

SUICIDE PREVENTION, INTERVENTION, & POSTVENTION

**Policy Guidance for
Law Enforcement Agencies**





Executive Summary

OVERVIEW

Law enforcement is an inherently stressful and unpredictable profession, where officers regularly engage in volatile and dangerous situations. To meet this challenge, law enforcement must prepare and train for any scenario. An enormous amount of time, funding, and resources are dedicated to training officers and ensuring that they have the skills and equipment they need to perform their jobs safely and effectively. It is the nature of police training and work to prepare for all potential outcomes while on the job. The same level of preparation must apply to officer suicide prevention and mental wellness. In addition to the physical danger and unpredictability of the profession, law enforcement officers also deal with high levels of stress and trauma exposure within a culture that has historically reinforced a negative stigma around seeking mental health treatment. While the profession comes with known and inherent risks, there are often few resources and limited infrastructure in law enforcement agencies to target and prevent suicide.

In the last several years, more attention has been devoted to this problem, particularly with the creation of the National Consortium on Preventing Law Enforcement Suicide (Consortium), a multidisciplinary group of experts with the common goal of preventing officer suicide. The International Association of Chiefs of Police (IACP), the Education Development Center (EDC), and the National Action Alliance to Prevent Suicide (Action Alliance), with support from the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, have partnered to facilitate the Consortium and produce recommendations and resources to equip agencies to tackle this problem and reduce barriers to help-seeking, such as cultural norms that can prevent officers from speaking up and addressing mental health concerns.¹ Based on the authors research, it appears that there is still a significant gap in the number of law enforcement agencies that have written policies and procedures to prevent suicide, intervene when an officer is at risk for suicide, or provide support after a suicide occurs. This resource seeks to fill that gap by providing guidance and outlining recommendations that should

be considered by agencies and the law enforcement profession when developing these policies. This resource is designed to complement existing agency policies on related issues such as peer support, wellness, and employee assistance programs (EAP).

WHO IS THIS DOCUMENT FOR?

These considerations are intended for leaders and personnel involved in developing policies and protocols for law enforcement agencies. The information contained within this document is designed to be general policy guidance and applicable within law enforcement agencies regardless of department size or setting (urban, suburban, rural, campus or tribal).

While the overall focus of this guidance is for sworn personnel, it is critical to have measures in place that apply to non-sworn employees, as well. This guidance can be appropriately tailored for both sworn and non-sworn staff. As policy and procedures are written and implemented, it is important to consider how they will apply to non-sworn staff (e.g., dispatchers, administrative staff).

HOW IS THIS DOCUMENT INTENDED TO BE USED?

Agencies should use this document to inform development, implementation, and evaluation of their own suicide prevention, intervention, and postvention policies and standard operating procedures (SOPs). This resource outlines considerations for developing or strengthening policies and contains commentary and research that explains some of the elements in the policy considerations. Because this is designed to be comprehensive policy guidance, it may be useful to reference other existing policies (such as an employee mental health and wellness policy or a fitness for duty policy). This document is created as guidance and is not intended to conflict with or supersede any existing model policy guidance from the IACP; other organizations; or any existing local, state, tribal, or federal laws.

GLOSSARY

For the purposes of this resource, we define some common terminology:

