Standardized Curriculum for the B10 Suicide Core Training Course

International Conference of Police Chaplains
2010

INTERNATIONAL CONFERENCE OF POLICE CHAPLAINS
STANDARD LESSON OUTLINE AND LESSON PLAN

Course Title: Suicide **Course Number:** B-10

Course Level: Basic **Class Time:** 1.5 Hours

Training Objectives:

*The goals of instruction in the **B10 Suicide Core Training Course** are to provide the student with:*

- A general understanding of suicide including factual information relative to suicides;
- An understanding of how depression is related to suicide;
- An understanding of how substance abuse is related to suicide;
- Signs/intervention for suicide prevention;
- Tools for responding to scenes of suicide threat or completion;
- An overview of police suicides;
- Information regarding aftermath issues;
- General chaplain health and wellness and
- Resources

Method: Small group exercises/discussion/scenarios, role play, handouts/articles, peer-to-peer learning, interactive teaching.

Summary: For students/participants to have a general understanding of suicide (and related issues), prevention/response actions with special focus to prevention of police suicides and self care for Chaplains.

Handouts:

- *2008 Police Suicides*
- *Family Survivors of Police Suicide*
- *Pain Behind the Badge*
- *Police Suicide: An Executive Perspective*
- *Youth Suicide Prevention Fact Sheet*

Resources:

- Grieving a Suicide: A Loved One's Search for Comfort, Answers & Hope by Albert Y. Hsu
- Ripples of Suicide: Reasons for Living by Harold Elliott

- Rolling Back-Up/In Harm's Way Video (LASD)
- The Empty Chair: The Journey of Grief After Suicide by Beryl S. Glover &
- Glenda Stansbury
- The Pain Behind Badge (http://www.100wattproductions.com/clips/ThePain/Pain.htm)

Training Aids:

- QPR (Question, Persuade, Refer)/Dr. Paul Quinnett
- Role play/exam

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Lesson Outline

I. Facts about SUICIDE
- A. Is suicide a problem?
- B. Why do people commit suicide?
- C. Is there a particular kind of person who is most prone to suicide?
- D. What are the causes of suicide?

Myths about SUICIDE

II. Depression and SUICIDE
- A. Definition of a person in depression
- B. Clinical depression vs. "blue mood"
- C. Types of depression
  1. Major depressive disorders
  2. Bipolar disorders or manic–depressive disorder
  3. Dysthymia
- D. Symptoms of clinical depression
- E. Depression relative to suicide

III. Substance Abuse and SUICIDE

IV. SUICIDE INTERVENTION

Warning signs

At risk individuals vs. intervention

V. Responding to the scene of a SUICIDE

VI. Police Officer Suicide
- A. Twice any many die by their own hand each year than are killed in the line of duty
- B. Underreported or misclassified
- C. Warnings/ Triggers in police suicides
- D. Coping strategies for suicide prevention
- E. When a suicide occurs; ***Remember a person for how they lived not how they died.***
  1. Debriefing
  2. Funeral
  3. Surviving family

VII. Aftermath Issues

VIII. Chaplain Health and Wellness

IX. Resources

Role play exercise/exam

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Detailed Lesson Plan

- **Introductions**
- **Overview of workshop**
- **Expectations for today's workshop (on board)**
- **Outline**
- **Ask questions/contribute as we go**

I. Facts about SUICIDE

A. Is suicide a problem?

Over 34,000 people kill themselves each year. Many suicides are not reported. Death rates could be as high as 100,000 each year. There are more than 5 million attempts each year and over 500,000 people commit suicide each year worldwide.

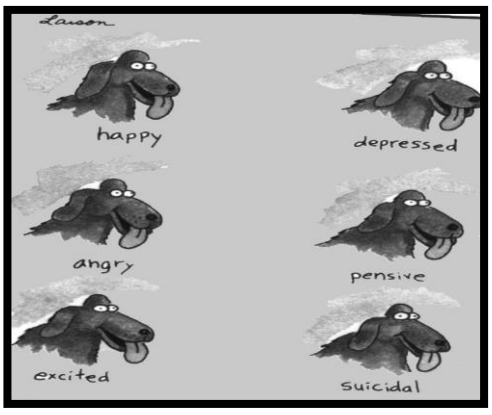
Have group share re: experience with suicidal person or person who committed suicide. What made that death different? What was the impact?

