QPR: Police Suicide Prevention

A 5-year veteran uniformed police officer, in acute distress about his wife divorcing him, hints to his shift supervisor, "Forget that transfer I asked for; I've decided to work things out permanently."

The shift supervisor takes him aside and asks, "What's the matter? Is something going on in your personal life?"

After this inquiry, the officer announces that his wife is leaving him, describes his sense of devastation, and laments his inability to reverse her decision.

The supervisor says, "I'm worried about you and concerned for your safety. Have you had any thoughts about killing yourself?"

The officer nods.

"Then I want you to see a professional immediately -- strictly confidential. I'll make arrangements. Chaplain or psychologist?"

"Psychologist," the officer replies, accepting help. Then he asks, "Do I have to give up my badge and gun?"

"No," replies the supervisor. "But for your safety you have to promise me you will not kill yourself until you've gotten some help. Are you willing to do that?"

"Okay," the officer sighs. "Okay, okay… How soon can I see the psychologist?"

"Today. I will take you myself," replies the supervisor.

Suicide is a tragedy that impacts tens of thousands of people each year: family members, friends and colleagues. Suicide also has an impact on those in law enforcement, whether as direct observers of a death by suicide, as survivors of a family member or friend's suicide, or as a person struggling with his or her own personal thoughts of self-destruction. The fact is we expect a lot of law enforcement personnel and they, in turn, expect a lot of themselves. The weight of the badge is heavier than many realized when they initially entered this profession. As stated by Sargent Bryan Skinner, "Being a police officer is not something I do, but something I am." **(1)**

The weight of the badge CAN also weigh heavily on family members. When men and women take up this profession of serving the public they are inadvertently choosing a lifestyle fraught with responsibility, stress, exposure to trauma, isolation and a constant need to be in emotional control. Balancing all of the various roles and emotions can be difficult. Posttraumatic stress disorder (PTSD), depression, alcohol abuse, relationship problems are all too often unhealthy consequences of this profession. Unfortunately, so, too, is suicide.

With only one hour of training, police officers and others can be taught to make more effective interventions in the suicidal crisis of another individual. Because of this one-hour training, the supervisor in the above interaction was able to apply a direct and effective suicide intervention. Called QPR, the intervention consists of three bold steps: *questioning* the meaning of possible suicidal communications, *persuading* the person in crisis to accept help, and *referring* the person to the appropriate resource.

Whether a supervisor, colleague or friend, the fact is that we are all in a position to potentially make a difference in the life of a suicidal person. If we are to make such a

difference, each of us must be willing to take action. That action may be directed at people close to us or in interactions with members of the larger community. The important thing to remember is that taking action can and does help save lives.

BACKGROUND

In taking steps to make a difference, it is important to realize that the supervisor in the opening scenario did all of the right things at the right time. Because of the supervisor's interventions, the officer provided a good faith promise to not kill himself and received the necessary professional help immediately, resulting in a positive outcome.

Typical of most suicidal crises, the nature of the officer's troubles took a long time to develop, but appeared brief, transient, and remedial during the crisis itself. A timely and caring discussion about his hinted plan to commit suicide ("I've decided to work things out permanently"), together with an immediate referral, enabled this officer to receive the counseling necessary to prevent a suicide attempt. This officer weathered his emotional storm and returned to duty in a few days with his pride and self-esteem intact. Many face similar emotional storms in life. Too often in the past, those in key positions to help have either not known what to do or were incapacitated by a lack of information about suicide, its nature and did not have the confidence to act. Fortunately, times are changing, as is the willingness to get involved in the lives of potentially suicidal persons.

Three things happened in the scenario with the officer to help avert a possible tragedy, not only for the officer and his family, but for the department as well. First, the

supervisor recognized that the officer's struggle with depression and suicide was not about a "good officer gone bad," a powerful title used by Gene Sanders, Ph.D. in an article looking at PTSD issues for police officers **(2).** Rather, the supervisor recognized an individual in distress and implemented effective skills in suicide prevention. These same skills could just as easily have been used with a family member, a friend or citizen in distress.

