

# Suicide by Cop

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# Overview

1. Suicide by Cop – by the numbers
2. Motivation
3. Verbal, Behavioral, and Contextual Signs
4. Engagement Strategies with the Suicidal Individual

# Suicide by Cop (SbC)

- Definition

1. The individual engages in behavior that poses an apparent risk of serious injury or death
2. Intent = to precipitate the use of deadly force by law enforcement against the individual

- Frequency

1. Varies somewhat from study to study
2. Most recent estimate (Mohandie et al., 2009) = **36%** of officer-involved shootings (OIS); goes up to **41%** if include completed suicides during SbC incidents

# LA County Sheriff's Department 1987-1997

- 96% male
- 18-54 years old
- 46% had a firearm; 46% had a stabbing instrument  
8% had replica
- 58% asked police to kill them
- 58% had psychiatric history
- 38% had previous suicide attempt
- 50% were intoxicated
- 42% had DV history
- 38% had legal history

# Charlotte, North Carolina 1992-1997

- 94% male
- 63% had firearm; 24% had knife, 3 other objects, 3 unarmed
- Over half were intoxicated
- 45% had family/relationship problems
- 46% were precipitated by a domestic dispute
- 2/3 were not planned

# Oregon & Florida 1998

- All except one were male
- All were armed and 60% used their weapon
- 40% were intoxicated
- 50% had previous suicide attempt
- 40% had mental health history (60% had symptoms of depression)

# SbC – Hostage & Barricade Situations

(Mohandie & Meloy, 2010)

- 84 hostage, barricade, & jumper cases reviewed
- 66% later determined to be SbC, 2x the likelihood in the overall sample
- Survival rate = 33%, compared to 61% in OIS
- Some suicidal individuals will hurt or kill others in their quest to provoke deadly force against them

# Suicide by Cop (Mohandie et al., 2009)

- Summary Characteristics of SbC Subjects:
  1. Average age = 36
  2. Overwhelming majority (**95%**) = male
  3. **62%** had known or probable mental health history
  4. **80%** armed during incident
    - ✓ **60%** had a firearm (**86%** = loaded & operational)
    - ✓ **19%** = feigned or simulated weapons



# Suicide by Cop - Incident Context

1. **51%** killed during SbC encounter
2. Law enforcement killed in **1%** of cases, injured in **16%** of cases
3. **81%** of incidents unplanned & spontaneous
4. Most common police service call type = domestic violence or family disturbance (**15%**)
5. **87%** exhibited suicidal communication before or during incident
6. **95%** = non-complaint with law enforcement commands
7. **36%** = under the influence of alcohol

# SbC vs. OIS (Officer Involved Shooting)

## SbC more likely to

1. Exhibit verbal and behavioral threats to harm others
2. Exhibit psychotic symptoms
3. Die or be injured during the incident (97%)

## OIS MORE likely to

1. Flee from law enforcement
2. Exhibit consistent escape behavior
3. To be armed during the encounter

# SbC Risk Factors

- Types of SbC Risk Factors
  1. Verbal clues
  2. Behavioral clues
  3. Contextual clues
- Current state of the research does not allow for specific predictions or precise probabilities
- Each situation must account for its unique blend of factors

# Verbal Clues to SbC Risk

1. Demands that authorities kill him/her
2. Sets a deadline for authorities to kill him/her
3. Threats to kill/harm others
4. Says wants to go out in a “blaze of glory” or “won’t be taken alive.”
5. Gives a “verbal will”
6. Tells hostages he/she wants to die
7. Looking for a “macho” way out
8. Offers to surrender to the authority in charge
9. Elaborate plans for own death
10. Expresses hopelessness and/or helplessness
11. Emphatic that “jail not an option”
12. Biblical references (e.g., Book of Revelation, resurrection)

# Behavioral Clues to SbC Risk

1. Demonstrative with weapon
2. Points weapon at police
3. Clears a threshold to fire a weapon
4. Shoots at police
5. Reaches for weapon with police present
6. Attaches weapon to body
7. Countdown to kill hostages or others with police present
8. Harming hostages with police present
9. Forces confrontation with police
10. Advances when told to stop
11. Suspect = the one who called police

