

# **PREVENTING SUICIDE**

## **A RESOURCE FOR POLICE, FIREFIGHTERS AND OTHER FIRST LINE RESPONDERS**



Department of Mental Health and Substance Abuse  
World Health Organization

This document is one of a series of resources addressed to specific social and professional groups particularly relevant to the prevention of suicide.

It has been prepared as part of SUPRE, the WHO worldwide initiative for the prevention of suicide.

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## FOREWORD

Suicide is a complex phenomenon that has attracted the attention of philosophers, theologians, physicians, sociologists and artists over the centuries. According to the French philosopher Albert Camus, in *The Myth of Sisyphus*, it is the only serious philosophical problem.

As a serious public health problem it demands our attention, but its prevention and control, unfortunately, are no easy task. State-of-the-art research indicates that the prevention of suicide, while feasible, involves a whole series of activities, ranging from the provision of the best possible conditions for bringing up our children and youth, through the effective treatment of mental disorders, to the environmental control of risk factors. Appropriate dissemination of information and awareness-raising are essential elements in the success of suicide prevention programmes.

In 1999 WHO launched the SUPRE programme (Suicide Prevention), its worldwide initiative for the prevention of suicide. This booklet is one of a series of resources prepared as part of SUPRE and addressed to specific social and professional groups that are particularly relevant to the prevention of suicide. It represents a link in a long and diversified chain involving a wide range of people and groups, including health professionals, educators, social agencies, governments, legislators, social communicators, law enforcers, families and communities.

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The resources are now being widely disseminated, in the hope that they will be translated and adapted to local conditions - a prerequisite for their effectiveness. Comments and requests for permission to translate and adapt them will be welcome.

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## PREVENTING SUICIDE A RESOURCE FOR POLICE, FIREFIGHTERS AND OTHER FIRST LINE RESPONDERS

Suicide is recognized as an important public health problem and a major source of preventable deaths worldwide. For every person who commits suicide, there are 20 or more who will attempt suicide. The emotional impact for family and friends affected by completed or attempted suicide may last for many years.

First interveners, such as police officers, firefighters and other responders are often a first line resource for people who have significant mental health, emotional, or substance abuse problems and who may be suicidal. Yet, they are often not well trained in the signs and symptoms of serious mental illness, nor do they always know the most appropriate actions to take when suicidal behaviours are a concern.

Police officers, firefighters and other first line responders are increasingly called upon in situations involving mental health emergencies, such as suicidal crises. Consequently, they occupy an important role in community-based suicide prevention: by ensuring that persons with mental disorders receive appropriate mental health treatment, by removing access to lethal means from people at high risk of suicide, and by recognizing the suicide potential in situations involving domestic disputes or where potentially deadly force is exercised. First responders are in a unique position to determine the course and outcome of suicidal crises.

Their respective institutions may help reduce suicides in the community: by ensuring that first line responders are appropriately trained to recognize the signs and symptoms of mental illness, to identify the risks of suicide, and to understand local mental health legislation and how it is used by community

agencies, by developing specialized programmes to help them manage mental health and suicidal crises in the field, and by helping to create the inter-agency linkages needed to facilitate access to health and mental health care.

This booklet is written for police officers, firefighters and other first line responders who deal with people in psychological distress, including those who are suicidal. They are often the first ones involved in situations where suicidal behaviours, such as a suicide threat, suicide attempt or completed suicide, have occurred. They work in crisis situations where prompt and efficient interventions are needed and are therefore called "first interveners" or "first responders". This may also include those who first contact the family and friends of a person who committed suicide, such as forensic doctors, religious leaders, or even employers.

The booklet places suicide in the broader context of community mental health and identifies a number of principles and key activities that can be used as part of a broader community-based suicide prevention strategy. It does not cover suicide prevention in jails and prisons or starting a survivors' or self-help group for those who are left behind, as these issues are addressed in separate publications in this series (1, 2). This series also includes resources for general physicians, primary health care workers, counsellors, teachers, media professionals, and workers (3, 4, 5, 6, 7, 8).

## SUICIDE FACTS AND FIGURES

Suicide and attempted suicide are major public health challenges. The World Health Organization (WHO) has estimated that approximately one million people commit suicide every year. This represents one death every minute, almost 3,000 deaths every day, and one suicide attempt every three



seconds. More people die from suicide than from armed conflict and, in many places, from traffic accidents. In many countries, suicide is one of the top three causes of death among adolescents and young adults between the ages of 15 and 24 years, and one of the top ten causes of death overall. Worldwide, suicide rates have increased by 60% over the last half century. For every suicide that occurs, there are 10 to 20 or more suicide attempts.