- **Gatekeeper training** – a suicide prevention training program that specifically trains people how to recognize and identify warning signs in those individuals who may be at risk of and how to assist those persons in getting needed support and services.
- **Imminent risk** – when there is a close temporal connection between the person’s current risk status and actions that could lead to their suicide. Imminent risk indicates that urgent actions are needed to reduce the person’s risk, and if no actions are taken, the person is likely to engage in actions that may cause serious harm or result in death. Imminent risk may be determined if a person has a plan, the means, and an intent and capability of implementing their intent to die by suicide. Trained and certified medical and licensed mental health professionals may determine if a person meets this standard through a suicide risk assessment. If a person is deemed to be an imminent risk to themselves, there may be legal ramifications limiting a person’s free movement (for example, a person may be held for further psychological evaluation or treatment if determined to be at imminent risk of suicide or self-harm).ⁱⁱ
- **Qualified mental health professional (QMHP)** – an individual who is licensed as a mental health professional and has an in-depth understanding of the law enforcement culture. Typically, this would also include expertise on substance use disorder and trauma-related disorders.ⁱⁱⁱ
- **Suicide risk assessment** – refers to a comprehensive evaluation done by a clinician to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a course of treatment. Although assessments can involve structured questionnaires, they also can include a more open-ended conversation with a patient and/or family and friends to gain insight into the person’s thoughts and behavior, risk factors (e.g., access to lethal means or a history of suicide attempts), protective factors (e.g., immediate family support), and medical and mental health history.^{iv}
- **Suicide intervention** – actions taken to reduce a person’s likelihood of attempting suicide. This may take many forms, including outpatient mental health treatment, creating a safety plan, and/or inpatient mental health treatment.
- **Suicide postvention** – the activities taken after a suicide death which promote healing, support those impacted, and reduce the risk of suicidal thinking and behavior for those impacted. Postvention response should be comprehensive and organized.^v
- **Suicide prevention** – a comprehensive set of actions taken to reduce the likelihood of suicide and suicidal behaviors. These can take place on an individual, group, organizational, or community level. Suicide prevention activities most often are designed to reduce risk factors and increase protective factors.
- **Suicide screening** – refers to a procedure in which a standardized instrument or protocol is used to identify individuals who *may be* at risk for suicide. Suicide screening can be done independently or as part of a more comprehensive health or behavioral health screening. Screening alone cannot determine someone’s risk for suicide but can be used to determine when a more in-depth suicide risk assessment is needed. Unlike suicide risk assessments, many suicide screening instruments can be used by anyone with training in the use of the screener. Basic suicide screening is a skill that law enforcement officers and the general public are encouraged to gain.^{vi}
- **Upstream prevention** – efforts/approaches that are designed to help build skills and proactively create healthy individuals, organizations, and conditions so that when a crisis does occur individuals already have the internal or external resources needed to be able to respond.
- **Trauma-informed** – an approach and understanding providing recognition that trauma is prevalent and that the impacts of trauma are pervasive. A trauma-informed organization uses this knowledge to inform settings, policies, procedures, and practices. Being trauma-informed promotes a culture of safety and healing.

Policy Guidance

SUICIDE PREVENTION

Key prevention activities that should be put into SOPs and/or official department written policy include:

1. The creation of a comprehensive suicide prevention plan for the entire department that considers the needs of both sworn members and non-sworn staff.^{vii} This will help to set the tone and establish the culture of the agency as one that supports wellness. This plan should include:
 - I. Policy statement setting the department culture^{viii}
 - a. Emphasize the understanding that policing is an inherently dangerous and stressful profession that will typically expose officers to traumatic events repeatedly and normalize the need at any point in one's career to access help from peers or professionals to address that psychological trauma and exposure.
 - b. Clearly and directly address the stigma around seeking and obtaining mental health support, encouraging officers to proactively take care of themselves. Where possible, make it clear that the act of seeking help for mental health challenges will not, in and of itself, be a barrier to someone remaining in law enforcement. Be clear that the agency believes in and encourages proactive care of each person's mental and emotional wellness.
 - i. While they may not be specifically included in policy, consider providing first-hand accounts or vignettes of officers who successfully received help and are thriving to show others that it is possible. This will be helpful for promoting and building trust in your policy and to emphasize the fact that the agency is prioritizing mental health, and ensure culture and policy are aligned.
 - c. Provide mental health and wellness resources, clearly articulating confidentiality requirements and expectations.

TRAINING

From the start of their careers, all department members (sworn and non-sworn) should receive yearly training on the basics of suicide prevention, often called "gatekeeper training." There are several evidence-

based gatekeeper training resources available that have proven successful for law enforcement.^{ix} At a minimum this training should include:

- I. Warning signs of a person at risk of suicide
- II. Risk and protective factors for suicide
- III. What a safety plan is and how to support someone at risk for suicide by using their safety plan
- IV. How to ask someone if they are thinking of suicide
 - a. What to do if someone indicates they are thinking of suicide and/or is showing signs of suicide risk
 - b. Available resources and how to access help both within and outside of the department
 - i. This should include emergency and crisis services, and, if a person is at imminent risk for suicidal behaviors, how to access an emergency assessment for suicide risk
 - ii. Additionally, training should include education on what to expect when the available resources are used. For example, 'what will happen when/if I reach out?' A better understanding of the resources and programs will, ideally, minimize the fear of the unknown and increase the likelihood someone reaches out.

Consider training the peer support team in additional suicide prevention measures. It is important for the entire department to have basic gatekeeper training; However, peer support members should have supplemental, on-going training.