Second, the supervisor acted immediately, with courage. He also offered strong support. Too often, those close to the individual contemplating suicide respond to suicidal communications with denial, fear, avoidance, and passivity. No matter how unintended, this type of response often heightens the sufferer's sense of isolation, helplessness, and hopelessness.

Third, immediate support was offered to the officer in the form of a mental health resource person and/or a trained chaplain. Having ready access to a safe, tolerant, and helpful professional often reduces the customary resistance that many officers, and others, feel when outside help is needed. The supervisor's willingness to accompany the officer to the initial appointment was also a form of support and likely increased the officer's willingness to follow through with the scheduled appointment.

SUICIDE RESEARCH

No matter what our occupation, no one is immune to everyday struggles and/or psychological difficulties. Some occupations are actually associated with an increased likelihood of experiencing such stress-related problems. At present, law enforcement is one of those higher risk professions. Perhaps this is because of the stress

of the job itself. Maybe it relates to the high standards that officers often place on themselves and, into the bargain, the high standards of service they provide to the public they serve. Regardless, too many law enforcement officers lives, and the lives of family members and friends, are impacted each year as a result of the emotional storm within and the suicidal journey that ensues.

While statistics remain limited, law enforcement personnel have been found to be over-represented in the suicide data. John Violanti, in his *book Police Suicide: Epidemic in Blue*, reported that "Overall, police officers had an increased relative risk for suicide over all types of death in comparison to municipal worker Suicide may thus be considered a potentially higher risk to officers when compared to other hazards of policing and other occupations" **(3)**. Data suggests a sad, but steady trend in which more officers lose their lives each year to suicide than to homicide. In a survey of the Nation's largest police departments, Gary fields and Charisse Jones of *USA Today* **(4)** reported that:

- In New York, 36 officers were killed in violent confrontations with suspects from 1985 to 1999. During the same time period, 87 officers took their own lives.
- In Los Angeles, 11 officers were slain while on duty from 1989 to 1999. 20 killed themselves.
- In Chicago, 12 officers were slain while on duty between 1990 and 1999. 22 officers killed themselves during that same time period.
- The FBI lost 4 special agents in the line of duty since 1993. 18 special agents killed themselves (during comparable years of 1993-1999.)

- The U.S. Customs Service lost 7 agents to suicide in 1998 alone.

Some research shows that the suicide rate of officers is roughly three times the national average **(5)(6).** Another researcher reported that the suicide rate among police officers doubled from 1950 to 1990 **(7).** Considering the emotional wreckage suicides cause in the community, for friends, colleagues, and family members, even a single suicide by a law enforcement officer is one too many.

Although research literature on suicide and its prevention has grown slowly due to a lack of funding, it is important to note that steady progress is being made. Researchers know a great deal more today than they knew ten years ago about the medical and psychological conditions under which people consider suicide. Among the information learned recently:

- Suicidal crises tend to be short, not long;
- Most suicides are completed by people suffering untreated clinical depression, often precipitated by chronic stress and complicated by acute or chronic alcohol intoxication;
- If treated aggressively, 70 percent of depressed, suicidal people will respond favorably to treatment in a matter of a few weeks; and
- The newer antidepressant medications cause few side effects that impair job or family functioning and, as a result, compliance with medication regimes results in excellent treatment responses. **(8)**

THE SUICIDAL JOURNEY

While some suicidal acts are impulsive, the majority of suicidal persons follow a known psychological route: from idea to act. The vast majority of American adults only think about suicide and never act on their thoughts. The act of suicide may or may not be fatal, but it is important to remember that the journey begins with the idea that suicide will solve all of one's problems and will bring an end to one's mental anguish and suffering. Suicide may also be seen as a way to escape an intolerable situation.