Suicide is the result of a complex interchange of factors, chief among them, the following:

### Mental illness

Worldwide, many of those (65-95%) who complete suicide have a mental disorder. Indeed, the risk of suicide is up to 15 times higher among people who have a mental disorder compared to those who do not. Although mental disorders are considered a risk factor in Asian countries as well, there is evidence that they are not as frequent in suicidal behaviours, but that impulsiveness plays a greater role.

High suicide risk is particularly associated with acute episodes of illness, recent hospital discharge (almost half commit suicide before their first follow-up appointment), or recent contact with a mental health service. Approximately 25% of people who complete suicide will have been in contact with a mental health agency in the year prior to their death. Specific mental disorders that have been linked to suicide include depression, substance abuse, schizophrenia, and personality disorders. Substance abuse and personality disorders are more common among men, and depression is more common among women. Co-occurring conditions are particularly common among those who complete suicide. For example, depression combined with alcohol abuse occurs in about two thirds of those who complete suicide.

Therefore, the presence of a mental and/or substance use disorder is one of the strongest predictors of suicide, making the identification and treatment of psychiatric and substance use disorders an important prevention strategy (9).

### Intention to die

A clear intention to die is also a strong predictor of future suicide. The suicidal intent may range from serious intent, involving meticulous planning and choice of a lethal method, to low intent or even an ambivalent feeling, reflected in a lack of planning and a failure to conceal the act. A person is at high risk if they express a clear intent, have an immediate plan, and have access to weapons or other means (10). It is important to recognize that the intent may fluctuate even within a short period of time (a day, several hours or even less), making regular monitoring of risk an essential component of an effective suicide prevention plan.

### Previous suicide attempt

The rate of suicide for people who have previously attempted suicide is significantly elevated, particularly in the first years following their attempt, making a previous suicide attempt another strong predictor of future suicide. Approximately half of those who complete suicide have a prior history of suicide attempts, and a quarter will have attempted suicide in the year prior to their death. Suicide risk can persist over time; therefore, a previous suicide attempt can be an important predictor of suicide even if it occurred many years ago.

## Access to firearms, pesticides, or other lethal means

As firearms or pesticides can be immediately lethal, access to guns, rifles or pesticides is of significant concern if they are readily available or if an individual has expressed suicidal ideas or made past suicide attempts. In addition, individuals may have access to medications (even their own psychotropic treatment medications) or other toxic substances (such as pesticides) that could be used to commit suicide. There is a clear need to restrict access to means of suicide as a key suicide prevention measure (9, 11).

## Gender

Across diverse countries, 10-18% of the population report having had suicidal ideas at some time in their lives, and 3-5% have made a suicide attempt. Women are marginally more likely to report suicidal ideas compared to men and up to two or three times more likely to attempt suicide. However, men are more likely to complete suicide, often because they choose more violent and irreversible means (9).

## Age

Suicides can occur at any age, but they occur more frequently in certain age groups (9). For example, suicides can occur in children as young as 10 years of age; however, these are extremely uncommon, accounting for less than 1% of all suicides. The young (15-24 years) and the elderly (over 75 years) are at the highest risk of suicide of all age groups.

## Psychosocial stressors

Psychosocial stressors that can contribute to suicidal behaviours are multiple and often interrelated. They include the loss of a close relationship such as through death or divorce, loss of employment and other work-related losses, chronic illness or disability, chronic pain, legal proceedings, interpersonal conflicts, and other major life events. People who are divorced or separated are 2-3 times more likely to have suicidal ideas than those who are married, and 3-5 times more likely to make a suicide attempt (12).

## THE CONTRIBUTION OF POLICE, FIREFIGHTERS AND OTHER FIRST LINE RESPONDERS TO SUICIDE PREVENTION

Police, firefighters, emergency personnel and others who are often the first to be called to deal with persons having mental health emergencies are, for exactly this reason, an important component of effective community-based suicide prevention strategies. Police, for instance, have always occupied the role of “street corner psychiatrists”. However, increasingly, their day-to-day interactions are bringing them into closer contact with mentally disordered offenders.

The ultimate aim of suicide prevention is to reduce deaths by suicide; however, it is equally important to reduce the frequency and severity of suicide attempts. Among the most effective strategies to prevent suicidal behaviours are the provision of appropriate treatment for individuals suffering from mental or substance use disorders, and the control of access to the means to commit suicide. Police officers, firefighters, emergency personnel and other first line responders can make important contributions to suicide prevention in the following ways:

## Knowledge of risks

When faced with a mentally ill person or offender, first interveners must be alert to the possibility of a suicidal act as well as the possibility of danger to others (including being personally attacked). It is important to clear the scene and ensure that the individual has adequate space.

