



PARTNERS IN PREVENTION:

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**UNDERSTANDING AND  
ENHANCING FIRST  
RESPONSES TO  
SUICIDE CRISIS  
SITUATIONS**

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KNOWLEDGE, SKILLS,  
ATTITUDES AND  
CONFIDENCE OF  
POLICE

# ACKNOWLEDGEMENTS

We would like to acknowledge the Traditional Custodians of the land on which our services are located. We pay our respects to the Elders both past and present and acknowledge Aboriginal and Torres Strait Islander peoples across the State. We continue to recognise that to Close the Gap we need to work together with Aboriginal and Torres Strait Islander people, communities, staff and stakeholders to ensure that we are meeting the needs of the community.

We acknowledge those who experience suicidality and those lost to suicide, and their families, friends, loved ones, and others who are affected by suicide.

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### Queensland Police Service

The authors wish to acknowledge the support and assistance from the Queensland Police Service in undertaking this research. The views expressed in this publication are not necessarily those of the Queensland Police Service and any errors of omission or commission are the responsibility of the authors.

### Roses in the Ocean

The views expressed by people with a lived experience of suicide engaged in consultation throughout this project and publication are their own specific perspectives and do not endeavour to represent all lived experience perspectives. We acknowledge that all lived experience insights are valuable and important.

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# OVERVIEW

Individuals who experience a suicide crisis often come into contact with police or paramedics. Those who have experienced a suicide crisis report deficiencies with the existing system, and police and paramedics report that responding to these events is one of the most challenging aspects of their role. However, little is known about the nature, extent, precipitating factors, pathways and outcomes of a suicide related call-out, and what responses will most effectively and compassionately meet the needs of those in crisis. *Partners in Prevention: Understanding and Enhancing First Responses to Suicide Crisis Situations*, funded by the Queensland Health Suicide Prevention Health Taskforce, was established in 2017 to address these knowledge gaps and inform systems enhancements.

## Project overview

The Partners in Prevention project encompassed five major initiatives:

|   |  |
|---|--|
|    | <p><b>DATA LINKAGE</b></p> <p>A linked data study about individuals who came into contact with Queensland Police Service or Queensland Ambulance Service between 2014 and 2017, and their health services use and outcomes between 2013 and 2018.</p>          |
|   | <p><b>SERVICE MAPPING</b></p> <p>An integrated service mapping of collaborative services involving police, ambulance and mental health services up to January, 2018.</p>   |
|  | <p><b>PERSPECTIVES FROM LIVED EXPERIENCE</b></p> <p>A workshop to gather lived experience perspectives on optimal first responses to suicide crisis situations, and situations involving a recent bereavement due to suicide.</p>                              |
|  | <p><b>LITERATURE REVIEWS</b></p> <p>Reviews of literature on: optimal care pathways following a suicide-related call to emergency services; evaluation frameworks for collaborative suicide crisis interventions; and data linkage studies in suicidology.</p> |
|  | <p><b>KNOWLEDGE, SKILLS, ATTITUDES AND CONFIDENCE OF POLICE</b></p> <p>A mixed methods study of knowledge, skills, attitudes and confidence of police in responding to suicide crisis situations.</p>  |

## Our partners

|   |  |   |                                       |
|---|--|---|---------------------------------------|
|  | QUEENSLAND CENTRE FOR MENTAL HEALTH RESEARCH |  | ROSES IN THE OCEAN                    |
|  | QUEENSLAND AMBULANCE SERVICE                 |  | BRISBANE NORTH PHN                    |
|  | QUEENSLAND HEALTH                            |  | QUEENSLAND ALLIANCE FOR MENTAL HEALTH |
|  | QUEENSLAND POLICE SERVICE                    |  | QUEENSLAND MENTAL HEALTH COMMISSION   |

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# SUMMARY

## Why we did this

Emergency service agencies including police, ambulance and mental health are frequently required to be at the frontline of responders to mental health crises in the community, where people may have significant mental health, emotional, or substance misuse problems and may be suicidal. Given the extent of police interactions with individuals who are at risk of suicide, it is critically important that police responders be able to accurately and confidently identify suicide risk, initiate field-based interventions, and facilitate onwards referrals to appropriate services, without perpetuating stigma or judgement.

## What we did

This study aimed to capture existing knowledge and skill levels of Queensland Police Service (QPS) staff, and to measure attitudes and confidence in responding to individuals who experience suicide crisis.

