OUTSIDER
CONSULTING, LLC

LAW ENFORCEMENT MODEL POLICY:

SUICIDE PREVENTION, INTERVENTION, AND RESPONSE

"While there's life,
there's hope."

-Cicero

User Assumes All Risk and Liability for Use of this Document

Nothing in this document is meant to diagnose or treat mental illness. Anyone experiencing suicidal thoughts should seek immediate help from a mental health professional, 911, a hospital emergency room, or the National Suicide Prevention hotline at 1-800-273-8255 (1-800-APE-TALK).

Outsider Consulting, LLC, is posting this resource for use by professionals who are seeking to better understand and take action regarding the issue of suicide. The purpose is to pass on knowledge and provoke thought. **Anyone using any information in this document assumes all risk and liability, and by use consents to hold harmless Outsider Consulting, LLC, and its Member, Jamey Gadoury, who authored the original document.**

Your use is acknowledgment that suicide is a complex issue, and you will study and understand it for yourself before implementing policy.

A Note from the Author, Jamey Gadoury

Disclaimer and Terms:
I have compiled this Model Policy as a tool for law enforcement professionals who seek first to prevent suicide and then to respond well if one were to occur in the organization. I am a student - not an expert - of suicide. This document is only a starting point. It is meant to spur thought and action, not to serve as the end-all. All are encouraged to analyze the recommendations, review with other leaders and trusted mental health professionals, and use what is helpful. **Any user assumes full responsibility and liability, and by use acknowledges that suicide is a complex issue** that they will study and seek to understand before implementing any policy or protocol.

I want agencies to have the least barriers possible to good policy and practice. **Therefore, any public agency may freely use and edit with no attribution to this author.** Commercial distribution & derivatives are permitted **with attribution** to this author. **When attributing this document, users will annotate that Outsider Consulting, LLC, and Jamey Gadoury are held harmless and free of liability for any use of the information.**

All are encouraged to review and appropriately credit the referenced authors.

Acknowledgements:
I have gleaned the following information from both the referenced sources and many other inputs on suicide and its prevention / response. These inputs have been both personal and professional, and include experience, in-person conversations, books, videos, programs, and online materials. Special thanks to my professor, Dr. Karen Mason, and to Dr. Thomas Joiner, whom I have never met, but whose book has been extremely helpful in framing my thinking. Thank you also to Heidi Harper for sharing your story, thoughts, and pain so candidly. Thanks also to Karen Solomon and the other folks at Blue H.E.L.P. for including me, and to Praevius and Vet Works / WILL Interactive, for my first significant exposure to suicide prevention.

Terminology:
In order to have the policy apply broadly to all professionals in an organization, I have used “members” rather than “officers” in nearly all situations.

Bio:
Jamey Gadoury has a BS from West Point in Psychology and an MA in Counseling from Gordon Conwell Theological Seminary. He instructed at the Army’s Ranger School, led in combat in Afghanistan and Iraq and has taught and facilitated suicide prevention classes for the Army and Law Enforcement. He serves leaders and organizations in their development.

MODEL POLICY

As of March 30, 2018

DATE:

MEMORANDUM FOR RECORD

SUBJECT: Suicide Prevention, Intervention, and Response

PURPOSE: The purpose of this memorandum is to establish a clear protocol in regard to suicide risk and possible death by suicide among Organization personnel. This protocol does not address issues of suicide for community members who are not affiliated with this Organization.

1. **Suicide is a complex topic**. We recognize that new data and best practices are constantly evolving. Our current protocol is based on the knowledge currently available to the Organization. We commit to reviewing this protocol annually and updating responsibly as we are aware of new information.

2. **PREVENTION**

   The Organization takes a holistic approach toward suicide prevention. Just as suicide is a complex issue, successful prevention will always be the result of multiple, positive factors. Additionally, successful prevention may never be fully known, as it is a phenomenon that is difficult to prove in the negative. Indeed, if our prevention efforts against suicide are done far enough upstream, it will be impossible to truly measure effectiveness, since elevated risks in this area would not be noted.

A. The Organization recognizes that mindset is an important aspect of prevention and protection, and acknowledges the following about suicide:

1) Suicide is the decision of the individual who completes it. This does not change issues of mental illness and other factors that are often part of the complex experience of someone who is suicidal. However, an individual who dies by suicide - and no one else - is the one who makes the decision.

2) Thus, many suicides CAN be prevented.