Once a person considers suicide, the notion may be discarded as a bad idea or, if relief is not forthcoming, the journey to suicide may continue onward. If it continues, the increasingly suicidal person must find a time, place, and means to make an attempt. The journey may be short or long. Sometimes the journey takes only hours, but typically it takes a matter of weeks or even years. For most people, the "hot phase" of a suicide crisis begins and ends within approximately three weeks.

If help arrives in time, and before a suicide attempt is made, most lives can be saved. More than one reader of this book has likely already saved one or more lives from suicide by intervening in the journey to self-destruction.

METHODS OF SUICIDE

As part of the journey, people contemplating suicide must make a decision about the method they intend to use to bring about death. This decision almost always reflects the person's values, identity, training, and/or the availability of the selected method. Thus, anesthesiologists tend to use drugs, pilots may use an aircraft, and law enforcement officers most frequently will use a firearm, as do the majority of Americans. Self-

inflicted gunshot wounds have been the leading cause of death by suicide for both men and women in the United States for several decades, and firearms are now the method most chosen by American teenagers **(9).** Unlike other less lethal methods with which one may attempt suicide, the use of a firearm provides little opportunity for rescue, resuscitation, or second chances. According to unpublished research by Vena and Violanti, not only do police officers overwhelmingly select firearms as their method of suicide, but experience a 6.4 greater risk of dying by a self-inflicted gunshot would that do people in other occupations **(10).**

THE NATURE OF SUICIDAL COMMUNICATIONS

The success of the QPR method hinges on the fact that those considering suicide generally tell someone, either by word or deed, what they plan to do before they do it. This interpersonal communication functions as a window of opportunity for people in contact with the person contemplating suicide to intervene by acting boldly to stop the suicidal journey.

Unpublished research from the U.S. Department of the Navy found that among 41 completed suicides, 90 percent of those who took their lives communicated their intentions prior to their deaths **(11)**. In 66 percent of these cases, the person directed suicidal communications to a shipmate, spouse, family member or significant other. Unfortunately, an opportunity to query potentially suicidal PERSONS occurred in only 34 percent of these cases when, according to the records, these SAILORS had contact with clergy or professional healthcare providers. These data suggest there may have been

many “missed opportunities” to interrupt suicidal journeys already in progress and to make appropriate interventions and referrals.

Suicidal communications or clues most frequently fit into four basic categories: direct verbal, indirect verbal, behavioral, and situational. Direct verbal communications are relatively easy to understand and do not require special listening skills or interpretive powers. “I’m going to shoot myself” is easy enough to understand. However, if an intervention is to be successful, appropriate and supportive action is required *at the time the communication is sent*. We have an old saying in suicide prevention, “Whatever you do, do *something*!”

One experienced sheriff advised that when he was in the acute phase of his one and only suicide crisis, he drove up to an old friend having coffee in his patrol car. When his friend rolled down the window, the sheriff said, “I’m going to kill myself tomorrow.” His friend stared at him in apparent disbelief, rolled up his window, and drove off. Fortunately, the officer survived his crisis.

All suicidal communications are not as direct and easily interpreted as illustrated in the above example. Because potential rescuers may reject direct communication about suicidal intent, suicidal persons frequently revert to what are called “coded clues” or “hints” that they may be considering suicide. These indirect verbal threats may be more challenging to interpret, but they can be understood, especially with a little training. The statement, “I’m going to eat my gun” says nothing about suicide per se, but anyone familiar with firearms knows what this means. An even more subtle example of an indirect clue can found in a recent mystery novel involving police officers as the central characters. The book, *Red Light*, by T. Jefferson Parker describes a scene in which two

officers investigating a murder are discussing the fact that the wife of one of the partners is dying of a brain tumor. “Fly away, fly away…. That’s what I’m good for. When this is over (meaning his wife’s death), I’ll do it.” In this excerpt, the police officer is giving an indirect or *coded* suicidal communication. The initial response of his female partner is to think “It seemed a witless invasion to ask, ‘*What will you do?’.*” Yet, the novel reflects that she clearly knew what was being communicated. Fortunately, the female partner quickly contacts a psychiatrist friend, shares her concerns, is reminded of risk factors and clues of suicide police officers considering suicide and is encouraged to actively intervene using the skills she learned at a QPR training several months prior **(12).** Is this recently published novel written for purposes of entertainment? Yes. But, is it also a reflection of a very real situation that could be encountered? Most definitely.

