for suicide attempts, with such risk clustered earlier in life. Gay men, lesbians, and bisexual persons have higher rates of suicidal ideation attempts, and completions than do heterosexual individuals.

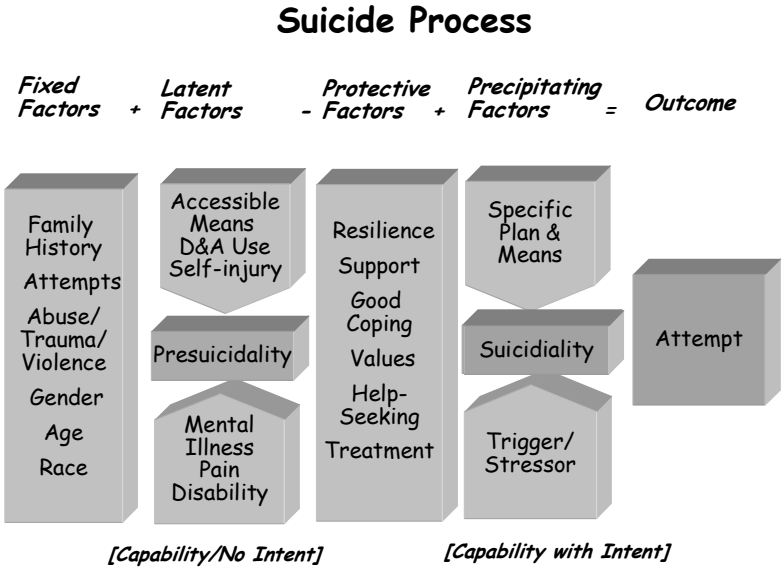
Some risk factors constitute long-term or life-long vulnerabilities to suicidality (e.g., trauma). Others facilitate attempts (e.g., alcohol use, gun access). Risk factors may cluster and interact. Generally, more risk factors means more risk, but serious risk may be present in individuals with only a few known risk factors.

10) What are the protective factors?

Protective factors are behaviors, characteristics, and other variables found to offset risk factors of suicide and precipitants of suicidal behavior. They contribute to feeling that life is worth living. The main protective factors for suicide:

- Strong family, social ties, support sources
- Optimism, resilience, life satisfaction, emotional stability
- Strong self-esteem, sense of self-worth
- Good problem-solving, coping skills, and willingness to seek help
- Religiosity, spirituality
- No firearms in household
- No alcohol or drug use

Female gender and being non-white (Afro-American, Asian, Latino) are protective factors. Social support is a strong protective factor because it increases self-esteem and self-efficacy. The buffering role of protective factors is shown in this diagram:



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11) What are the danger signs and warning signs?

The Danger Signs:

Danger signs are pre-crisis, early indications of emerging risk that should result in the individual having immediate contact with a health care provider. These include:

- Hopelessness ("There's no way that I can make things better")
- Feeling trapped ("I feel like there's no way out")
- Withdrawal from family or friends
- Anxiety, agitation, sleep problems (too much or too little)
- Dramatic mood changes
- No reason for living ("Life isn't worth living")
- Reckless, risk-taking behavior

The Warning Signs:

Warning signs are the earliest detectable indicators of heightened suicide risk in the near-term (i.e., minutes, hours, days), and should trigger an immediate crisis intervention response. These include:

- Threatening to hurt or kill self
- Looking for ways to kill self
- Talking or writing about death, dying, or suicide

These are the most specific warning signs but there are others. Among them are:

- Citing a doable plan specifying how and when
- Giving away valued possessions (e.g., pets, CDs, books, tools, money, etc.)
- Making unexpected visits or calls to family members or friends
- Settling up affairs, making a will, dictating funeral arrangements

Warning signs are fairly clear-cut when observed (but they are not always visible or voiced).

"Any person has the potential to become suicidal when confronted with a situation that produces emotional pain and is believed to be inescapable, interminable, and intolerable." [5]

[5] *Chiles, J. & Strosahl, K. (1995).* ***The Suicidal Patient: Principles of Assessment, Treatment, and Case Management****. Washington, DC: American Psychiatric Press.*

12) How is suicide risk identified?