3) However, not ALL suicides can be prevented.

4) Efforts to prevent suicide should NEVER be used for judgment, guilt, or shame regarding any who have died by suicide or their survivors.

5) **Suicide prevention is about officer and member safety, and it is a worthy objective.**

6) Any Organization member who is aware of a fellow member who is struggling in the area of mental health or is suicidal to any degree **has a moral and ethical obligation to help that member obtain help and recover.**

7) All Organization members have a moral and ethical obligation to remove obstacles (such as stigma) to seeking help for suicidality or mental health issues.

8) It is an honorable, courageous act for a member to seek help regarding their own suicidality or other mental health issues.

9) If a member dies by suicide, the member's family should be supported - emotionally and materially - to the fullest extent possible.

10) Suicide prevention is closely tied to robust efforts to maintain mental health

B. Our Organization commits to the following steps toward prevention:

1) Conduct a full assessment in conjunction with the implementation of this protocol. This assessment includes review of Organization realities regarding suicide and mental health, including knowledge, culture, and available resources.

2) Review this protocol annually, with feedback from all personnel in the organization.

3) Establish a comprehensive mental wellness and suicide prevention program. The program shall include, at a minimum, the steps in the following chart. The chart is based on research published by Mishara and Martin regarding the Montreal Police Service, Montreal, Quebec, Canada.

"In the 12 years since the program began the suicide rate decreased by 79%, while other Quebec police rates had a nonsignificant (11%) increase."

- Mishara and Martin (2012)

Frequency	Who	What
*Annual	All members	Training that includes general information about suicide and suicide prevention, specific risk and warning signs, and techniques for peer support. The Organization shall take steps to ensure that trainers are able to relate well to the members being trained, and will conduct follow-up regarding how the training was received.
*Annual	All leaders / union representatives	Includes advanced training on identifying members who may be at risk and linking them to appropriate resources.
*Ongoing	Organization / All members	Emphasis on and expansion of currently available resources. This includes: -Increased awareness of the Employee Assistance Program (The Phone number for this is xxx-xxx-xxxx.) -Establishment of or access to police-specific hotline. (Existing hotlines for suicide prevention / crisis will be used as stop gaps until this can be fully resourced***.) NOTE: This Organization shall NEVER utilize a hotline that consists of voicemail or is ever unmonitored.***
*Ongoing	Organization / All members	Awareness campaign within the Organization. This will be an ongoing effort to ensure effective awareness for all members. This will incorporate feedback and ideas from members. Possibilities include posters, articles, messaging from leaders, brochures, etc.
Ongoing / Annual	Spouses, Family	All new spouses / family shall receive brochures on mental health resources available to members and their families. Additionally, annual training and forum will be available to all family members to update knowledge and make the Organization aware of changing needs or gaps. The intent is that all family members will know where to turn for support for themselves or the member.
Ongoing / Annual	Retirees	All upcoming retirees will receive relevant information about the unique challenges and risks of retirement, including the potential for significant adjustment issues and risk of mental health issues. On at least an annual basis, retirees from this Organization shall be invited back to receive updates on mental health resources AND to interact socially with current members.

***Based on and expanded from Mishara & Martin 2012 report on Montreal Police Service**

4) Additionally, training will include at least three components. This is toward the goal that suicide prevention efforts in this Organization stay fresh, engaging, and measurably impactful. Our training will be rooted in the mutual duty to protect Organization members and fellow professionals. The three components are:

a) Presentation of current, relevant facts and best practices in suicide prevention.

b) Presentation of stories regarding suicide. These stories may be of surviving family members, surviving fellow professionals, or of persons who have been suicidal and survived.

c) Active participation by ALL members to design creative ways to keep themselves and fellow members alive and mentally healthy.

5) The Organization shall take continual steps (measured quarterly) to improve the quality and accessibility of mental health resources for all members. We take the viewpoint that there is always something we can improve, and we commit to remaining active in this area. Our members and their families deserve that commitment.

a) The Organization will ensure that mental health counselors for Organization personnel are kept separate from counselors for suspects, offenders, or victims. We see this as a necessary separation to foster trust among Organization personnel and very important resources.

b) The Organization shall develop and maintain a “health” mindset that constantly looks for and implements methods to promote physical, mental, and spiritual health in all members.

c) Organization leaders, managers, and supervisors are expected to lead the way by actively seeking out mental health resources and being *appropriately* candid with members about doing so.