# Behavioral Clues to SbC Risk

12. Continues hopeless acts of aggression even after incapacitation by gunfire

13. Self-mutilation with police present

14. Pointing weapon at self when police present

15. Refuses to negotiate

16. No escape demands

17. No demands

18. Inducing “chemical courage” via intoxication

# Contextual/Situational Clues to SbC Risk

1. Recently killed a loved one or pet
2. Recently gave away money/possessions
3. Recently diagnosed with serious medical condition or life threatening illness
4. Recently experienced a traumatic loss/life event (e.g., death of a loved one, divorce, loss of job, etc.)
5. Recently committed a crime

# SbC – Operational Consequences

(Mohandie, personal communication, 2011)

- While many suicidal individuals who provoke police shootings will not necessarily respond to intervention, some will
- The intervener needs to know that s/he may not be receptive to intervention because the subject is not looking at the officer as a resource for help, but as a tool for his/her demise
- Exercise great caution, as suicidal individuals in this context can be and often are dangerous to others
- *Suicide - a response to intolerable and inescapable pain*



# Motives for SbC

- Motives for any type of suicide
  - ✓ Feelings of hopelessness, helplessness, desperation, anger, or revenge
  - ✓ End intolerable emotional “pain”
- Motives specific to SbC
  - ✓ Belief that suicide indicates weakness
  - ✓ Religious beliefs forbidding suicide
  - ✓ Practical issues (e.g., life insurance, shame to family/loved ones, pain, possible failure)

# Operational Tips

- Obtain background information on subject
  - ✓ Contextual clues
- Pay attention to clues about
  - ✓ Intent, plan, means
- Identify the problem
  - ✓ instrumental or expressive

# SbC: The Aftermath

- Common emotional reactions can include:
  - ✓ Guilt
  - ✓ Anxiety
  - ✓ Memory problems
  - ✓ Lowered self esteem
  - ✓ Disruption in appetite
  - ✓ Nightmares
  - ✓ Hypersensitivity/Hypervigilance
  - ✓ Anger
  - ✓ Sleeplessness
  - ✓ Depression

# SbC: The Aftermath

- In many instances, the timing, speed at which the encounter escalated and officer's perception of immediate danger to self or others left him or her with no choice but to use deadly force
- Second guessing on the part of the officer is common

# Self-Care

- Police officers have a suicide rate twice that of the general public
- Police officers die by suicide twice as often as being killed in the line of duty
- Police culture and job stress can pose obstacles that make it difficult for officers to seek help for depression
- Learn about depression and suicidal thinking so that you can get the help you need if you begin to think about suicide

# Self-Care

- Understand that you are facing physical changes in your brain, not weakness on your part
- Stress creates changes in the brain that cause people to feel suicidal, so be aware of the risk you run in this highly stressful job, and find ways to decompress that are healthy
- See the National Police Suicide Foundation ([www.psf.org](http://www.psf.org)) for more information on setting up a suicide prevention program for your department

**SUICIDE**

# Suicide

(Kingshott, 2009)

- Suicidal individuals commonly fall into one of the following types:
  1. A Cry for Help - does not plan to complete suicide
  2. Single Minded/Self - plans to complete suicide and will hurt those who interfere with their plan
  3. Single Minded/Other – plans to complete suicide but only with the help of others
  4. Insecure /Ambivalent – can be convinced to consider alternatives



# Assessing Suicide Risk

- ***Intent***
  - ✓ Goal of death or ambivalent
- ***Plan***
  - ✓ Vague or specific
- ***Means***
  - ✓ Low or high availability
  - ✓ Low or high lethality

# Engaging with Someone Who May be Suicidal

# Symptoms that Interfere with Law Enforcement Commands

- **Ability to respond can be affected by:**
  - ✓ Difficulty attending to, thinking, and remembering
  - ✓ Physical slowing or agitation
  - ✓ In extreme cases, the person may be psychotic (i.e., out of touch with reality)
  - ✓ ***Self-medication:*** Individuals with severe mood or thought disorder may self-medicate with alcohol or illicit drugs in an attempt to feel better
  - ✓ Substance abuse will worsen the above symptoms and make a person more prone to suicide by increasing impulsivity and decreasing judgment

# Suicide: Select Myths and Facts

(AFSP website, 2013)

## 1. Talking about suicide might cause a person to act

- ✓ False – it is helpful to show the person you take them seriously and you care. Most feel relieved at the chance to talk

## 2. People who take their own life are selfish, cowards, weak or are just “looking for attention.”

- ✓ False – More than 90% of people who take their own life have at least one and often more than one treatable mental illness such as depression, anxiety, bipolar disorder, schizophrenia and/or alcohol and substance abuse. Even if you think they are just “crying for help” - a cry for help is a cry for help - so help.