The difference between death vs. suicide *(surprise, feel robbed, shame, unfinished business, media, violent death scene, blame and unanswered questions, stigma in grief)*

Suicide: Often Worse Than a Line of Duty Death *Dennis Conroy, PhD*

- Lack of specific focus for anger
- Confusion caused by lack of protocol
- Suicide fragments a department
- Individual moral/religious values come into play
- Mental health of some employees are effected
- Relationship of the deceased with surviving employees.
- Where and how the suicide was committed

Often times, management or society is blamed!



Approximately 80 percent of suicides have communicated their intent
(John Violanti "Police Suicide: Epidemic in Blue") – What do you look for?

B. Why do people commit suicide?

- 10% for no apparent reason
- 25% are classified as mentally unstable
- 40% commit suicide on impulse, for relief of pain or for revenge
- 25% commit suicide after weighing the pros and cons of living and dying

People want to stop the pain.

It is a bout a loss of HOPE or perceived loss of HOPE. *(A sense of aloneness makes us target for wrong thinking, what I think/cognitive vs. what I believe/emotional, value/purpose)*

C. Is there a particular kind of person who is most prone to suicide?

- Dependent, dissatisfied, who continually makes demands, complains, controls
- Inflexible, inadaptable, who alienate others with his demands
- Low feelings of self-esteem who needs constant reassurance of self-worth
- Most at risk—white male, 45 years or older, divorced or alone, alcohol problem, without job or profession.

Children are 2 times as likely to commit suicide if their parent committed suicide. Single never married are 2 times more likely. Male officers are far more likely than female and married with small children have the lowest rate. Men 4x as likely to commit suicide – 73% of suicides are white males. Women more attempts. 10-35% leave a note. Over 90% of those who die by suicide have mental illness at time of death. According to Suicide Prevention Center: July/August highest rate of suicide, Saturday has fewest suicides, Wednesday the highest.

D. What are the causes of suicide?

In small groups discuss causes of suicide and types/methods of suicide.

Myths about SUICIDE

A. Myth: Suicidal people are fully intent on dying.
Fact: Most suicidal people are undecided about living or dying, leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling. Often this "cry for help" is given in code.

B. Myth: Suicide strikes more often among the rich, or conversely, occurs more frequently among the poor.
Fact: Suicide is neither a rich man's disease nor a poor man's curse. It is common through all levels of society.

C. Myth: Suicide is inherited and "runs in a family".
Fact: Suicide does not run in families. It is an individual matter and can be prevented. However, the suicide of a family member can have a profound influence on others in the family.

D. Myth: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.
Fact: Although extremely unhappy, they are not necessarily mentally ill. Their overpowering unhappiness may result from a temporary emotional upset, a long and painful illness, or a complete loss of hope.

E. Myth: People who talk about suicide don't do it.
*Fact: Out of 10 people who kill themselves, 8 have given definite clues to their intentions. Suicide threats **must** be taken seriously.*

F. Myth: Once a person is suicidal he is suicidal forever.
Fact: Happily, individuals who want to kill themselves are "suicidal" for only a limited time. If saved from self-destruction, they can go on to lead useful lives.

G. Myth: Suicide happens without warning.
Fact: Research shows that the suicidal person gives many clues and warnings. Recognize these cries for help can cave a life.

H. Myth: Improvement following a suicidal crisis means that the suicidal risk is over.
Fact: Most suicides occur within 3 months following the beginning of "improvement" - when the individual has the energy to put his morbid thoughts and feelings into action. Relatives and physicians should be especially vigilant during this period.

II. Depression and SUICIDE

According to the World Health Organization:

- Depression will be the #2 illness by 2020!
- Depression is common, affecting about 121 million people worldwide.
- Depression is among the leading causes of disability worldwide.
- Depression can be reliably diagnosed and treated in primary care.
- Fewer than 25 % of those affected have access to effective treatments.

Depression is the common cold of emotions. Depression is part of God's design as it allows us to deal with losses. Depression can be a healthy response and healing emotion. Depression is a warning sign for us to slow down or to pay attention to what is going on.