Men may sometimes also make what are called “dire predictions.” Prior to his death, one man made the statement to his wife after she filed for divorce, “You will find a dead man in a car in front of the house.” Another man stated to his doctor, “Don’t worry about me, I’ll be six feet under next week.” These “dire predictions” related to specifically to the intent of these men to kill themselves – and both did.

Individuals in a suicidal crisis do not always verbally communicate their intentions, but rather may act out their distress. Engagement in these behaviors could indicate a plan to end their lives. These behavioral clues may be difficult at times to interpret, in part because there can be several different reasons for their occurrence. Behavioral clues include making a will, giving away prized possessions, stopping church attendance or making funeral arrangements. When combined with possible verbal clues,

or even a strong “gut reaction” that something is amiss, these behavioral clues can be part of an overall picture of despondency and potential suicidal considerations.

Finally, it is important to realize that “suicidal situations” are not communications, but an acute stress context in which an individual feels caught up in a web of seemingly impossible circumstances for which suicide becomes an acceptable solution. For example, best friends since elementary school, two 13-year-old boys start high school together. Two weeks later, one of the boys is struck and killed by a drunk driver. Feeling depressed and isolated, and maybe never having experienced the death of someone close to him before, the young man left behind may begin to view suicide as the only answer for coping with his pain and loss. In his mind, he may also see his own death as a way of re-joining or being with his friend. Developmental considerations, experience in coping with past loss or trauma, the amount of social or professional support available, etc. all contribute to the equation of risk and need to be addressed.

For law enforcement personnel, a fear of public exposure following an arrest or the threat of an investigation that may lead to arrest or negative public attention, creates a special crisis situation in which no face saving exit may appear open. In these circumstances, suicide may seem to be the only way out. Any time a senior member of the force, a high ranking officer or anyone who wears the uniform is about to be exposed in the media for criminal behavior or otherwise humiliated in public, aggressive outreach and intervention is recommended.

LAW ENFORCEMENT APPLICATIONS

QPR has particular application to law enforcement environments, both within a department and through Employee Assistance Programs (EAPs). The nature of close-knit associations and the necessity of teamwork make the training of officers in QPR a necessity. It is often co-workers on the force who may be in the most likely position to see warning signs of risk that could lead to a life-saving intervention. Similarly, spouses and family members may pick up on different clues. More opportunities for early intervention exist when members of a socially integrated organization (including families) are trained to recognize a potential suicide crisis in progress and are trained in what steps to take to interrupt the suicidal journey.

QPR, like CPR for emergency medical interventions, is also very applicable within the broader community setting. Officers respond on a regular basis to calls of violence, substance use or abuse, suicidality and homicidality. Many of these calls have, at their root, a distressed individual who may be feeling hopeless and questioning if his/her life is worth living. Our increasing awareness of the phenomenon referred to as "suicide by cop" is but one other example. Although the "relationship" between the police officer and community member may be a new one, the possibility of successful intervention still exists and the methodology of QPR can be easily be applied.

In the same way a homicide requires opportunity (some experts have referred to suicide as homicide in the 180th degree), so too, does a suicide. Distressed individuals often create this opportunity by picking a fight with a friend, avoiding colleagues, resigning from the department ball team, engaging in increased alcohol use or by withdrawing from the very people who might help them survive. Police officers, and those who work with them, must raise their own awareness about the depth and breadth

of this problem and learn to recognize that social withdrawal may be a sign that something is seriously wrong. The more people who know what to do and when to do it, the tighter the suicide prevention safety network becomes and the better the chances that any given individual caught up in a personal crisis can survive that crisis.