INCORPORATION OF "UPSTREAM" SUICIDE PREVENTION APPROACHES

In the field of suicide prevention, "upstream" efforts refer to proactive approaches that are designed to help build skills and create healthy individuals, organizations, and conditions so that if and when a crisis does occur, individuals already have sufficient internal and/or external resources needed to respond effectively. These approaches are applied universally to all individuals.

Agency policies, procedures, and culture should encourage officers to engage in proactive wellness activities, and agencies should offer these types of programs to the extent they are able. These opportunities can help establish a robust officer safety and wellness program.

Some suggested classes and skills include:



Resiliency training



Yoga/Meditation classes



Mindfulness programs



Exercise/Gym memberships or facilities



Stress management skills



Peer support

Wellness education and services should be provided starting in the academy and continue throughout an officer's career. It may be necessary to provide a schedule of wellness options, whether that be on a weekly, monthly, or annual basis. It is important to consider how you present these services - make them convenient, accessible, and productive to maximize participation. Additionally, participation of agency leadership, along with officers, will go a long way in strengthening culture and minimizing stigma.

When possible, consideration should be given to allowing officers to attend these services and classes, as well as therapy sessions, during their shift. Providing officers the convenience of attending classes or therapy sessions on-duty affords them the convenience and accessibility to support. Attending sessions on-duty also helps normalize participating in wellness activities. It demonstrates that the agency is invested in officers' well-being and can help to lower the stigma associated with help-seeking.

It is important to maintain wellness training and classes throughout an officer's career. They should be offered starting in the academy and continue on a regular basis.

ANNUAL MENTAL HEALTH WELLNESS VISITS

The mental health of officers is as vital as their physical health. To further normalize and destigmatize mental health, agencies should consider implementing a policy requiring yearly mental health wellness visits to coincide with the annual physicals that officers must complete. Policies should clearly outline the purpose of a mental wellness visit and differentiate it from a mental health or wellness evaluation, which would inform fitness for duty.

MULTIPLE ACCESS POINTS TO SUPPORT

Mental health and wellness assistance may be carried out by various individuals and teams including:

- **Peer Support Teams**
- **Family Support Teams**
- **Mental Health Clinicians**
- **EAPs**

Policies should be clear about all types of services, providers, and programs available to staff, particularly with regard to someone at risk for suicide. Agencies may wish to consider explicitly employing a "no wrong door" policy, which will allow an individual seeking support to decide who they would like to go to for that support without creating unnecessary barriers to further support or treatment based on whom they initially contacted. For example, a peer support team member, chaplain, and front-line supervisor should all be able to refer an officer to a mental health professional the same way that a family support team member could.

PEER SUPPORT TEAMS

Peer support teams are critical sources of support for the continued health and safety of officers. Significant research and resources currently exist to assist departments in the development of these teams.^x Peer support team members are more likely than other officers to encounter officers who are struggling with their mental health or who are in mental health crisis. This being the case, departments should:

- I. Ensure that policies establish peer support teams. These policies should outline the types of support provided by each, the duration of support, and how these teams engage in suicide prevention activities.
 - a. Consider training peer support team members as trainers in gatekeeper training programs. Ensure that they are able to consult with mental health professionals regarding mental health concerns of peers.
- II. With the assistance of a QMHP, establish clear parameters around what type of support is appropriate to be provided by peers, and when to engage professional mental health clinicians or support.
 - a. For example, peer support teams should be used to provide social and emotional support designed to prevent suicide and enhance mental health. They should be trained in recognizing warning signs and when to refer individuals for intervention and treatment for mental health concerns. Qualified mental health professionals should be immediately available to assess and treat suicidal thoughts and/or crises. It is not within the role or scope of the peer support team member to conduct an assessment of suicide risk.

- b. All forms of support (peer, family, spiritual, and clinical) can be provided without limitations on time or number of visits. However, if an officer requires support from a peer support team for an extended period, team members should consider referral for mental health treatment or assessment.
- III. Consider requiring regular meetings or visits with representatives from peer support, to coordinate prevention services, triage any problems and ensure communication and coordination are effective. It may be advantageous to familiarize officers with the peer support team, ensure they know how to access the services, and acclimate them to a proactive approach to support. This will help tremendously when crisis situations occur, and multiple avenues of support are called upon.
 - IV. Ensure all individuals who are part of peer support have access to the peer support or officer wellness program leader and QMHPs for consultation, both regularly and when concerns arise.
 - V. Consider state and federal laws and regulations when creating peer support teams and policies. Ensure all laws and regulations regarding confidentiality are being met. Peer support members need to have a clear understanding of their duties and any parameters of this position.
 - VI. Ensure appropriate resources are available for peer support team members. The peer supporters are in a unique position because they are addressing the traumas and experiences of others, on top of their own. It is important to be sure they are protected and afforded the support they need.