A. Definition of a person in depression
A person that exhibits symptoms that interfere with normal functioning--Including sleep,
appetite, and the capacity for work and social relationships.

B. Clinical depression vs. "blue mood" (normal rhythms of life)

C. Types of depression

1. Major depressive disorders: Major depressive disorder is also known as major depression, clinical depression, or unipolar depression. The term **unipolar** refers to the presence of one pole, or one extreme of mood- depressed mood. This may be compared with bipolar depression which has the two poles of depressed mood and mania (i.e., euphoria, heightened emotion and activity).

Different people are affected in different ways by major depression. Some people have trouble sleeping, they lose weight, and they generally feel agitated and irritable. Others may sleep and eat too much and continuously feel worthless and guilty. Still others can function reasonably well at work and put on a "happy face" in front of others, while deep down they feel quite depressed and disinterested in life. There is no one way that people look and behave when they have major depression. However, most people will either have depressed mood or a general loss of interest in activities they once enjoyed, or a combination of both. In addition they will have other physical and mental symptoms that may include fatigue, difficulty with concentration and memory, feelings of hopelessness and helplessness, headaches, body aches, and thoughts of suicide.

It has been shown that other mental health conditions may often co-exist with major depressive disorder. Some of these are alcohol/drug abuse, anxiety and panic disorders, obsessive-compulsive disorder, eating disorders, and borderline personality disorder. Major depressive disorder should be taken very seriously since up to 15% of those with this condition die by suicide.

2. Bipolar disorders or **manic–depressive disorder** (also referred to a bipolarism or manic
depression) is a psychiatric diagnosis that describes a category of mood disorders defined by the presence of one or more episodes of abnormally elevated mood clinically referred to as mania or, if milder, hypomania. Individuals who experience manic episodes also commonly experience depressive episodes or symptoms, or mixed episodes in which features of both mania and depression are present at the same time. These episodes are usually separated by periods of "normal" mood, but in some individuals, depression and mania may rapidly alternate, known as rapid cycling. Extreme manic episodes can sometimes lead to psychotic symptoms such as delusions and hallucinations. The disorder has been subdivided into bipolar I, bipolar II, cyclothymia, and other types, based on the nature and severity of mood episodes experienced; the range is often described as the bipolar spectrum.

Signs and symptoms:

Bipolar disorder is a condition in which people experience abnormally elevated (manic or hypomanic) and abnormally depressed states for a period of time in a way that interferes with functioning. Bipolar disorder has been estimated to afflict more than 5 million Americans—about 1 out of every 45 adults. It is equally prevalent in men and women, and is found across all cultures and ethnic groups…everyone's symptoms are the same, and there is no blood test to confirm the disorder. Researchers postulate that bipolar disorder may be caused by chemical imbalances in the brain. Bipolar disorder can appear to be unipolar depression. Diagnosing bipolar disorder is often difficult, even for mental health professionals. What distinguishes bipolar disorder from unipolar depression is that the affected person experiences states of mania and depression. Often bipolar is inconsistent among patients because some people feel depressed more often than not and experience little mania whereas others experience predominantly manic symptoms.

Depressive episode:

Signs and symptoms of the depressive phase of bipolar disorder include persistent feelings of sadness, anxiety, guilt, anger, isolation, or hopelessness; disturbances in sleep and appetite; fatigue and loss of interest in usually enjoyable activities; problems concentrating; loneliness, self-loathing, apathy or indifference; depersonalization; loss of interest in sexual activity; shyness or social anxiety; irritability, chronic pain (with or without a known cause); lack of motivation; and morbid suicidal ideation. In severe cases, the individual may become psychotic, a condition also known as severe bipolar depression with psychotic features.

Manic episode: Mania is generally characterized by a distinct period of an elevated, expansive, or irritable mood state. People commonly experience an increase in energy and a decreased need for sleep. A person's speech may be pressured, with thoughts experienced as racing. Attention span is low and a person in a manic state may be easily distracted. Judgment may become impaired; sufferers may go on spending sprees or engage in behavior that is quite abnormal for them. They may indulge in substance abuse, particularly alcohol or other depressants, cocaine or other stimulants, or sleeping pills. Their behavior may become aggressive, intolerant or intrusive. People may feel out of control or unstoppable. People may feel they have been "chosen," are "on a special mission," or other grandiose or delusional ideas. Sexual drive may increase. At more extreme phases of bipolar I, a person in a manic state can begin to experience psychosis, or a break with reality, where thinking is affected along with mood. Many people in a manic state experience severe anxiety and are very irritable (to the point of rage), while others are euphoric and grandiose.