Screening is the basic technique for finding suicide risk factors and risk. It involves simple direct questioning. It requires training but not clinical skill or judgment. It does not evaluate or estimate an individual's level of suicide risk.

Screening questions must be direct:

- Do you feel others would be better off without you?
- Have you ever thought about killing yourself?
- Are you thinking about it right now?
- Do you have a plan on how to kill yourself?
- Do you have the means to carry out this plan?
- Have you tried out or rehearsed your plan?
- Have you ever attempted suicide?

Based on a screening an individual may be referred for a suicide risk assessment to identify treatable risk factors and to assure safety. An assessment is a clinical judgment to determine the degree of suicide risk. It is usually performed by a psychiatrist and requires clinical skill and expertise. It is based on an interview, observation, and other sources. It weighs both risk and protective factors. It may involve a risk rating scale.

Assessments attempt to establish the foresee-ability of a possible suicide through the reasonable determination of an individual's suicide risk. Assessments cannot predict when an individual will complete suicide. Assessments have short shelf lives because of the transience and volatility of suicide risk.

13) What are some of the myths of suicide?

Egregious beliefs about suicide abound. Here are some of the most common misconceptions:

Misconception	Reality
Those who talk about suicide are "all talk" and won't complete suicide.	Talking about suicide is a warning sign and many who talk about it do complete suicide.
Those who have attempted suicide are single-mindedly dedicated to dying.	Suicidal people only want to be free of hurt and would go on if their pain would end.
Asking someone if they are thinking about suicide will only give them "ideas."	Asking is often the only way to determine risk and to show that you care.
Those who have attempted suicide are at very low risk of actually completing suicide.	Many suicide victims have made one or more previous suicide attempts.
If someone says that he is suicidal, telling him to "do it" will snap him out of it.	This may be the single worst thing that anyone can do. Never say "go ahead and do it."
Surviving a suicide attempt shows that the individual wasn't really serious about dying.	An attempt always involves the intent to die.
Most suicides occur with little or no warning	Most people do mention what they are feeling and show signs of suicide
Improvement following a suicidal crisis means that the suicidal risk is over.	Many suicides occur following 'improvement'. Suicidal feelings can return.
Non-fatal acts are only attention-getting behaviors or only attempts to be manipulative	For some, suicidal behaviors are pleas for help. It is always better to err on the side of safety.
Once a person is suicidal, he or she will be suicidal forever.	Most suicidal crises are temporary, and will pass if help is provided.

14) What role does trauma play in suicidality and suicide loss?

Trauma is a psychological reaction to a harmful or life-threatening occurrence that is outside the range of normal experience and beyond control. Trauma's impact is pervasive, life changing, and enduring. It influences responses to future stressors.

Trauma can result from victimization and abuse, assault, injury, exposure to homicide, suicide, and other fatalities, surgery, serious accidents, and interpersonal losses, as well as disasters. ***Suicide attempts and losing a family member or close friend to suicide are extremely traumatic incidents.*** Suicidal crises can induce trauma and Post-Traumatic Stress Disorder (PTSD):

> People who suffered suicidal conditions, particularly conditions that were chronic, recurrent, or included one or more attempts, may also be victims of PTSD. Suicidal people meet the formal criteria for PTSD. Severe and prolonged suicidal pain is not something that most people suffer.[6]

The effects of trauma that may increase suicide risk include anxiety, depression, hopelessness, despair, anger, hostility, social isolation, impulsiveness, alcohol or substance abuse, self-destructive behavior, humiliation, shame, guilt, lessened self-esteem, a loss of personal beliefs, and feeling ineffective, distrustful, or threatened.

Those affected by trauma feel less connected or that they are burdens to families and friends. This generates hopelessness and depression, which may produce a desire to die. Trauma weakens resistance to serious self-harm.

Other risk factors may interact with trauma. These are a past history of suicidal behavior, mental illness, substance abuse, interpersonal conflict, and a background of abuse or violence.