FAMILY SUPPORT TEAMS

In addition to peer support teams, agencies should strongly consider implementing family support teams. While job-related stress and trauma undoubtedly affect officers, they can also lead to secondary or vicarious trauma for the officer's loved ones. Family support teams should be modeled after traditional peer support teams, with specific training on suicide prevention, active listening, and other mental health considerations. Family support team members should have access to the correct information if they need to refer someone to a QMHP or appropriate crisis service provider. These documents can provide additional guidance:

[Family Matters: Executive Guide for Developing Family-Friendly Law Enforcement Policies, Procedure, and Culture](#)

[Employee and Family Wellness Guide](#)

[How to Start a Law Enforcement Family Support Group](#)

DELINEATION OF ROLES FOR SUICIDE PREVENTION

- I. Command staff should receive clear instructions through policy directives on their role within agency suicide prevention. Modeling healthy behavior and engaging in activities to normalize help-seeking should be paramount for this level of leaders. Command staff should:
 - a. Be encouraged to check on each other and serve as peers to others in agency leadership.
 - b. Seek to establish a culture of wellness, model healthy behavior, educate officers regarding mental health and peer support services, and ensure officers do not view help-seeking as negatively impacting their career or livelihood.
 - i. Speaking openly about their own experiences (to the degree they are comfortable), reminding officers through written and verbal communication that support exists, encouraging officers to utilize resources, and regularly assessing the health and mental wellness of their officers should be included in their duties.
 - c. Continue to reinforce the information given at trainings, including being very clear that seeking mental health counseling or treatment alone does not equate to an automatic fitness for duty evaluation. Leadership should also consistently promote this message to address any concerns among officers. The role of the fitness for duty evaluation is truly a component of a comprehensive officer wellness program (Schlosser & Kudruck, 2021) and should be stressed to officers.
 - d. Understand their limits to confidentiality when a peer or officer is speaking to them and be able to articulate those confidentiality limits to peers and officers.
 - i. Many states have implemented requirements around law enforcement peer support confidentiality. Be sure to follow any state-specific requirements.
- II. Supervisors and field training officers are in a unique position in the agency to recognize officers who may be struggling with mental health challenges. Those in supervisory or leadership roles are also in a position of authority to be able to implement supportive actions when necessary.
 - a. Officers in these roles should receive clear instructions on how to identify officers who may be struggling and should receive in-depth training on how to appropriately engage and speak to someone about suicide or mental health concerns.

- III. In addition to suicide prevention gatekeeper training, supervisors, and Field Training Officers (FTOs) should also receive in-depth training on their confidentiality limits and understand their role in how to get someone a psychological assessment or emergency treatment if needed. Supervisors and FTOs should understand their limits to confidentiality when a peer or officer is speaking to them and be able to articulate those confidentiality limits to peers and officers they supervise.
- IV. Line officers are more likely to recognize a peer who is struggling. They should be empowered to intervene with ready access to information on how to talk to peers they may be worried about, available resources both within and outside the department, and information about how to connect the person they are concerned about with the most appropriate resource.
 - a. Resources provided should be within the department and include anonymous, external resources to increase the likelihood that officers will reach out for help if needed.
- V. Non-sworn staff should be aware of the resources available to them, and this should be clearly detailed in department policy.

SUICIDE INTERVENTION

When developing policies around intervening with officers and agency staff who may be at increased risk for suicide, agencies should consider the following:

PROCEDURES FOR INTERVENING IN THE CASE OF A SUICIDAL CRISIS

Agencies should have emergency policies that dictate how to intervene if an agency member is indicating being in a suicidal crisis. These policies should:

1. Define what constitutes a suicidal crisis.
2. Clearly outline detailed steps to be taken if an agency member is deemed to be in a suicidal crisis.
3. Provide clear and concrete guidance about who a family member, colleague, supervisor, or any other concerned individual should contact if they believe that an officer is in a suicidal crisis.

LEVEL OF INTERVENTION

Agencies may have a variety of mental health supports and psychological well-being offerings available to staff. These can be vital sources of support, and all have a role to play in an agency. However, these supports vary in their capacity to offer appropriate care to an officer at risk for suicide. Agencies should consider the following when determining policies around suicide intervention by members of peer support teams, family support teams, and others.