## Knowledge of the legislation

Although first interveners are a major source of referrals to psychiatric and emergency services, they are often discouraged by the long wait times and the restricted access to inpatient beds (13). To be effective mental health gatekeepers, first interveners not only must understand their local mental health legislation (which varies by jurisdiction) and the criteria permitting involuntary assessment and treatment, they must also understand how these are operationalized by their local mental health system in light of available resources (14). Inter-agency coordination and cooperation is essential if emergency referral processes are to be streamlined to support the first interveners who are making emergency referrals. Good knowledge of the law in relation to the provision of psychiatric assessment and treatment services within the criminal justice system is also essential for appropriate management of offenders with mental disorders who are suicidal (15).

## Involuntary admission

Police should be considered as important first line responders by other early interveners, such as firefighters or emergency personnel, because they can facilitate access to medical and psychiatric evaluation and treatment. Police can use discretionary judgement to determine whether a charge can be laid and the person taken into custody, or whether they should

be transported to a local emergency room for medical and psychiatric assessment and treatment. In most locations, police have the legal authority to commit someone to a hospital under mental health legislation for a psychiatric evaluation whenever there is probable cause that the person is suffering from a mental disorder and is a danger to themselves or others (14).

## Controlling access to lethal means

Controlling access to the means of suicide is an important prevention strategy available to police officers, firefighters and other first line responders. For example, suicide rates drop in communities where access to handguns has been restricted. The presence of guns in the home is associated with an increased risk of suicide. Restricting access to guns is particularly important in situations involving domestic violence as these can escalate into suicide or murder-suicide scenarios.

First responders are also in a position to help limit access to other lethal means (such as medications, pesticides or other toxic substances) by helping family members of high risk individuals understand the importance of collecting and storing away these substances and ensuring, for instance, that only small amounts of potentially lethal treatment medications, such as antidepressants, are available (9, 11).

## Suicidal vengeance and domestic disputes

Individuals who attempt suicide by firearm comprise a subgroup of attempters who require special consideration from first interveners. They are typically male and attempt suicide using a shotgun or rifle that is available in the home. The shooting is commonly preceded by a crescendo of domestic disputes, fuelled by longstanding alcohol abuse, and immediately

precipitated by an argument with a partner. The suicide often becomes an overt act of vengeance, particularly in situations involving court orders prohibiting contact or conflict over the custody of children. The partner may also be threatened with a gun and the situation may escalate into a murder-suicide. Perpetrators will often have a long history of personality problems and conflict with the law, and will be well known to local police or paramedics. If they survive their suicide attempt and are hospitalized, they will commonly claim to have shot themselves accidentally, despite overwhelming evidence to the contrary. In these situations, the use of a gun is not an isolated act of violence, but the culmination of a pattern of violence against a backdrop of repeated domestic incidents. Because the majority of these individuals are known to police and other community health personnel, there is great potential to avert suicidal crises through early identification, referral to appropriate substance abuse intervention, and removal of firearms from the home, particularly if an attempt has occurred.

#### Referral to mental health services by police (police diversion)

The principle underlying police diversion is that individuals who primarily require psychiatric treatment should be identified as early as possible in the criminal justice process (at the time of police contact or initial detention) and diverted out of the criminal justice system into appropriate mental health alternatives. Increasingly, police are being asked to avoid unnecessary criminalization of the mentally ill by participating in diversion programmes.

The main goal of police-based diversion programmes is to avoid arrests by making direct referral to community mental health programmes. The success of diversion programmes rests on integrated mental health services being available to support police. This means that close working relationships between

police and mental health organizations must be established (15). In some communities, specialized crisis response sites have removed many of the barriers police face when referring mentally disordered offenders for psychiatric assessment (16).

## Suicide by deadly force

One of the most difficult crisis situations for police to address occurs when an individual engages in life-threatening behaviour to provoke officers to fire, either to protect themselves or a civilian bystander. This has been termed "police-assisted suicide" or "suicide by cop" and has been estimated to account for 10% to over 40% of officer-involved shootings (13). Recognizing this potential outcome, being able to identify the signs and symptoms of seriously mentally disordered behaviour and following locally established inter-agency guidelines for the management and de-escalation of such crises will help to minimize lethal outcomes.