Hypomanic episode: Hypomania is generally a mild to moderate level of mania, characterized by optimism, pressure of speech and activity, and decreased need for sleep. Some people have increased creativity while others demonstrate poor judgment and irritability. Others experience hypersexuality. These persons generally have increased energy and tend to become more active than usual. They do not, however, have delusions or hallucinations. Hypomania can be difficult to diagnose because it may masquerade as mere happiness, though it carries the same risks as mania. Hypomania may feel good to the person who experiences it. Thus, even when family and friends learn to recognize the mood swings, the individual often will deny that anything is wrong.

Mixed affective episode: In the context of bipolar disorder, a mixed state is a condition during which symptoms of mania and clinical depression occur simultaneously (for example, agitation, anxiety, aggressiveness or belligerence, confusion, fatigue, impulsiveness, insomnia, irritability, morbid and/or suicidal ideation, panic, paranoia, persecutory delusions, pressured speech, racing thoughts, restlessness, and rage).

3. Dysthymia is a chronic type of depression in which a person's moods are regularly low. However, it is not as extreme as other types of depression. The main symptom of dysthymia is low, dark, or sad mood nearly every day for at least 2 years. The symptoms are less severe than in patients with major depression, but people with this condition can still struggle with:

- Feelings of hopelessness
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Poor appetite or overeating
- Poor concentration

The exact cause of dysthymia is unknown. *As with major depressive disorder, dysthymia occurs more women in women than in men and affects up to 5% of the general population (probably a high percentage). Dysthymia can occur alone, or together with more severe depression or another mood or psychiatric disorder.*

D. Symptoms of clinical depression:

A major depressive episode is present if five or more of the following nine symptoms are present during the same two-week period. At least one of the five symptoms must be either a depressed mood or loss of interest or pleasure.

- Feeling sad, anxious or helpless
- Feeling worthless or guilty
- Changes in appetite or weight
- Thoughts of death, morbidity or suicide
- Psychomotor retardation or agitation
- Trouble concentrating, remembering or making decisions
- Trouble sleeping or sleeping to long
- Loss of interest in things you used to enjoy
- Loss of energy or feeling tired all the time

E. Depression relative to suicide

III. Substance Abuse and SUICIDE

A. Alcohol is a factor in high percentage of suicides: risk of suicide in alcoholics is 50-70% higher than general population.

B. Drugs/alcohol have a disinhibitory effect (takes away impulse control).

C. Drugs/alcohol change our perception and our ability to deal with those perceptions.

D. Drug/alcohol users are at greater risk of committing suicide.

IV. SUICIDE INTERVENTION

Early Warning Signs of Suicidal Ideation/ 28 warning signs that can be used to help those possibly contemplating suicide:

1. For some time he/she has been depressed, not himself, he/she does not have any energy or motivation.
2. He/she is no longer involved in sports and pays no attention to his/her physical attention.
3. He/she is introverted, withdrawn, solitary, shy and even awkward, he/she does not have much to say anymore or says nothing at all, he/she does not confide in anyone.
4. He/she is an alcoholic or is turning more to alcohol.
5. He/she is given to having accidents with his/her personal car and his/her service vehicle.
6. He/she is anxious, anguished.
7. He/she looks very tired or is suffering from overwork.
8. He/she has told others about his/her thoughts of suicide.
9. He/she uses tranquilizers.
10. He/she is emotionally unstable.
11. He/she is having trouble concentrating and often hurts himself/herself.
12. He/she has a discipline file.
13. He/she is arrogant, aggressive, impulsive, or violent.
14. He/she is very proud and unable to deal with frustration.
15. He/she often cries.
16. He/she is nervous or more nervous than before.
17. He/she has talked about killing someone.
18. He/she is an insomniac.
19. He/she appears to be very pensive.
20. He/she has complexes.
21. He/she is jealous.
22. He/she is disillusioned.
23. He/she suffers from high blood pressure.
24. He/she has tried to commit suicide.
25. He/she uses tranquilizers combined with alcohol.
26. He/she has written one or more strange letters to those close to him/her in which he/she talked about life, death, the purpose of life, or has made his/her last wishes known in case something were to happen to him/her.
27. He/she has written or rewritten his/her will and talked about it in a weird and unusual way.
28. He/she has let it be known in a mysterious way that he/she had something important to do.