Police staff, including sworn officers, police recruits and civilian call-takers, were recruited with the aim of obtaining a varied sample across a range of positions, ranks and police districts. Consenting participants completed a survey of their knowledge, attitudes and confidence in handling suicide crisis situations. The survey included a modified version of the Attitudes to Suicide Prevention Scale, tailored to police responders; the Mental Illness Clinicians' Attitudes (MICA-4) questionnaire; and six questions on experiences of suicide and training in suicide prevention. Interested participants were invited to undertake a qualitative interview on their experiences, training and skills, confidence, and the roles of police in suicide prevention.

A total of 218 police staff completed the survey, including 126 (58%) police officers, 75 (34%) police recruits, and 17 (8%) civilian call takers. Of these, 21 police staff participated in a qualitative interview.

## What we found

### Experiences of suicide and suicide crisis

- The majority of police officers (88%) and 13% of police recruits identified that they had professional experience of suicide crises.
- Forty-eight percent of police officers and 32% of police recruits identified that they had a personal experience of suicide or attempted suicide.

### Training in responding to suicide crisis

- Almost all police officers (98%) and 36% of recruits reported that they had undergone some form of training in mental illness or suicide prevention, or vulnerable persons training.
- More than half (61%) of police officers reported that they had undergone suicide prevention training and 27% of recruits identified having had prior suicide prevention training.

### Knowledge

- The average score for knowledge of suicide prevention among police staff to a 10-item questionnaire was seven out of ten, indicating an overall high level of knowledge.
- Police responses indicated that the majority believe that persons at high risk of suicide should be subject to the use of legislative powers to involuntarily transport, examine or treat a patient.

## Skills

Police officers identified two key skillsets, and numerous strategies, that they considered important when responding to suicide crises: 1. Communication techniques; and 2. Ways of coping with stress associated with responding to suicide crises.

## Attitudes

- Both survey and interview responses indicated that police staff saw responding to suicide crises as a legitimate part of their role as police, specifically related to the oath to preserve life and community safety.
- Fewer than half of those surveyed (42%) considered that responding to those in suicide crisis was a rewarding aspect of their job.
- Fewer than one in five (19%) police staff agreed that they were uncomfortable assessing someone for suicide risk, indicating that police staff feel comfortable assessing individuals for suicide risk.
- Issues of stigma associated with mental illness were identified. While almost all staff indicated that they would feel comfortable working with a colleague with mental illness (94%), slightly fewer (85%) indicated that they felt as comfortable talking to a person with a mental illness as they do talking to someone with a physical illness.
- Over one-half of police staff (53%) stated that they would not disclose experiencing a mental illness to their colleagues for fear of being treated differently. Overall, police officers indicated less willingness to disclose a mental illness to colleagues for fear of being treated differently (58%) than did police recruits (45%).

## Confidence

- The majority of those surveyed (70%) agreed that they felt that they could accurately identify situations where a person is at risk of suicide. Confidence in this was higher among police officers (82%) than police recruits (48%).
- Fifty-seven percent of police staff agreed that they knew how to approach and question people at risk of suicide.
- While confidence levels tended to be high overall, police staff appeared to be more confident in identifying and establishing suicide risk, than in approaching an individual at risk.
- Confidence was lowest among police staff with respect to knowing how to refer people in need to appropriate services. Fifty-five percent of those surveyed agreed that they knew how to refer people at risk of suicide to the services most appropriate to their needs and level of risk; confidence was higher among police officers (64%) than police recruits (39%).

## Organisational factors

- Many police staff who were interviewed highlighted that they had witnessed a process of positive cultural change within the QPS. Changes included positive changes to the culture of the service over time, improved training for officers and recruits, and promotion of communication-based resolution to crisis situations.
- A range of opportunities for organisational improvement were also highlighted by interviewees, including a need for more access to high quality training, further exploration of models of service with health and QPS partnership (e.g. co-responder programs), and continued culture change.

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## Conclusions

QPS staff identified overall high levels of knowledge, skills, attitudes and confidence. Ongoing initiatives to foster collaboration, knowledge exchange, and mutual support between police and health services are important to improving knowledge and confidence among police staff in responding to individuals in suicide crisis. Health system enhancements are also required to ensure that police can access appropriate health expertise when required and that appropriate services are available for them to utilise, as alternatives to transportation to emergency departments. Additionally, the needs of police responders and their families need to be addressed. QPS should continue to invest in initiatives to destigmatise mental illness within the police.

# INTRODUCTION

## Background

Emergency service agencies including police, ambulance and mental health are frequently required to be at the frontline of responders in mental health crises in the community, where people may have significant mental health, emotional, or substance misuse problems and may be suicidal. Because of this, first responders are widely acknowledged to have an important role in community-based suicide prevention, with the World Health Organization noting that: “first responders are in a unique position to determine the course and outcome of suicidal crises.” (World Health Organization, 2009)

The increasing frequency of interactions between police and individuals with mental illness accounts for a growing percentage of overall police activity (Butler, 2014; Hails & Borum, 2003; Ogloff, Davis, Rivers, & Ross, 2007; Reuland, Schwarzfeld, & Draper, 2009). In Australia, these interactions account for as much as 50% of police time being spent responding to events involving individuals with mental illness (National Mental Health Commission, 2013).