# Trauma Informed Engagement

- Most individuals seeking public behavioral health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences.
- These histories can have a big impact on how someone responds to engagement efforts.

# Trauma Informed Engagement Tips

- What not to say
  - ✓ *“What’s your problem?”*
  - ✓ *“What’s wrong with you?”*
- What to say
  - ✓ *“What happened to you?”*

# Helpful Engagement Tips

1. How would I feel if that were happening to me?
  - **Case example: Satan's bride**
2. An ounce of empathy...
3. What have you done/going to do about that?
  - **Case example: Grandma and the 12 gauge**

# Approaching a Suicidal Person

(Woody, 2003)

- FBI studies have shown that an officer who lets his or her guard down and appears “weak” is more likely to get injured or killed
- Some officers believe that hardnosed command-type vernacular is correct in all situations
- **Officer safety comes first, but...**
- Commands can be less effective when trying to deal with someone in a suicidal crisis



# Approaching a Suicidal Person

(Woody, 2003)

- A person with mental illness in a suicidal crisis responds better to a calm, understanding tone of voice
- The uniform can be very frightening to people in suicidal crisis, and it becomes worse when an officer commands a person hearing voices to “*stop and desist.*” This is not a suggestion to let down your guard
- A wise officer can camouflage his/her “action ready” status in such situations

# Steps to Take in Addressing a Mental Health Crisis/Suicidal Crisis (Anderson, 2008)

1. Get collateral information and cooperation on safety issues if possible
  - a. Check safety concerns with family/friends at the scene, get their cooperation
  - b. Ask about history of suicide attempts
  - c. If some in attendance are not taking the suicide threat seriously, assure them it cannot be ignored

# Addressing a Mental Health Crisis/Suicidal Crisis

2. If no immediate danger: **talk to the person in crisis**
  - a. If there is no obvious or immediate danger, use a calm non-confrontational approach in voice and body language
  - b. Move slowly and casually and make normal eye contact
  - c. Allow space and time for panic, fear, anger, grief or other emotions to cool

# Addressing a Mental Health Crisis/Suicidal Crisis

2. If no immediate danger: talk, cont'd
  - d. If person is highly agitated or threatening, say something like, *“We need to talk about your troubles and make sure you are safe. Let's just sit down and talk.”*
  - e. Do not use a confrontational posture
  - f. The suicidal person needs to feel non-threatened before he/she can hear offers of help

# Addressing a Mental Health Crisis/Suicidal Crisis

- Use first names and speak slowly: *"Bob, I'm a police officer. My name is Liz. Don't be afraid of us. We are here to help you. Are you able to understand me?"*
- Wait for answer and explain: *"We need to make sure you are safe."*
- Wait for an answer. *"I understand if you are feeling a lot of emotional pain and maybe it's difficult to talk. Can you tell me what's troubling you, so we can help?"*
- Wait for an answer. If the person is unable to respond coherently to such questions, medical attention may be urgently needed

# Addressing a Mental Health Crisis/Suicidal Crisis

3. Establish safety and control, removing weapons, pills
  - ✓ **If the person is responsive,** *"Bob, how can I help? Do you want to tell me about the thoughts you're having right now?"*
  - ✓ **Make sure no medications can be accessed.** Don't leave the suicidal person alone or with any pills until a hospital assumes care
  - ✓ **If you decide to bring the person in:** *"We need to get you some help and medical attention. We need to work together to make sure you are safe, OK? Nothing dangerous should be near you right now (such as pills, weapons or potential weapons, car keys). Anything like that, we need to secure them so you won't be harmed."*

# If You Write a Pink Slip on Criterion #1

- Represents a **substantial risk of physical harm to self** as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
- **Translated into English =**