Other signs: *Increased drug/alcohol abuse, becomes withdrawn from friends/family, becomes accident prone/risk tasking, is disillusioned or hopeless, lack of energy/motivation, loss of love for profession, emotional-cries easily, gives away things, change in sleep patterns, decreased appetite, feelings of guilt/shame and self-hatred, writes or re-writes will, no longer concerned for appearance, talks of suicide, plays with gun.*

At risk individuals vs. intervention

1. At risk individuals
    a. Suicidal ideation
    b. Risk factors
    c. Lethality still “low”
    d. Intervention options

2. At risk individuals--Objectives
    a. Engage
    b. Identify
    c. Inquire
    d. Assess
    e. Action

3. Intervention
    a Plan ready or in action
    b. Lethality “high”
    c. Immediate intervention necessary.

4. Intervention—Objectives
    a. Approach
    b. Assess
    c. Contain
    d. Acknowledge / Validate feelings
    e. Identify alternatives
    f. Develop plan of action
    g. Refer for help

5. Assessment (7 factors)
    a. Resources
    b. Prior suicidal behavior
    c. Current suicide plan
    d. Symptoms
    e. Stress
    f. Gender
    g. Age

6. Big “3” (CPR)
    • Current suicide plan
    • Prior suicidal behavior
    • Resources

7. Risk assessment scale
    0--Low risk
    1--Medium risk
    2--High risk

V. Responding to the scene of a SUICIDE

A. Remember all cases like this are ruled a homicide first and backed down as the investigation is ongoing.

B. Get as much information as possible including whether there was a suicide note.

C. Find out if the body is viewable.

D. Answer questions honestly, compassionately, offering no opinions (what to say/not say i.e. regarding "hell", St. Francis of Assisi – "ministry of presence")

E. Deal with grief issues i.e. suicide impact on faith, hope.

F. Be aware of traumatic stress symptoms (including self – avoid identifying w/ victim)

G. Handle like you would a death notification as far as support.

VI. Police Officer Suicide

Suicide #1 killer of LEO's in line of duty but not considered line of duty death (funeral and other implications)

NYPD Survey of ranked factors in law enforcement suicide:

- depression
- relationship conflicts or personal losses
- easy access to firearms
- drug and alcohol abuse
- financial difficulty
- internal investigations
- fear of secret getting out
- legal problems

Risk factors: *clinical depression, marital problems/relationship issues, loss from divorce/death, terminal illness, internal audit, indictment, disability/retirement, feelings responsible for partners death, involved in a shooting, being arrested.*

Being in control – high importance to officers... they just don't see a way out!

A. Twice any many die by their own hand each year than are killed in the line of duty (approx. 300). *Having a firearm in the home increases risk for suicide five fold.*

B. Underreported or misclassified

C. Warnings signs for police suicides:

- Threatens to harm self
- Prior suicide attempt (s)
- Disturbance in sleep/appetite/weight
- Thinking is constricted – all or nothing, black or white
- Increased risk-taking behavior
- Increase in alcohol use or prescription drug abuse

- High-risk behaviors or self-destructive behaviors
- Has plan and means for suicide
- Emotionless/numb
- Angry/agitated i.e. explosive behavior/outbursts
- Sad/depressed
- Hopeless, not future-oriented; giving away valued possessions
- General behavioral/personality changes
- Appearance changes
- Problems at work/home
- Recent loss (status, loved one)
- Retirement
- Dismissed
- Under investigation
- Socially isolated/withdrawn

Triggers – What occurrences may trigger suicidal tendencies?