## HELPING SOMEONE WHO IS SUICIDAL

People who feel suicidal often express hopelessness and depression. They see suicide as the only way to solve their problems and eliminate their suffering. Although suicide is difficult to predict, a large proportion of those who eventually kill themselves will give more or less clear warning signs of their suicidal intentions in the weeks or months prior to their death. These are not harmless bids for attention, but important cries for help that should be taken seriously. Warning signs include both behavioural and verbal clues such as (12, 17):

- Being withdrawn and unable to relate to friends and co-workers;
- Talking about feeling isolated and lonely;



- Expressing feelings of failure, uselessness, lack of hope, or loss of self-esteem;
- Constantly dwelling on problems for which there seem to be no solutions;
- Expressing a lack of support or belief in the system;
- Speaking about tidying up affairs;
- Giving some other indication of a suicide plan.

If asked, they may have definite ideas or a plan about how to commit suicide. Finding out about the nature of their ideas and extent of planning is central to assessing the level of risk. Answers to questions about how, when, where, and why can give an indication of how well shaped the suicidal plan is, and whether the individual feels any ambivalence toward death.

In addition, suicidal people who are demonstrating warning signs are at greater risk if there has been:

- A recent loss of a close relationship;
- A change (or anticipated change) in work circumstances, such as a lay off, early retirement, demotion, or other workplace change;
- A change in health;
- Increased misuse of alcohol or other drugs;
- A history of suicidal behaviour or history of suicide attempts in the family;
- Current depression.

Police officers, firefighters and other responders who believe someone is suicidal are in a unique position to help as follows (12, 17):

- Approach all situations involving someone who is suicidal as a psychiatric emergency and act accordingly. Never assume that suicidal ideas or gestures are harmless bids for attention or an attempt to manipulate others.

- Clear the scene and keep yourself and others who may be present safe.
- Give physical space. Don't get too close to the person too soon. Sudden movements, attempts to touch the person, or the introduction of others into the scene, may be misunderstood.
- Express acceptance and concern. Avoid sermonizing, arguing, problem-solving, giving advice, or telling someone to "forget about it". It is important to convey an attitude of concern and understanding.
- Engage the individual. Encourage the person to talk. Most suicidal people are ambivalent about dying. Asking someone if they are suicidal or otherwise talking about suicide will not tip them over the edge, but will provide a sense of relief and a starting point for a solution. To assess intent, ask if the individual has a plan, access to lethal means, or has decided when to act.
- Remove access to all lethal means of self-harm, particularly firearms, and toxic substances (such as large supplies of psychotropic medications, or pesticides).
- Suicide may be averted if people receive immediate and appropriate mental health care. If the individual fulfills mental health act criteria, take immediate action to ensure that the individual is committed to a hospital for psychiatric assessment and treatment. If the individual does not appear to meet mental health act criteria, it is still important to ensure that they have prompt access to mental health and substance abuse treatments. As most individuals are ambivalent about suicide, they will agree to receive treatment. Pre-arranged agreements with local hospitals, community mental health and addictions agencies will facilitate this process.

- Never leave a potentially suicidal individual alone based on their promise to visit their mental health worker or the hospital. Ensure that family members or significant others are on the scene and accept responsibility for help seeking.

## WHEN A SUICIDE ATTEMPT OCCURS

When a suicide attempt occurs, police officers, firefighters and other responders are usually requested to deal with the crisis, provide basic help, and arrange for the person to be transferred to a health centre if necessary. First responders must also deal with family members and significant others.

First interveners are responsible for responding to a crisis in the most adequate and efficient way. In doing so, they need to go through various stages:

- First, they have to check a person's vital signs following the suicide attempt and apply resuscitation, as appropriate. They need to remain calm to be able to make the right decisions in a situation dominated by emotional stress and anxiety.
- Second, immediate contact with emergency health care, depending on the nature of the suicide attempt, and mental health care needs to be established. In many situations, it will be important to identify the drugs or toxic substances used in the attempt and determine the amount ingested. It will be helpful to take unused pills and empty bottles to the emergency treatment centre so that treatment personnel can verify the substances that have been ingested.

- Third, it is necessary to establish the first contact or relation with the person who attempted suicide. The relationship must be relaxed, non-threatening, empathic, and friendly.
- Fourth, after having established the first contact, communication needs to be initiated. The person should feel free to say what she or he feels. Open-ended questions should be asked, such as “How do you feel?” From this point on, it is the person who will guide the communication and who will give clues as to how to understand and help her or him. An important element that needs to be taken into account is guilt. The person can feel guilty because of conflicts they may have been experiencing. In this context, professionals who intervene should be careful with what they say in order to avoid making the person feel even more guilty. Along the same lines, they must avoid making accusing statements, criticizing the person’s behaviour, or disapproving of what they hear and encounter.
- Fifth, if transfer to a medical facility is not warranted, then every effort should be made to remove further lethal means and ensure that the individual has a family member or close friend to oversee their recovery and manage treatment referrals.
- Sixth, the suicidal individual must be connected to mental health and addictions services to ensure appropriate treatment and follow-up. Referrals to mental health agencies should be done independently of any medical treatment that is required.
- Finally, if significant others are present, they may be emotionally distraught, confused, angry, or overwhelmed by the circumstances. First responders need to exercise

tact, compassion, sensitivity, and support to all of those present. If the suicide attempter is unconscious or badly injured, those present also may be a valuable source of information (such as the drugs ingested or past history of suicide attempts). If significant others are not present, it may be necessary to establish contact with them in order to obtain this information.