# Addressing a Mental Health Crisis/Suicidal Crisis

## 4. Be non-judgmental

- ✓ Helps establish & maintain rapport and trust
- ✓ Show empathy for how the person feels
- ✓ Engage the person and work together
- ✓ Keep your remarks short and simple. Listen attentively
- ✓ Show that you are listening to the person's views and concerns (even if you don't agree with them)

(Justice Institute of BC, 2005)



# Addressing a Mental Health Crisis/Suicidal Crisis

## 5. Positive steps & problem-solving

- ✓ *"What would make it easier for you to cope with your problems?"* Wait for answers
- ✓ *"Problems can be solved. We will get help for you. What is the biggest problem that is overwhelming you right now?"*
- ✓ Get an immediate commitment from trusted family members/friends to work on helping with that problem if possible
- ✓ Have them agree to make arrangements for referral to the support system - mental health center caseworker, clergy, advocacy group

# Addressing a Mental Health Crisis/Suicidal Crisis

6. Abrupt suicidal behavior and the use of force
  - ✓ The unexpected can always happen: an interruption of carefully built rapport, a topic that touches a raw nerve, and the person may abruptly make a suicide attempt
  - ✓ It may be risky but the only choice is rapid physical response to interrupt the act

# Addressing a Mental Health Crisis/Suicidal Crisis

## 7. Medication

- ✓ Ask the suicidal person about medication (possible overdose or stopped taking meds)
- ✓ Ask one simple question at a time: *"Are you on any medication or other treatment? What is it? Are you forgetful about taking it? How many taken in last 24 hours? Do you have your medication with you? Where is it?"*
- ✓ Have someone bring it to you
- ✓ Make sure the medication accompanies the person to hospital/crisis center (in your possession or with ambulance driver)

**FOR THE NON-CLINICIAN:  
NOW WHAT?**

# Now What?

- How do I remember all this?  
✓ **SLAPPS**
- What do I do?  
✓ **QPR**

# SLAPPS

- **S**pecifics of Plan
- **L**ethality of Means
- **A**ccessibility of Means
- **P**roximity of Rescue
- **P**revious Attempts
- **S**ubstance Abuse

# QPR

- **Question, Persuade, Refer**
- Not counseling or treatment
- Offers hope and/or protection
  
- ***Ask a question, save a life***
- Most suicidal people communicate their intent sometime during the week before an attempt
- Asking the question is more important than how you ask, ***but***
- Be direct: ***“Are you thinking about killing yourself?”***

# How NOT to Ask the Suicide Question

- “You’re not suicidal, are you?”



# Persuade

- Listen to the person describe the problem
- Do not rush to judgment – what seems like a molehill to you may be a mountain to the suicidal person
- Suicide is not the root problem – it is a desperate solution to a situation seen as painful, intolerable and inescapable
- Be directive – *“I’d like you to come with me.”*

# Refer

- Suicidal people usually believe they can't be helped
- Refer = taking the suicidal person directly to someone who can help
- In a law enforcement context, “refer” means taking the person into custody and bringing him/her to a hospital or crisis center
- You are not responsible for crisis counseling

# Addressing a Mental Health Crisis/Suicidal Crisis

- To Hospital/Crisis Center:
  - ✓ *"Now we need to get help for you, some medical attention and support. It's for your personal health and safety. OK, let's go. Someone can come with you and be in the waiting room."*
- If hospital attention is not indicated
  - ✓ Suggest that the person get some follow-up care
  - ✓ Get agreement for trusted family member or friend to be involved in the follow-up, and to ensure person is not left alone

# Permanent Solution-Temporary Problem

- Depression interferes with the ability to think clearly. A depressed person cannot think clearly about right or wrong, cannot think logically about their value to friends and family, cannot realistically evaluate problems
- Would you try CPR if you saw a heart attack victim?
- Don't be afraid to try QPR when someone is dying more slowly of depression
- Depression is a treatable disorder, and suicide is a preventable death

# Resources

## **The Ohio Suicide Prevention Foundation**

2323 West Fifth Ave - Suite 160

Columbus, OH 43204

614-429-1528

<http://www.ohiospf.org/>

## **The Suicide Prevention Resource Center**

<http://www.sprc.org/>

**QUESTIONS?**

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