With very few exceptions, most people in caught up in a crisis situation will benefit from counseling, even when the problems driving the crisis threatens their careers and futures. This is true of law enforcement personnel as well the general public. QPR proves especially helpful in environments where individuals at risk are unlikely to seek assistance on their own because they believe that voluntarily seeking mental health care may result in public shame or could damage their careers.

Because of the reticence to seek help, A mild depression may become a serious and debilitating one. The person may turn to alcohol use as one means of coping with their distress or symptoms of depression, thus seriously impairing their judgement. The person in crisis may also become more irritable or angry, and withdraw from those who could help. Unfortunately, these “coping strategies” only tend to make matters worse and, unless early detection and referrals are made, may require formal disciplinary actions.

By reducing the stigma of mental health treatment, counseling, and expanding the pool of properly trained individuals so that effective, officer-friendly mental health services are more readily available, positive changes are possible. If necessary, a direct order to seek counseling is better than doing nothing. Doing nothing may be interpreted by the potentially suicidal person as not caring, or confirmation that life is, in fact, just as hopeless as they currently perceive it to be.

Another reason associated with the elevated risk for suicide may be the tendency for law enforcement personnel to be reluctant to seek help voluntarily or in a timely fashion. This can be true, to a lesser degree, for the rest of the population as well, but the hesitance appears to occur with even greater prevalence among police and sheriffs department officers. Unfortunately, if suffering from stress-induced depression, the psychological condition of suicidal people tends to worsen over time and leads, in some cases to a sense of utter hopelessness that clouds their thinking. When added to the well-documented risk factors of being a white, black or Hispanic male **(13)** and working in a high-stress environment that requires access to a firearm, a potentially toxic psychosocial formula for personal disaster exists.

Similar characteristics can be true of the impact of the officer's stress on family members or loved ones. As shared by Skinner, "Although tragic events are part of my nightly entourage, both professionalism and emotional survival require police officers to care from a distance. However, this suppression of feelings takes its toll at home and our personal relationships often suffer. I sometimes wonder if my family views me as a stranger - a living consequence of the stress" **(1)**.

This dynamic can make it difficult for the officer to deal with his/her own emotional struggles, or to be present and able to address difficulties being encountered by family members. Whether an officer, loved one or a distressed member of the community, the psychological pressure builds to a powerful crescendo. It is at this point that suicide may not only be considered, but may be seen as the most viable solution to the current situation.

GATEKEEPER TRAINING

Gatekeepers, or first finders, represent those people in every community or institution who, because of their contact with those at risk for suicide, are in a position to identify and refer people thinking about suicide or have already begun their journey to attempt suicide. The QPR gatekeeper-training module enhances general awareness about suicide, teaches the warning signs of suicidal thinking and behavior, and explains three basic intervention skills. The training module also includes a QPR information booklet and a three-part folding card, summarizing key information on the nature of depression and suicide, the role of alcohol in suicide crises, and, if necessary, how to access the involuntary civil commitment laws to save a life. At present, all 50 states have laws on the books to help interrupt the suicidal journey. Although these laws vary from state to state, when a law enforcement officer believes an individual may harm him- or herself, or commit suicide, the officer is obliged TO contact a mental health provider to ensure that those individuals receive a mental health evaluation, or take that person to a hospital.

Gatekeepers can be anyone trained in QPR. Following QPR training of executives in a health maintenance organization, two women asked to speak privately with the instructor. The first woman stated, “A family friend told me my 16-year-old son held a pistol to his head at the Christmas party last week. Should I be concerned?” This question led to an affirmative answer and an immediate referral for evaluation of this teenage boy. The boy had been considering suicide for several weeks. Pointing a gun to his temple may have indicated a behavioral rehearsal.

The second woman told the instructor, “My husband has kept a revolver near our bed all of our married lives. He recently took it to the pawnshop and hocked it. When I asked him why he’d done that, he said ‘Don’t ask stupid questions!’ What should I do?” In this case, the woman brought her husband to the instructor’s office. The instructor, also a mental health provider, conducted a suicide risk assessment. Interestingly, the gentleman said, “I wasn’t going to use the pistol… but I was going to go to the lake and gas myself.”

