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The Impact of Suicide Calls on Police

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Data collected in 2007 by the Centers for Disease Control and Prevention revealed that suicide occurred at rates nearly twice that of homicide. For all age groups combined, suicide ranked as the eleventh leading cause of death in the US and among the top five causes in several age groups in 2007 (CDC, 2011), (table 1). Police officers are the first responders to crises, yet little is known about the impact and stressors of responding to completed suicide calls.

Table 1. Suicide Rank as Cause of Death

Age Group	Suicide Rank
10–14	4th
15–24	3rd
25–34	2nd
35–44	4th
45–54	5th

Centers for Disease Control [CDC], 2011

Police Stressor Survey

In a preliminary study of over 225 officers in Massachusetts, we identified issues and circumstances reported by officers dealing with suicides. We asked police officers to identify the issues or specific circumstances related to responding to suicide calls that could cause/have caused them to feel the most stress or anxiety.

A total of 225 usable surveys were obtained, with 684 issues/circumstances identified. Findings suggest that suicide calls present personal and professional challenges, with short and long-term impact for police officers, their departments, and their communities. These data show that suicide calls are often critical incidents in police officers' careers and are among the highest anxiety- and stress-provoking circumstances to which police officers must respond (table 2).

Table 2. 10 Most Common Stressors for Police

Stressor	% Reporting Stressor
Dealing with survivors	39
Emotional impact on officer	35
Young victim	30
Managing crime scene	29
Emotional impact on survivors	26
Victim known to officer	19
Suicide method	16
Reason for suicide	15
Graphic/gruesome death	13
Officer safety	13
Death notification	12

"Normal" Work Stressors

Policing is a high-demand and high-stress profession (Miller, 2008), in which police officers are exposed to a wide variety of stressors. "Normal" work stressors typically fall into two categories: (1) stressors on-the-street (e.g., dealing with extremes such as weather and high risk situations, shift changes, experiencing "high impact" crime areas, and fear of serious injury or death); and (2) departmental stressors (e.g., lost promotional opportunities, mistrust of management, punitive discipline, and police brutality issues).

Critical Incident Stressors

In addition to these routine ongoing stressors, officers often experience critical incident stress. A critical incident (CI) is any event that has an unusually powerful, negative impact on police personnel because the event exceeds the range of ordinary work-related stressors or hassles (Everly & Mitchell, 1997; Miller, 2008). In one report, 26% of officers involved in CIs experienced some form of Post-Traumatic Stress Disorder (PTSD) one month later (Martin, McKean & Veltkamp, 1986; Koch, 2010; Pienaar, Rothman & Van De Vijver, 2006). This was seen to be especially true after a call involving a death. Significant literature exists to support the idea that police officers experience high-level stress when arriving on-scene at a traumatic incident (Brown & Campbell, 1994; Kirschman, 1997; Paton & Violanti, 1996).

Impact of Critical Incidents

Failure to acknowledge and address the emotional impact of CIs may result in serious, and sometimes devastating, personal and professional consequences for those officers involved, both on individual and departmental levels. Research on predictors of police suicide (Violanti, 2004, Cross & Ashley, 2004) has demonstrated that CI exposure and PTSD symptoms seem to significantly increase:

- Alcohol Use
- Suicidal Ideation/Suicide
- Mood Disturbance
- Domestic Violence
- Use of Excessive Force

Suicide of a police officer represents a major CI. The CDC reports a suicide rate for the general population of nearly 12 per 100,000 (Heron et al., 2009). Police suicide rates are estimated to be significantly higher at 18 per 100,000 (Ritter, 2007). Studies have documented that within a specific period, some law enforcement agencies have had more officer deaths from suicide than from line-of-duty homicides (Hackett & Violanti, 2003).

Barriers

Despite the tragedy of suicide and its toll among police officers, a major barrier for dealing with this issue is the pervasive code of silence consistent within the law enforcement culture. Stigma surrounding mental health problems prevents officers from self-reporting depression or other problems, fearing that they will be perceived as being weak. Reluctance to self-disclose emotional problems stems from fears of reassignment and loss of weapon-carrying privileges. Co-workers are often hesitant to turn in a troubled officer despite concerns about a comrade's need for help (Miller, 2008). Even with the high rate of police suicide, "experts estimate that less than 10 percent of the 18,000 police departments nationwide actively work to prevent suicides within their ranks" (Antlfinger, 2008).

Recommendations for Police Training and Mental Health Providers

The Special Commission on Massachusetts Police Training (2010) found that Massachusetts spends only $187 annually per officer for training in general. By comparison, New Hampshire spends $933, and Vermont spends $1,525. The expertise to provide such training and to help officers manage CI stress currently exists. Despite this, it is implemented in only a few departments. Based on feedback we have received, we recommend that officers receive mandatory training to:

- Detect suicidal risk in officers and the public
- Facilitate appropriate referrals for help
- Develop/enhance skills to communicate with surviving family/friends
- Understand challenges inherent in suicide calls
- Recognize signs and symptoms related to CI stress associated with responding to suicide calls

Delivering mental health care to the law enforcement community is challenging. Police officers often resist counseling for reasons including officers being skeptical of outsiders and having difficulty trusting mental health professionals. Conversely, therapists sometimes do not understand police work, nor can they comprehend the daily stresses officers encounter (Kureczka, 1996).

We recommend that counselors have a thorough understanding of policing, as well as comprehensive knowledge of the police force and its demographics. Therapists must be familiar with the organization of the police department and its power structure to understand the work environment of affected officers. Further, building rapport and assuring officers of the confidentiality of information revealed is essential and requires time and diligence by mental health professionals. Through such efforts, the therapeutic effects of counseling can be realized.

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