1. Members of peer support teams, family support teams, command staff, and others should have immediate access to and consult and/or refer to a mental health professional if an officer is in a suicidal crisis or at risk for suicidal behavior. QMHPs should be making suicide risk assessments, determinations of suicide intervention, and decisions about next steps.
2. Members of peer support and family support teams should have additional training on what to do in the case of a suicidal crisis. This training should include:
 - a. When and how to consult or make referrals to assess, provide treatment, and maintain the safety of an officer in a mental health crisis.
 - i. Agencies should consider developing relationships with culturally competent mental health providers in the community to facilitate referrals as needed.
 - ii. Referrals to resources should be provided to any officer experiencing a mental health crisis and could be provided by a variety of people including supervisors, peer support members, or others.
 - iii. In the event of a mental health crisis, law enforcement professionals who are aware the person is experiencing a crisis should ensure that the officer successfully connects with these resources, rather than simply providing the contact information for a resource. This may mean directly facilitating the officer's connections with the resource. This could be by offering or driving them to an appointment, making the phone call for them, etc.
 - b. Procedures to be taken by people in these supportive roles if an officer appears to be or is screened to be at risk for suicide.

SUICIDE RISK ASSESSMENT

Accurate assessment of risk is an integral part of suicide prevention. A suicide risk assessment is a comprehensive evaluation done by a qualified mental health professional to confirm suspected suicide risk, evaluate the immediate danger to the person, and decide on a course of treatment. Suicide risk assessments should only be done by QMHPs. Agency policies should outline when and how to connect agency personnel at risk for suicide with a provider who is qualified to make a thorough suicide risk assessment. These policies should include:

- I. The circumstances under which a QMHP should be contacted to conduct a suicide risk assessment.
- II. Naming and describing who is qualified to complete a suicide risk assessment. These policies should:

- a. Outline that a QMHP will complete a suicide risk assessment.
- b. Define who meets the criteria for a QMHP.
- III. Clear guidance on confidentiality expectations.
- IV. Training of officers and agency staff in Suicide Prevention.
 - a. While only a QMHP trained in suicide prevention can appropriately assess someone's suicide risk, all agency personnel can have a role to play in preventing suicide. Therefore, agencies should have policies that outline actions agency personnel should take if they suspect a colleague is at risk for suicide including:
 - i. Specific steps that should be taken.
 - ii. People or persons to whom concerns should be reported.
- V. Information on when officers will be mandated to complete mental health assessments as a part of fitness for duty evaluations.
 - a. For more information on fitness for duty evaluations, agencies are encouraged to look to the [IACP's Psychological Fitness for Duty Evaluation Guidelines](#).

CONFIDENTIALITY

1. Policies should clearly outline confidentiality expectations and limitations around external and internal services, such as therapy and peer support and suicide risk assessments. Laws vary from state to state regarding confidentiality, the limits of confidentiality, and privileged communication. Officers should be informed, at the beginning of services, about the limits to confidentiality. All confidentiality-related guidance should be consistent with federal, state, and local laws. These policies should:
 - a. Define how the law enforcement agency maintains confidentiality. Outline what services and service providers are considered confidential. Some service providers (e.g., mental health clinicians) are required by law to keep most information confidential, whereas this may not be the case for other supportive relationships (e.g., peer support relationships).
 - b. Describe the circumstances in which confidentiality should be expected.
 - c. Describe the circumstances under which confidentiality does not apply and with whom the information should be shared. This information should be informed by best practices, as well as any laws that dictate this

practice in the jurisdiction where the agency is located.

- d. Describe any potential consequences for a breach of confidentiality protocol.
- 2. Educate agency staff and families on confidentiality and its limits. Policies should clearly outline how agency personnel should respond if they become aware of a colleague at risk for suicide. This should include:
 - a. To whom and how to report this information.
 - b. A timeline for reporting this information.

RISK REDUCTION GUIDELINES

Agencies should have clear policies regarding what should be done to reduce the risk for an officer who is deemed to be at risk for suicide. These policies should include clear guidance regarding:

1. Who can make determinations about the removal of firearms from officers deemed to be a danger to themselves or others. Although supervisors and other staff may have to make emergency decisions about the temporary removal of firearms for the safety of officers they feel are at immediate risk, the decision to remove a firearm for a longer period of time should be made after a full assessment by a QMHP.
2. The circumstances that necessitate the temporary removal of a service weapon due to a suicidal crisis.
3. What should be done with service weapons that are removed from an officer's possession. (e.g., in the event that an officer is deemed to be at high risk of suicide, the department may arrange for the safe storage of their agency-issued firearm).
4. The requirements and process for the return of a service weapon. It is important to note that a psychological fitness for duty evaluation is a likely component of the eventual return of an officer's service weapon.