In both of these cases, someone close to the suicidal individual, not a professional, asked the *question*, and the individual was *persuaded* to accept a *referral* for assistance. Such recognition and referral activity is common in the hours, days and weeks following QPR training. Similarly, a mental healthcare organization found that, through mandatory QPR trainings for their staff, not only did they improve knowledge about suicidal risk factors and warning signs in their patients, but also proceeded to conduct active interventions on several staff after the trainings occurred **(14).** It is very likely that lives were saved because of these interventions. That’s what QPR is all about.

A REASON TO HOPE

By acknowledging and responding to the need to provide proper training, perhaps the nation’s attitudes about suicide and prevention are changing. The oldest organization for suicide research and suicide prevention, the American Association of Suicidology, has aided and assisted a number of new organizations to grow and flourish. A group called Suicide Prevention Advocacy Network (SPAN) has been instrumental in advocating for suicide prevention and influencing the political system to recognize

suicide as a national problem and to allocate funding to help in awareness raising and prevention activities. In recent years, other organizations have formed to further the cause of suicide prevention and to assist those left behind. These include the American Foundation for Suicide Prevention (AFSP), 1-800-SUICIDE, Suicide Awareness Voices of Education (SA\VE) and Survivors of Law Enforcement Suicide S.O.L.E.S.) and the National Police Suicide Foundation. Still other groups, such as the Law Enforcement Wellness Associates, strive to offer information and training to support law enforcement personnel on a variety of topics, including preventing suicide.

The Surgeon General of the United States Dr. David Satcher, has also been a leader in efforts to reduce the stigma associated with mental illness and has been a champion in suicide prevention, recently issuing his National Strategy for Suicide Prevention **(15)**. Suicide is being spoken about and changes are being made.

CONCLUSION

Although suicide is always complex, multi-determined and multi-faceted, most experts feel the majority of suicides can be prevented. Increased knowledge, coupled with straightforward intervention, can help cut through the denial, ignorance, resignation, and apathy many people feel about our ability to prevent suicide. Some people's cultural consciousness contains dangerous and erroneous myths about suicide, myths that add to the problem, not help solve it. Many of these societal myths serve to foster and reinforce the sense of hopelessness that suicidal people experience on their journey toward self-destruction. For example, if you believe suicide is inevitable and that it cannot be prevented, you are unlikely to act boldly when intercepting a suicidal communication.

Likewise, if you believe that people who talk about suicide don't do it, you are unlikely to take a direct or indirect verbal suicide threat seriously. Sadder still is the case of one man who sharEd that he had been told that talking about suicide actually *lowers* the risk for suicide. Because of this misinformation, when a friend shared his plans to shoot himself, an opportunity for intervention was lost, and one more survivor of suicide was added to the population.

Suicidal people may communicate their intentions to commit suicide to several people, or to only one other person. Therefore, everyone must learn what to do, but especially law enforcement support staff, dispatchers, administrative personnel, employee assistance providers, officers, family members and community members. These basic, necessary steps can be learned in as little as an hour, and may save a life. If unable and/or unwilling to take such steps themselves, everyone must at least know whom to contact if they become suspicious or concerned that someone they know may be considering suicide.

QPR does not require an advanced degree to administer, just as those applying cardiopulmonary resuscitation (CPR) do not have to be physicians or cardiologists. In fact, assuming the role of diagnostician or trained counselor is discouraged. The act itself involves intervention and referral, not a formal psychological evaluation, ongoing treatment or counseling. Merely learning what intervention steps to take, and when to take them, can mean the difference between life and death.

People expect an officer trained in CPR to apply knowledge and skill in an attempt to save the life of a citizen or fellow officer if they are not breathing and do not have a heartbeat. Wouldn't people expect the same officer, similarly trained in suicide

prevention, to make a good-faith effort to save another life in peril? Indeed, a good faith effort to prevent suicide is not a matter of choice but a matter of duty.

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