Trauma sufferers at risk of suicide include self-injurers, those making frequent threats or non-fatal attempts, veterans and members of the military, physicians, emergency responders, sexual assault victims, individuals with brain injury, and disabled persons.

Re-traumatization can be a result of recurrent suicidal behavior in persons who have been acutely suicidal or who endured a suicide loss. Even a low level of suicidal ideation may trigger a trauma response in an individual who survived a past serious attempt. .

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[6] *Conroy, D. (N.D.) "Why is it so hard for us to recover from being suicidal" at www.metanoia.org/suicide/ptsd.htm*

15) What about police suicides?

Suicide among police officers claims more lives than deaths in the line of duty. It commonly believed that police officers are at high risk of suicide and that the problem is getting worse.

Studies suggest that these factors are involved: access to firearms; marital problems; alcohol use; and job stresses such as exposure to trauma and death, including suicide; difficult administrative policies, changing assignments, long and irregular work hours; and public mistrust.

The recent ***New Jersey Police Suicide Task Force Report*** (January 2009)[7] found:

- There were 5 police suicides in NJ from 2003–2007 out of 33,200 personnel.
- This is a rate of 15.1/100,000, which is more than double that for the state as a whole.
- The rate is only slightly above the suicide rate for males 25-64 (14/100,000), the demographic group of the officers who completed suicide.
- Firearms were involved in 80% of the police suicides.
- There was no evidence that police suicides are increasing

Most officers are members of a high risk group, adult males, with access to firearms, another very serious risk factor. Retired officers carry their risk with them on leaving the force.

Joiner's theory helps explain police suicide. The nature of police work coupled with firearms familiarity creates the capability for lethal self-harm. Depression tied to personal or work problems is fertile ground for development of the desire to die. Risk is enhanced by veteran status, alcohol use, traumatic experiences and a don't-admit-weakness occupational culture.

Female officers complete suicide less frequently than males but more often than women in general. Female officers can acquire the same capability for lethal self-harm as male officers. They also have the same problematic lifestyle and job-related stress issues.

[7] *http://www.state.nj.us/humanservices/dmhs/NJ_police_suicide_TF_rept_jan2009.pdf*

16) How can police suicide be prevented?

Officers must know that asking for help will not result in punitive action; that all information will be confidential; and that resources are available to help them deal with their problems. *All* personnel, including civilian and management must know the signs of depression and suicide and what to do if they see them in themselves or in co-workers. Some further options are:

Professional Counseling - This can be in the department, the union, or the community. Independent sources may be most practical. Referrals to local behavioral health agencies should be available.

Police Chaplains and Outside Clergy - Clergy assure confidentiality, avoid stigma, and appeal to the religious. Clergy of various religions should be available. Using clergy may be necessary in small communities with few local resources.

Peer Counseling - Peer counselors are officers trained to provide emotional support and make referrals when needed. This can involve access to peer counselors in other departments. Peer counselors are volunteers serving on their own time.

"No Fault" Firearms Securing Policy - Officers should be able to discretely surrender duty and personal firearms for temporary safekeeping without penalty or the implication that they are incompetent or being disciplined.

Stress Education Program – Stress recognition, techniques of physical exercise, proper nutrition, interpersonal communication methods, and coping styles.

Family Education Program – Orientation to police functions, problems in police marriages, methods for effective communication, and the family as a source of support.

Pre-retirement Counseling – Officers should be prepared for the difficult transition to life away from "the job" well before their departure from active duty.

Provision should also be made for the aftermath of a departmental suicide. Critical Incident Stress Management (CISM) is too structured and closure-oriented for suicides. It is preferable to have an officer who has experienced a colleague's suicide speak to those who wish such help.

17) What are some crisis intervention basics with a suicidal individual?

A suicidal person may not ask for help, but that doesn't mean that help isn't wanted. Most suicidal people are ambivalent – they don't want to die - they just want to stop hurting.