6) Each member of this Organization will create a “Live For” kit. Each member who joins the Organization likely has things that, in the midst of a life-threatening crisis, come to mind as a reason to live, something for which survival is necessary. Friends, family members, goals, a pet, service, a higher calling, and meaningful service are just a few examples. These motivations and reasons to live may differ for each individual. Suicidality is a life-threatening crisis. In order to prepare for it and other crises, each member will create a kit or box, physical or digital, that contains reminders of these things to live for or of reasons for hope. Items should include memories, the present, and future hopes and aspirations. (See the Virtual Hope Box app as a digital option.)

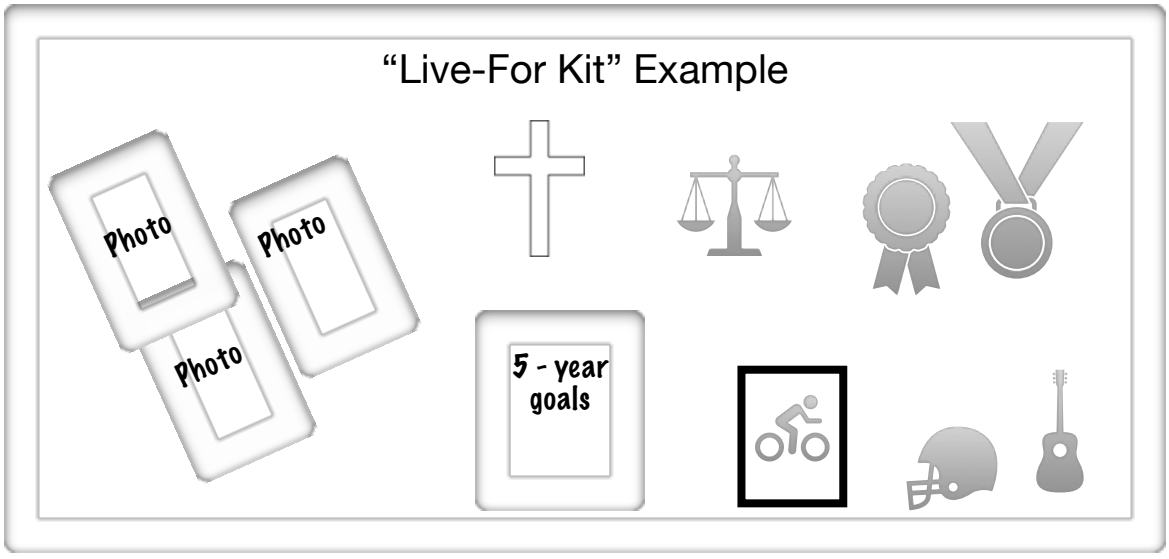
a) Each member will create and regularly update his or her Live-For Kit. The goal is to steadily increase the number and strength of things to live for, as well as to increase the member’s awareness of them. Photos, creeds, quotes, awards, symbols, and patches are a few examples.

b) This kit is meant to provide a daily reminder of things to live for, and can be a source of motivation and strength when the member faces threats and crises.

c) Each member shall select at least one trusted colleague with whom they share contents of this kit, and who has permission to ask about items and their status.

d) The Organization recognizes that steps like this may be initially uncomfortable or foreign to members. However, this Organization will assume nothing regarding members’ mental health and will take all steps necessary to strengthen health. This resolve is supported by data: According to annual data gathered by Blue H.E.L.P, the number of law enforcement deaths by suicide are comparable to the number of line of duty deaths - from all causes, measured annually.

(Photos, awards, faith symbol, reminder of justice being served, hobbies, etc.)



3. **INTERVENTION**

Intervention is our unique obligation to one another as members of the law enforcement profession. Therefore, all Organization members shall intervene in a fellow member's situation if there is thought, "gut feel," or warning signs that the fellow member may be struggling or in danger of self-harm or suicide. Since law enforcement suicide attempts usually involve extremely lethal means, we may have only one chance - if any - to "see it." Members are also responsible to seek help if they are struggling in the area of mental health or suicidality. To that end, all leaders, managers, and supervisors in this Organization are expected to encourage both self-referrals for help and intervention on behalf of fellow members. This Organization shall NOT penalize personnel for seeking help.

A. **Mindset.** Just as this Organization's mindset is critical for Prevention and all aspects of Suicide response, each member's mindset is critical to how he or she will respond to a suicide crisis or a fellow professional in distress. All members should be able to say the following:

1) I know the red flags to be aware of for someone in mental distress or suicidal crisis.