SUICIDE POSTVENTION

Following a death by suicide, comprehensive postvention support and services should be provided to officers and surviving family members. In addition to addressing the trauma that suicide can cause to family members, friends, and colleagues, the risk of additional suicides increases when someone dies by suicide. Thus, to support the health and safety of their officers and broader communities, agencies should develop policies that address suicide postvention.

SUPPORT

Agencies should adopt policies specifically detailing the roles of peer support, chaplains and religious or spiritual support, and support offered through other

employee resource programs (e.g., in-house mental health providers, EAP) in the aftermath of a death by suicide. Agencies should consider how long support can be accessed or provided by these roles and allow for flexibility and may wish to set minimum standards or lengths of time.

- I. When possible, postvention support should be available for up to one year following a death by suicide. Peer support and family support teams can play a critical role at this time in supporting officers and surviving family members. Additionally, these teams play crucial roles in recognizing and intervening if individuals need extra support. Agencies should have established relationships with one or more QMHP who treat first responders who can be a good resource for providing longer, ongoing support.
- II. Agencies should have a written list of resources for fellow officers and their family members detailing the types of support offered, how to access the support, when the support is available (e.g., 24/7), and any cost for services. This list should be ready to be disseminated in the event of a suicide. This is recommended in addition to a detailed listing and overview of programs that are likely already available at the agency level. When in crisis, people digest smaller pieces of information more quickly and a resource sheet of this nature would be helpful to ensure they get connected in a timely manner if they need assistance.

SCREENING DURING POSTVENTION EFFORTS

Officers can be at increased risk of suicide following the death by suicide of a colleague. Agencies should be concerned about preventing further deaths during this period of time. Although agencies may wish to focus on suicide prevention efforts following a death by suicide, it is not recommended that agencies take on widespread, general educational suicide prevention training at that time. *Postvention support should focus on recognizing warning signs.* Agencies should work with psychological services or mental health professionals to determine:

- i. A process for selecting and offering evidence-based training programming on recognizing the warning signs of suicide.
- ii. Prioritizing who gets this training first. Suggestions for how to prioritize groups is suggested below.
- iii. Timelines for training delivery roll-out and suggestions based on agency size for postvention efforts.
- iv. Timelines for training completion.

Agencies should adopt policies that focus on identifying signs of risk, processes for screening, referral, ongoing departmental support, and follow-up. Particular groups of officers may be at heightened risk after a suicide and agencies may wish to adopt policies that prioritize providing peer or other support to these groups, including triaging them in screening efforts:

- I. Those with a close connection to the officer (work/shift partner(s), close friends, supervisors).
- II. Individuals who see a part of themselves or their situation in the person who died by suicide.
 - a. Officers who have shared work experiences with the colleague who died may be at increased risk. For example, an officer who was in the same academy class with the officer who died by suicide, or an officer who was recently involved in a particular call or critical incident with the person who died by suicide.
 - b. Additionally, individuals dealing with similar life circumstances to the officer who died by suicide may be at increased risk. For example, another officer going through a marital separation may be particularly vulnerable if the decedent was also dealing with marital separation/concerns/divorce.
- III. Individuals who have recently (in the past 90 days) demonstrated suicide risk, communicated suicidal thinking, and/or struggled with significant mental health concerns.

FUNERALS AND HONORS

Plans and details for funerals, memorials, and anniversaries should be handled in consultation with the family of the officer. Agency policy should allow families who wish to be very involved in the planning and open about the cause of death, be involved to the extent they are comfortable. It is also important to respect families who do not want the department to be involved and prefer to have a private funeral and not discuss the cause of death.

- I. Agencies may wish to consider creating a small team or designate individuals to fulfill these roles to assist with postvention considerations of suicide deaths in advance of a death occurring. These individuals should receive training or special education from professionals in the field of suicidology that prepares them to work with family members in the aftermath of a suicide. As appropriate, it may be useful to consult with or add a cultural liaison to the team if there may be considerations specific to cultural matters of which the individuals assigned to these duties may need to be aware (for example, this may be the case for tribal law enforcement agencies).