Here are some "Don'ts" that apply to anyone who might be suicidal:

- Do not leave him/her alone or let him/her go off alone
- Do not be judgmental
- Do not argue, debate, analyze, or moralize
- Do not try to cheer him/her up
- Do not try to shock or challenge (i.e., say "Oh, go ahead and do it if you want to!")
- Do not accept "I'm okay now." (Nobody recovers immediately from suicidality.)
- Do not be sworn to secrecy

Here are some "Do's":

- Ask if he/she is thinking about suicide
- If yes, go on to screen for risk
- Take the intent or threat very seriously
- L-I-S-T-E-N !!!
- Show that you care and <u>say</u> <u>it</u>

If there is no apparent immediate danger (and no lethal means in view):

- Tell her/him that help is available and you can see that he/she gets it.
- Let her/him have some space.
- Try to get her/him to another area in case there are hidden means.
- Remove car keys, if possible.

If there is apparent immediate danger - <u>ACT</u>:

- Say that you are getting help or taking her/him for help
- See that the person receives a psychiatric evaluation

18) What about hospitalization and suicide?

Imminent risk of suicide is a reason for an involuntary psychiatric evaluation under the PA "Mental Health Procedures Act":

> Clear and present danger to self shall be shown by establishing that within the past 30 days... the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this act. …A clear and present danger may be demonstrated by the proof that the person has made threats to commit suicide and has committed acts which are in furtherance of the threat to commit suicide

An involuntary evaluation is indicated when strong threats or other expressions of intent are present, a doable plan and/or lethal means are available, and an attempt or other serious suicidal behavior was carried out. In PA, officers may petition an involuntary evaluation by submitting a written statement of personally witnessed behavior ("302") to a County Mental Health Delegate.

Based upon the psychiatric examination inpatient care may be ordered for those with suicidal ideation with a specific plan with high lethality (e.g. plans to shoot self and has a gun), high suicidal intent (e.g. "I can't take this any longer, I just want to die."), a past history of attempts or severe anxiety, agitation or perturbation, and the absence of community supports.

Hospitalization provides safety, crisis stabilization, comprehensive assessment, and development of an aftercare plan. Hospitalization prevents a suicide but may not deter future suicidality.

Suicide risk is very high for the month after a psychiatric hospital discharge irrespective of the reason for admission. Explanations include strong risk factors among those needing inpatient care, inadequate pre-discharge risk assessments and aftercare planning, gaps in treatment between inpatient and outpatient settings, and a lack of understanding of post-discharge risk by patients and families. Suicidality accounts for most readmissions within 30 days of discharge.

19) What about "suicide-by-cop"?

"Suicide by cop" (SBC) occurs when an individual using lethal means or what seems to be such means threatens an officer or others to provoke the officer to employ deadly force in self-defense or to protect others. SBC may account for between 10% and 50% of all police shootings. The Uniform Crime Report shows that there are less than 400 "justifiable homicides" by law enforcement yearly. Of these 40-200 may be an SBC.

A recent study of several hundred cases of this phenomenon in the US and Canada found[8] :

- 80% of the SBC victims possessed a weapon; 60% of these were firearms
- 50% of the victims discharged the firearm at police
- 19% employed a simulated weapon possession in making their threats

A disturbing finding was that SBC seems to be increasing, a trend noted by other studies.

National Violent Death Reporting System data for deaths resulting from "legal interventions," which includes SBC, indicates over 95% involved males, 62% were white, most were ages 20-54, and a significant number had a BAC of >0.08[9]. This suggests that SBC victims (and victims of police shootings in general) have a lot in common with other suicide victims.

In an SBC there is a desire to die and a doable plan likely to result in death. The plan may be a 9-1-1 call threatening harm to self or others or another ploy for drawing police as a prelude to some activity that will compel a deadly response by the police. There is a capacity for lethal self-harm; the victim completes suicide by putting himself in harm's way.

SBC attempters and completers may show danger and warning signs. They have risk factors. It is triggered by marital problems, job loss, legal issues and so forth. It is preventable and crisis intervention can be effective. Police must manage and contain the situation as best they can but remember that it is their job to protect themselves and others when necessary.