2) It is my duty to intervene

3) I *will* act courageously to intervene

4) I know the resources available

B. **Preparation**. All members shall regularly familiarize themselves with available resources (both within and without the Organization), risk factors, and warning signs. As there are numerous lists of risk factors and warning signs, it is important to regularly understand the "why" behind them, and how there may be variations specific to our profession and to us as individuals.

1) Organization resources (List here)

2) Additional resources (Examples)
   a) Blue H.E.L.P (weareblue help.com)

   b) National Suicide Prevention Hotline (1-800-APE-TALK, or 1-800-273-8255)

   c) California's "Know the Signs" www.suicideispreventable.org

3) **Risk factors.** These increase an individual's potential *risk* of suicidal behavior. (While the individual may not be currently suicidal, we should pay attention and remain alert.) Risk factors include (NOT exhaustive):

a) Access to a firearm. While firearms are an integral part of the job and often of personal life for our members, we also recognize that firearms are a well-researched risk factor in suicide. This is true even in law enforcement. For example, firearms are consistently the #1 method by which law enforcement officers die by suicide - sometimes over 90% (Aamodt & Stalnaker, 2001). All members will remember the risk that firearms carry in this area.

b) Significant loss or failure in career / professional identity

c) Significant personal loss or failure

d) History of suicide in family or history of suicide attempts

e) History of or current mental illness (depression, PTSD, etc.)

*__List based on and expanded from Mason, Joiner and ASFP (References)__

4) **Warning signs.** In contrast to risk factors, warning signs demonstrate that a person currently has behaviors that are consistent with the behavior of suicidal persons. Pay close attention. Ask. Warning signs include:

a) Talk about killing self, feeling trapped, or obsessed with death

b) Preparations for death (giving things away, updating wills)

c) Social or emotional isolation (which may be present even if someone is physically around people.)

d) Feelings of being a failure and / or a burden to others (e.g. "my family would be better off without me.")

e) Hopelessness

f) Acquiring materials that could be used for suicide

g) Equating life and death (e.g. death being a gateway to life)

h) A declining mental health condition

i) Sudden positive mood after being depressed for a while (This change can come from a sense of having arrived at a "solution.")

j) Noticeable increase in reckless or high-risk behavior (like substance abuse)

k) “Abuse” of sick leave. Or vague, changing reasons for taking it.

*__List based on and expanded from Mason, Joiner and ASFP (References)__

C. **Action.** The following steps are a general guideline for Organization members to respond to individuals who may be in distress or suicidal. **Each member should exercise judgment in following the intent of these steps in the most effective way possible.**

[The majority of these steps are based on content in Chapter 5 of Dr. Karen Mason’s book (see References.)]

1) Ask the question. There are many ways that a member may notice that an individual is thinking of suicide, including off-hand remarks or jokes. Ask the specific question, for example “Are you thinking of suicide?”

2) Ask specific follow-up questions to better understand the individual’s thoughts about suicide, intent, the presence of a plan, means to carry out the plan, and how soon the individual intends to carry it out. Additionally, consider how comfortable the individual appears with thoughts of suicide. (If an individual appears comfortable with thoughts of suicide and with the selected method, a member may assume a medium or high level of risk.)

a) Thoughts. Be curious and ask about how often the thoughts occur, for how long each set of thoughts lasts, and how intense the thoughts are. Additionally, consider how specific the thoughts are, and whether it is a vague desire to not be alive or an active desire to be dead.

b) Intent. Does the individual intend to kill himself / herself?

c) Plan. Does the individual have a plan and a method selected? How detailed is the plan?

d) Means. Does the individual have the means to carry out the plan? If death by firearm is the plan, does the individual have a gun in the home, or access otherwise? If hanging, does the individual have a location selected? Be aware of how much preparation has already occurred.

e) Imminence. When does the individual plan to carry out the plan? Has a timetable been selected? Date? Time?

3) Assess level of risk. Use the information gathered to make a judgment about risk. It is a judgment, not an exact criteria. Think of risk as a continuous scale going from low risk to highest risk. It is common for someone who is on the scale to move up and down that scale at different moments in time. (For example, moving quickly from medium to high risk and back down.) Generally speaking, someone is at the lower end of the spectrum if they are having only general or vague thoughts about suicide, while someone who calls you while holding a gun to their own head is at the highest end of the spectrum.