- a. The suicide postvention team's role should include providing recommendations and determining how to balance and respect department policy while also providing consideration of the family's desires and wishes in the event of any conflicts.
- II. Agencies may wish to include officer death by suicide into their existing officer death policies. This may include a determination that an officer's suicide is considered a line of duty death. Flexibility is key and any officer death policy should allow for adaptability specific to the circumstances of each death. For example, policies should be flexible enough so that officers who die by suicide during the commission of a crime (murder-suicide) do not have to be treated in the same manner as other suicide deaths.
- a. By signing the Public Safety Support Act of 2022, Congress authorized The Public Safety Officers' Benefits Program (PSOB) to process claims for the families of LE suicide survivors. This update recognizes the impact of exposures to traumatic events to public safety officers and their mental health and well-being, including the consideration of claims for officer death (or catastrophic injury) due to suicide (or an attempt to die by suicide). This legislation aimed to remove the stigma associated with suicide death and better support families in need.
 - b. To help destigmatize suicide and mental health and assist in the psychological healing and support of surviving family, friends, and colleagues it is a recommended best practice in the field of suicidology to treat death by suicide no differently than a non-suicide death. Agency policies may wish to specifically dictate that the same rules and guidelines apply in the aftermath of mourning a law enforcement death by suicide including:
 - i. Use of leave to attend the funeral
 - ii. Attendance/remarks by Chief, command staff, government/elected officials, or other dignitaries
 - iii. Provision of family support
 - iv. Police escorts
 - v. Public memorials/viewings
 - vi. Flag positions and honors
 - vii. Financial decisions (who will pay for the funeral)

PUBLIC INFORMATION OFFICER (PIO) GUIDANCE AND PROTOCOL

Agencies should have a formal policy dictating how information is released both internally and externally in the aftermath of a law enforcement suicide. This should be largely guided by the preferences and wishes of the surviving family members, though agencies will certainly need to do a death notification to the rest of the department. At a minimum, the family of the deceased officer should be notified that the agency will be releasing information, and whenever possible, should be consulted prior to the agency confirming the death and the release of information.

1. Considerations for managing communication within the department:
 - a. Agency leadership should meet to determine how, when, and under what circumstances to release information internally. Ideally, this should be determined on a case-by-case basis and informed by the wishes of the surviving family members of the deceased officer.
 - b. Agencies may wish to consider who confirms the death with the department. For example, deciding if a PIO should make the notification or if the head of the agency handles the responsibility.
 - c. Another factor of consideration should be whether the agency sends out a message to other officers encouraging them to seek mental health resources and destigmatize the death.
 - i. All communications both internal and external regarding notifications of an officer suicide death should include suicide-specific resources for other officers and/or members of the public.
 - d. When notifying the agency about a suicide death in the department, agencies may wish to use the opportunity to remind officers about their department's social media policies. While tributes and memories shared about colleagues are appropriate, officers should be cognizant of the fact that social media posts may be seen by surviving family members or the media and therefore should exercise caution when posting about a suicide death.
 - i. For internal communications, information regarding the agency's EAP and other mental health supports should be provided. This should be in addition to national suicide prevention resources such as the Suicide Prevention Lifeline and other law enforcement specific suicide prevention resources.

1. This information should specify hours available (in the event that a resource is not available 24/7) and include all information needed to access the resource (e.g., any special log-in information for EAPs).
 2. Any resources that are anonymous should be highlighted as such.
- e. Agencies should follow safe suicide messaging guidelines and incorporate those into their policies. More detailed information regarding safe messaging guidelines can be found in the [Messaging About Suicide Prevention in Law Enforcement resource](#).
- f. Notes or other forms of communication left by officers who die by suicide should be treated with the strictest confidentiality procedures and may be subject to rules of evidence. Information contained in suicidal communications should not be confirmed internally or externally by the department.

WHEN A SUICIDE DEATH OCCURS AT THE DEPARTMENT OR WHILE ON DUTY

The death by suicide of a colleague may influence many people within a law enforcement agency, but extra precautions should be considered for those within the agency who witness the death, are exposed to the death scene, or are involved in the death investigation. Agency policies should specifically acknowledge these groups of individuals and consider what extra support they may be able to provide to the officers who fall into those categories, such as:

- **Time off from work**
- **Providing peer support**
- **Group counseling or debriefings**
- **Access/referral to a licensed mental health professional or chaplain**

Agencies should understand that individuals who fall into these groups may have immediate and/or longer term needs for mental health support, which should be reflected in their policies. Additionally, the policies should outline the signs of acute trauma and suicide risk so that supervisors and colleagues can recognize and intervene if an officer appears to be struggling.