## WHEN A SUICIDE OCCURS

In the case of a completed suicide, police officers, firefighters and other interveners need to establish the first contact with the family and friends of the deceased. It is important that family members be provided with adequate care and support. They may feel guilty for not having been able to recognize the suffering in the past or to help the person.

It is always useful to refer them to psychological help, if they agree, and to give them contact addresses. It may also be helpful to put them in contact with local survivors groups (2). Family members often report experiencing negative and prejudicial attitudes from friends and colleagues, and find that survivors groups are helpful in identifying and managing this stigma.

## INTERNAL SUPPORT AT WORK TO MANAGE ISSUES IN THE FIELD

Different strategies have been used to provide support to first interveners who must deal with mental health crises in the field; among them mobile teams of police and mental health professionals, police with specialized mental health training to provide crisis intervention and liaise with mental health services, and specialized mental health consultants hired by the

respective institutions to provide on-site and telephone consultations to officers in the field (13). In some communities, specialized mental health courts have been developed to handle cases involving mentally disordered offenders (18). In mental health courts, specially trained judges and attorneys work with police and mental health experts to fashion appropriate treatment options and divert mentally disordered offenders out of the criminal justice system. These may take some of the pressure off police to find appropriate mental health dispositions in the community, particularly in areas where mental health resources are difficult to access. However, they may also place greater demands on police to recognize mental illness, de-escalate crises in the field, and establish appropriate connections with mental health agencies prior to, or instead of arrest and detention. In response to the increasing numbers of mentally disordered offenders in correctional settings, mental health courts are a fast growing part of an inter-agency, multi-disciplinary solution (19).

No single solution will fit all jurisdictions. Whatever solution is proposed, it should be developed through inter-agency cooperation and involve appropriate justice and mental health experts to:

- Create shared core values and goals with respect to suicide prevention strategies;
- Develop opportunities for cross-training and create strategies and protocols for managing crises in the field, including opportunities for debriefing after crises have occurred and stress management and coping;
- Maintain ongoing communication and inter-agency cooperation;
- Streamline police referral processes to local mental health agencies particularly in situations involving suicidal crises.

## TRAINING

Although police officers, firefighters and other first line responders must exercise discretion in identifying and managing people who are suicidal and may be mentally ill, they are rarely trained adequately for this role. To be effective community gatekeepers, they should (13):

- Recognize the pivotal role played by police, firefighters and other first interveners as mental health gatekeepers and first line responders to mental health crisis;
- Know how to recognize the major signs and symptoms of mental illnesses;
- Know what to do when a person is threatening to commit suicide;
- Know how to identify and de-escalate situations that involve people with a mental illness that may otherwise end in the use of deadly force;
- Understand the mental health services available locally, how to access them in an emergency, and how to access non-hospital based mental health and addictions resources when it is appropriate to do so. An up-to-date directory of mental health services in the community is an important tool;
- Understand how to apply the criteria for involuntary hospitalization and know how these are operationalized by local mental health providers; and
- Build close ties and maintain regular contact with mental health agencies and staff in order to facilitate handling difficult situations.

Even though first interveners are frequently confronted with situations where they must provide care or assistance to persons suffering from mental disorders, usually they have difficulties in addressing mental health issues. Mental health training has been suggested as part of general education

programmes and in certain professional areas. Training in these contexts should be based on real life situations. This can be done by running discussion groups moderated by a mental health professional where real situations are discussed. Discussion groups should meet regularly or include refresher sessions. These can be complemented by role playing sessions where participants try out different ways of communicating depending on the nature of the crisis. Including people who have previously attempted suicide as trainers in training sessions is an important way to destigmatize people with mental health problems and provide a human context to mental health and suicidal crises.

As civil commitment laws and community resources differ across communities, mental health training for first interveners, such as police officers, firefighters and other first line responders should be organized with the assistance of local community mental health agencies. This will help to build the interpersonal and agency relationships that are necessary to help first interveners deal with suicidal and other mental health crises.



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