4) **Take appropriate action. Inaction or hoping that an individual stays safe is not an option.** Members must exercise vigilance in keeping our own safe. With higher risk you will take more or more significant actions, and you will take them more immediately. **When in doubt, act.**

a) Emphasize the relationship. Members should ensure the individual is aware of the bond they share, and that the member can be depended on Conversely, ensure the individual knows the positive impact they have on you.

b) Confirm presence and relevance of “Live For” kit

c) Collaboratively draft an actionable safety plan

d) Ask further questions to ensure the individual has not glossed over the actual level of risk

e) Ensure that a suicide hotline number is in the individual’s mobile telephone and clearly labeled (Such as National Suicide Hotline 800.APE.TALK / 800.273.8255)

f) Call the hotline with the individual as a rehearsal, so that the brain circuit has been rehearsed *before* the individual is in further crisis.

g) Encourage treatment by a mental health professional

h) *Insist* on treatment by a mental health professional (elevated risk)

i) Do not leave the person alone (elevated risk)

j) Eliminate access to means to suicide, until further assessment and treatment is complete (elevated risk)

k) Call a suicide hotline with the individual (elevated risk)

l) Take the person to the emergency room or a psychiatric facility for screening (elevated risk)

m) Always assume the risk is greater than expected, observed, or known.

5) Follow up. Regardless of steps taken, a member should follow up with the individual to ensure that he / she is receiving adequate care, is safe, and knows that they can rely on the member.

Example Safety Plan

When feeling hopeless, depressed, or suicidal, I will take the following steps to keep myself safe. I will go as far down the list as necessary until I'm safe and no longer at risk. (If I am at risk of suicide, I will make sure to have a friend help me remove any access to things I might use for it.)

1. Ensure that I'm not around a place or things that I might use for suicide
2. Read something inspirational (Psalm, poem, quote)
3. Review my "Live For" kit
4. Chart how I'm feeling on a time graph
5. Take a walk
6. Go somewhere where I feel calm and connected
7. Call my partner (xxx) xxx-xxxx
8. Call my friend (xxx) xxx-xxxx
9. Call my pastor (xxx) xxx-xxxx
10. Call the National Suicide Prevention Hotline - 1-800-273-8255 (1-800-APE-TALK)
11. Call 9-1-1 and go to the Emergency Room

4. **RESPONSE**

While the goal is for prevention, if a member of the Organization dies by suicide, we will respond well. The Organization is committed to caring for the surviving family, honoring the fallen member, and protecting the rest of the Organization. We will demonstrate compassion as human beings and confer dignity throughout our response. This portion of the protocol specifically addresses an event of member suicide, and is thus related to the Organization's established protocol regarding member death in general. The Organization will actively nest this protocol within the Organization's general protocol for responding to any member's death, and ensure that there are no discrepancies or ambiguities between the two.

A. **Care for the Family.** The Organization acknowledges that experiencing a suicide in a family or Organization is a complex loss. Someone close has died, which carries normal feelings of loss and grief. Additionally, the death and its aftermath may be particularly horrific. Furthermore, the nature of suicide carries unanswered questions, shock and feelings of guilt. Many within the Organization will feel unequipped for this type of death. Because of this, we commit to our families that we will respond as human beings. In the midst of our own confusion, we will, in Joiner's words, "Just act right" toward the family (See References).

1) Attitude:

a) As an Organization, we will show compassion and never judgment.

b) As an Organization, we will advocate for the family to receive all official support and benefits allowed by law or policy. If these are insufficient, the Organization will lobby for a change in policy and / or find unofficial means of support.

c) For any area that the Organization is lacking knowledge or out of date (these will become evident in the aftermath) we will aggressively seek to gain knowledge and apply it.

d) Members will coach one another about helpful and non-helpful things to say. Members will remember that being present and saying little is often most helpful.

e) Slow down. The Organization and members often have to decide and act quickly to events. This is an event in which we will slow down. A member has already died, there are many aspects that do not need to be rushed. Members will remember to slow down and make thoughtful, collaborative decisions that are in the family's best interests.

f) The Organization and members will remember that this will be difficult for each of us. Despite that, we will act well toward the family.