Agencies may especially want to mitigate the impact on those officers who may have been exposed to the scene of that death and should encourage supervisors and command staff to be cognizant of temporary accommodations that may be needed. Agency policies should be trauma-informed and allow for flexibility to respond to the unique considerations of each situation when possible. For example, if an officer dies by suicide in the parking lot of a police station, agencies should be creative in considering alternate parking locations for other officers, particularly in the recent aftermath of the incident.

It is hoped that SOPs and policies around law enforcement suicide will never need to be used. The ultimate goal is to create a strong culture that reduces the risk of law enforcement suicides. Should an agency experience the tragedy of an officer or non-sworn suicide, having SOPs and policies in place will assist with implementing appropriate postvention procedures and understanding how to minimize suicide contagion.

SUICIDE POSTVENTION DATA COLLECTION

It is important to collect law enforcement suicide data to help agencies better understand and prevent suicide amount law enforcement officers. The Federal Bureau of Investigation has been statutorily tasked with collecting information on law enforcement suicide deaths and attempts through the creation of the Law Enforcement Suicide Data Collection (LESDC).^{xi} Submissions to the LESDC must be done by the officer's law enforcement agency and agencies should develop protocols around how to collect this information, who will be designated to collect and transmit this data, and appropriate protocols to follow for confidentiality purposes.

The adoption of official guidance or policy around suicide prevention, intervention, and postvention for law enforcement agencies is a vital step forward in supporting officer safety and wellness. This document addresses many of the elements that agencies should consider, but not all. Agencies may require consultation or additional assistance to accomplish comprehensive implementation of suicide prevention resources and programs. Technical assistance services for implementation are available through the Suicide Prevention, Intervention, and Postvention Resource Webpage: <https://www.theiacp.org/resources/national-consortium-on-preventing-law-enforcement-suicide-resource-webpage>.

RESOURCES

- i. For more resources please visit <https://www.theiacp.org/projects/the-national-consortium-on-preventing-law-enforcement-suicide>
- ii. National Suicide Prevention Lifeline. Policy for Helping Callers at Imminent Risk for Suicide. (2010). <https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Lifeline-Policy-for-Helping-Callers-at-Imminent-Risk-of-Suicide.pdf>
- iii. International Association of Chiefs of Police. Employee Mental Health and Wellness (2020). <https://www.theiacp.org/sites/default/files/2020-05/Employee%20Mental%20Health%2005-06-2020.pdf>
- iv. Suicide Prevention Resource Center. Suicide Screening and Assessment (2014). https://www.sprc.org/sites/default/files/migrate/library/RS_suicide%20screening_91814%20final.pdf
- v. National Consortium on Preventing Law Enforcement Suicide. After a Suicide in Blue. https://www.theiacp.org/sites/default/files/2021-04/244736_IACP_NOSI_AfterSuicide_p5.pdf
- vi. Suicide Prevention Resource Center. Suicide Screening and Assessment (2014). https://www.sprc.org/sites/default/files/migrate/library/RS_suicide%20screening_91814%20final.pdf
- vii. For more information see A Comprehensive Framework for Law Enforcement Suicide Prevention. https://www.theiacp.org/sites/default/files/2021-09/_NOSI_Framework_Final%20Copy%2001.pdf
- viii. For more information, please see the International Association of Chiefs of Police Employee Mental Health and Wellness Guide. <https://www.theiacp.org/resources/policy-center-resource/employee-mental-health-and-wellness>
- ix. See Choosing a Suicide Prevention Gatekeeper Training Program – A Comparison Table. (2018) Suicide Prevention Resource Center. https://sprc.org/sites/default/files/resource-program/GatekeeperMatrix6-21-18_0.pdf
- x. See the International Association of Chiefs of Police Peer Support Guidelines <https://www.theiacp.org/resources/peer-support-guidelines> and the National Consortium on Preventing Law Enforcement Suicide's Peer Support as a Powerful Tool in Law Enforcement Suicide Prevention https://www.theiacp.org/sites/default/files/2020-10/244736_IACP_NOSI_PeerSupport_p5.pdf
- xi. Federal Bureau of Investigation. Law Enforcement Suicide Data Collection Act <https://www.fbi.gov/services/cjis/ucr/law-enforcement-suicide-data-collection>

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