- Relationship breakup or divorce
- Discipline
- Debt
- Health problems or Disability
- Response to a critical incident
- The D's - Divorce, Depression, Discipline (lack of), Death, Devastation, Desperation, Deprivation (sleep), Disgrace, Disability, Drinking, Debt, Disease, Distance (emotional), Despair, Dread, Discounted, Dismissed, Dumped, Diss'd"

AID LIFE

A – Ask. Do not be afraid to ask 'are you thinking about hurting yourself?' or 'Are you thinking about suicide?' Have you thought about when?

I – Intervene immediately. Take action. Listen and let the person know he or she is not alone.

D – Don't keep it a secret.

L – Locate help.

I – Involve Command. Supervisors can secure immediate and long-term assistance.

F – Find someone to stay with the person now.

E – Expedite – Get help now. An at-risk person needs immediate attention from professionals.

Things to do when dealing with suicidal individuals:

- Ask permission to secure weapon include back up.
- Immediately contact your supervisor
- Identity someone who can provide on scene support
- Do not leave the person alone
- Assess if your safety is in jeopardy
- Assist individual in meeting responsibility until the situation is stabilized.

When the crisis has stabilized, get debriefed for your own peace of mind and self-care.

Small groups: have Chaplains 1. list needs of Officers and 2. list what we (Chaplains) can proactively do.

D. Coping strategies for suicide prevention

1. Talk to a Police Chaplain, Peer Support member, and/or Mental Health Professional.

2. Self Care:
   a. Rest
   b. Diet
   c. Exercise
   d. Stop harmful behaviors (i.e. drinking alcohol)
   e. Support system (Avoid isolation)

E. When a suicide occurs

Remember a person for how they lived not how they died.

1. Debriefing
2. Funeral
3. Surviving family

VII. Aftermath Issues

A. Biohazard cleanup
B. School or workplace defusings and/or debriefings
C. Long-term counseling and/or support group referrals
D. Suicide completion turns into suicide prevention—full circle (post-vention)

VIII. Chaplain Health and Wellness

A. Dealing with death

Have group share how they deal with and how has death has impacted them?

B. Wellness issues as an actively sought goal

Examples of what this looks like – have them develop plans in small groups.

IX. Resources

- Mental Health/Psychologists and CISD (Critical Incident Stress Debrief) Team.
- Peer Support.
- Chaplains – you are an instrument of God's hope.
- QPR: Dr. Paul Quinnett of the QPR (Question, Persuade and Refer) Institute believes we can help to prevent these suicides. QPR is not counseling but a form of suicide prevention and identifying those in need. We should be intentional in each other's lives, especially with law enforcement officers. QPR is intended to offer hope through positive action. QPR is intended to teach those who are in position to recognize the warning signs, clues and suicidal communications of people in trouble to ACT vigorously to prevent a possible tragedy QPR is about asking the hard questions (Are they depressed? Are they considering

suicide?), persuading them to get help and referring them to resources that would provide the needed help.

Role play/exam:
(One person plays a friend and one person plays the paramedic)

You are a 37-year-old married paramedic with no children. You were treated for whiplash a year and a half ago at the emergency room and were released. As the pain persisted, your doctor put you on narcotics, to which you eventually became addicted. After more than a year of using these medications, you decided to discontinue the drugs on your own and went into withdrawal. A few days later, you were selected to be given a random U.A. (urine analysis) at work. You are talking with a friend regarding your fears about the future.

Things that your friend is NOT aware of: that it is likely your career is over because of the positive U.A., as a teenager, you made an attempt to end your life in a high-speed crash, your spouse always shared how proud he/she was of you being a paramedic, your marriage started to suffer following the accident, but there has been talk for a divorce since he/she found out about the positive U.A., to ease the pain, you are now using alcohol instead of pain medications, you are having thoughts of suicide again, using your car so that it would look like an accident and your spouse would get the insurance benefit. **Somewhere during the discussion you say: *"Sometimes I wonder if it's all worth it."***

"Although suicide is always complex and multifactorial, most experts feel the majority of suicides remain preventable" Dr. Paul Quinnett, FBI Law Enforcement Bulletin

<u>Closing:</u>

- Review expectations for the day.
- Go around room and share 2 take-aways from training.
- Wrap up questions/comments/reflections.
- Complete evaluations and hand out certificates.