2) Immediate aftermath.

a) Members will receive the news with dignity

b) If the death is within the Organization's jurisdiction, we will - when possible - assign officers to the scene who are not close with the fallen person. [This section will be cross referenced with the Officer Death / Serious Injury protocol, and will be updated according to the merits of how best to meet professional obligations, support the family, and care for members.]

c) The Organization will immediately assign a liaison officer to the family. If possible, he will already have some relationship with the family. This officer will be responsible for walking with the family through the many practical steps.

d) The Organization will locate the closest support group for survivors, and seek to directly connect the group to the family.

When You're With the Family

1. **SLOW down**. Unlike most of our daily tasks, there is no rush for most of the things we will do. If we need equipment or uniforms, we can wait. Slow down and consider the implications of each step. Give time for the family to grieve.

2. **Be PRESENT.** Sometimes you don't need to say much, or even anything at all. Be present and available. If you're not sure what to say, say less. Return to the family more than once, even if it's uncomfortable. No family should go through this alone.

3. **WHAT, not WHY.** Our minds gravitate to the "why" - it's in our profession. But this mystery might never get solved. Instead of analyzing "Why," ask WHAT? For example, use W.I.N. - What's Important Now (Brian Willis.) Ask, "What does the family need?" "What can I do to help?" "What would I want for my family if I had died?"

3) Short term.

a) We will ensure that all counseling and religious support desired are made available to the family

b) The Organization and members will find ways to do things for the family, taking a proactive approach (e.g. just mowing the lawn) rather than a "well, let me know if you need anything" approach.

4) Long term.

a) The Organization and members will stay in touch with the family. The family will receive supportive contact from Organization personnel at least weekly for one year following the death. Contact will be at least monthly for year 2.

b) The Organization will actively work to facilitate and accelerate payment of any benefits available. If these seem insufficient, we will help the family in finding additional resources designed to aid surviving families of fallen members.

B. **Honor the fallen member.** The Organization's posture toward the fallen member will be one of honor. We will balance concerns regarding contagion effect with the need to honor the member. When possible, we will give the same honors we would give any of our fallen.

C. **Protect the force.** The Organization takes seriously the mental health risk that a suicide presents to the rest of the Organization.

1) The Organization will get all current information possible regarding contagion effect and how to best honor the fallen without glamorizing or over-simplifying the death. The Organization and members will make informed decisions.

2) The Organization will surge mental health and spiritual resources to meet needs within the Organization's members and families.

3) The Organization will review the death and circumstances to understand as much as possible about the suicide, and take any steps to immediately protect the remainder of the force. If we missed something as an Organization, we will own it without condemning individuals.

D. **Organization-wide and public communication.** In balancing honor and protection, Organization communications will follow these principles:

1) The Organization and members will talk openly that this was a suicide

2) The Organization and members will not glamorize the suicide

3) The Organization and members will avoid simplistic observations. Suicide can be very complex.

4) The Organization and members will refrain from any statements or implications that this was an escape or viable solution.

4) The Organization and members will not discuss details of the method or location (except when needed in less-public settings)

5) The Organization and members will discuss the honorable service of the fallen

6) The Organization and members will emphasize the need to reach out for help, and will specifically identify available resources.

5. **Responsibility.** The Deputy Chief of Operations will be the point of contact for this memorandum and has responsibility for maintaining and updating these protocols. Ultimately, the undersigned maintains full moral, legal, and procedural responsibility for every aspect of this protocol.

John A. Doe

Chief of Police

References

Aamodt, M. G. & Stalnaker, N. A. (2001). Police officer suicide: Frequency and officer profiles. In Shehan, D. C, & Warren, J. I. (Eds.) Suicide and Law Enforcement. Washington, D.C.: Federal Bureau of Investigation.

Harper, Heidi (2017-2018). Personal conversations. (Ms. Harper's husband died by suicide.)

Joiner, T. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press

Mason, K. (2014). *Preventing suicide: A Handbook for pastors, chaplains, and pastoral counselors.* Downers Grove, IL: IVP Books.

Mishara, B. L., & Martin, N. (2012). Effects of a comprehensive police suicide prevention program. Crisis: The Journal Of Crisis Intervention And Suicide Prevention, 33(3), 162-168. doi:10.1027/0227-5910/a000125

Websites:

AFSP - American Foundation for Suicide Prevention. https://afsp.org

Blue H.E.L.P. www.wearebluehelp.com

California's "Know the Signs." http://www.suicideispreventable.org

Military "Lifelines" program by Vetworks. http://vet-works.com

Willis, Brian - "What's Important Now?" http://www.lifesmostpowerfulquestion.com/resources/