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[8] *Mohandie, K. et al. (2009) "Suicide by Cop Among Officer-Involved Shooting Cases"* ***Journal of Forensic Sciences*** *54(2) 456-462.*

[9] *www.cdc.gov/ncipc/profiles/nvdrs/publications.htm*

20) What about suicide in jails?

The US jail suicide rate is more than four times higher than that of the general population, and three times the state prison rate. Jails are high risk environments for suicide. Smaller facilities pose greater risk than larger ones. A jail is a dangerous setting for a suicidal individual.

Most jail suicides are by hanging, which may be fatal in five to six minutes. Brain death can occur in four minutes. Prisoners may hang themselves from beds, clothing hooks, plumbing fixtures, cell doors, ventilation grates, windows, smoke detectors, or anything else available. Suicide by hanging can occur in many positions and does not require suspension.

Jails may hold individuals with serious mental illness, individuals in withdrawal from alcohol or drugs, and others traumatized by arrest and incarceration. These situational risk factors are in addition to those already present in many of those in custody.

A US Department of Justice report gave this overview of jail suicides[10]:

- Suicides account for almost one-third of jail deaths
- Male prisoners were 56% more likely to complete suicide than females.
- Jail suicide rates increased with age. Inmates, age 55 or older, had the highest rate.
- White inmates accounted for nearly three-quarters of all jail suicides.
- Violent offenders completed suicide at nearly triple the rate of nonviolent offenders.
- Parole violators have the highest risk among nonviolent offenders.
- Nearly a quarter took place on the date of admission or the following day.

Danger or warning signs may be present from the first contact. Officers must be aware that

> …suicide prevention begins at the point of arrest. What an individual says and how they behave during arrest, transportation to the jail, and at booking are crucial in detecting suicidal behavior. Arresting officers should pay close attention to the arrestee during this time…[11]

Transporting officers must share their observations on suicide risk with those taking custody of the prisoner. This also applies to detainees to be transferred to county or state prisons.

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[10] *Mumola, C. (2005)" Suicide and Homicide in State Prisons and Local Jails"* ***Bureau of Criminal Justice Special Report*** *U.S. Department of Justice Office of Justice Programs http://www.ojp.usdoj.gov/bjs/pub/pdf/shsplj.pdf*

[11] *Hayes, L. (2005)" A Practitioner's Guide To Developing and Maintaining A Sound Suicide Prevention" Policy* ***Jail Suicide/Mental Health Update*** *13(4) www.ncianet.org/suicideprevention/publications/update/spring2005update.pdf*

Appendix: Suicide death notification

Informing an individual or family of a suicide loss may be the most trying of police duties. Hearing of the loss is a critical point for most survivors. It can start their recovery or negatively affect them for years. Here are some guidelines:

- Keep the victim's name off the radio to keep media or curiosity seekers away from the home.
- Provide notification as soon as all facts are verified.
- Always go in person to demonstrate compassion and respect.
- Two people should go for more support and to manage any unexpected situation. It also allows separate discussions with those in the household, if necessary.
- Include a uniformed officer. The other member may be a nonuniformed officer, a Chaplain, a crisis or victim's service worker, or an EMT. Male/female teams are helpful.
- Start with something like "I have some very bad news for you." Speak slowly and give the available details. Always refer to the victim by name.
- Use wording like "he took his life" or "completed suicide." Make it clear from the outset.
- Never say things like: "I know how you feel." "Don't blame yourself, it was his choice." "He's in a better place now." "There was nothing anyone could have done."
- If the family denies that it was a suicide, don't argue. Refer them to the ME or Coroner.
- Try to not leave the family alone after notification (wait for clergy, friend, etc. to arrive).
- Answer questions about what happens next or give sources of assistance. Ask if there is anyone that you can call for them.
- Offer (but don't push) information about Survivors of Suicide or other grief resources.
- Stay long enough to show support. Close by saying: "We're very sorry that this happened."