It is vitally important that police staff are able to accurately and confidently identify suicide risk, initiate field-based interventions, and facilitate onwads referrals to appropriate services, without perpetuating stigma or judgement (Marzano, Smith, Long, Kisby, & Hawton, 2016). Secondary benefits to improving the knowledge, skills, attitudes and confidence of police staff include benefits to police themselves, in terms of awareness, destigmatisation of mental illness and suicide, and supporting help-seeking behaviours within their own organisations (Marzano et al., 2016).

## Aims

This study aimed to capture existing knowledge and skill levels of QPS staff, and to measure attitudes and confidence in responding to those in need as a result of suicide crisis.

# METHODS

## Ethical clearance

This study received ethical clearance from the Royal Brisbane and Women’s Hospital Human Research Ethics Committee (HREC/18/QRBW/250). Additionally, approval for this project was provided by the QPS research committee (DOC 184554533). We acknowledge the assistance of QPS, however the views expressed are not necessarily those of QPS and any errors of omission or commission are the responsibility of the authors.

## Study design

This research used a mixed methods design, incorporating:

- A short paper-based survey instrument, based on a series of validated (quantitative) survey instruments; and
- A semi-structured (qualitative) interview with police responders, in order to understand their perspectives and experiences in responding to suicide crisis situations.

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## Sample and data collection

This study focussed on the QPS workforce. The cohort included police recruits, general duties frontline officers, communication centre call-takers, recruits and instructors, as well as individuals who also undertake a specialist negotiator role directly involved in suicide crisis. A purposive sampling approach was taken, with researchers attending training sessions provided by the QPS to invite voluntary participation in both the survey and a structured interview. In order to recruit Senior Constables, who do not undergo routine face-to-face training, surveys were distributed through stations that were identified as having higher numbers of police of this rank. Interviews were undertaken by two members of the research team (FD and CM).

The terminology used to refer to QPS staff is as follows: police staff refer to all QPS employees surveyed or interviewed, including recruits, sworn and civilian members; police officers refer to all sworn members, including uniformed and plain clothed roles; police recruits refer to individuals undergoing police training.

### Survey

The quantitative component of this study comprised the following measures:

- Knowledge and skills: ten items from the Police and Suicide Prevention (PSP) survey (three response categories: agree, disagree, unsure; Marzano et al., 2016).
- Attitudes: 16 items regarding severe mental illness from the Mental Illness: Clinicians' Attitudes 4 (MICA-4; six point Likert-type response scale: 1-strongly disagree – 6-strongly agree; Kassam, Glozier, Leese, Henderson, & Thornicroft, 2010; Gabbidon J., Clement, Nieuwenhuizen, Kassam, et al., 2013); and 13 items regarding attitudes to suicidality in the PSP survey (Marzano et al., 2016), adapted from the Attitude Toward Suicide Prevention Scale (ATSP; Herron, Ticehurst, Appleby, Perry, & Cordingley, 2001). Twelve items had a five-point Likert-type response scale (1-strongly disagree – 5-strongly agree) and one item (What proportion of suicides do you consider preventable?) had a five-point response scale 1-none – 5-all.
- Confidence: four items on confidence in identifying a crisis situation, approach and questioning, establishing risk, and referral, from the PSP survey (5 point Likert-type response scale: 1-strongly disagree – 5-strongly agree; Marzano et al., 2016).
- Demographics: Age, gender, position, length of service, and location.

### Interview

The qualitative component of this study aimed to cover the following topics:

- Experience and training in suicide crisis response (e.g. *What training have you received regarding responding to suicide crisis?*)
- Confidence in responding to suicide crisis (e.g. *How confident do you feel about your ability to respond to a suicide crisis?*)
- Role and organisational concept in relation to responding to suicide crisis (e.g. *In terms of your role description, do you see responding to suicide crises as part of your role?*)
- Strengths and capabilities in dealing with suicide crisis (e.g. *What do you think could be done differently within the service to make a greater difference in the lives of the people you serve, in particular, people involved in or affected by suicide crisis?*)

Prior to interviews commencing, interviewers provided a working definition of 'suicide crisis situation' and 'responding to a crisis' to interviewees in order to help focus interviews. These definitions were as follows:

#### Suicide crisis situation

A suicide crisis was defined as including suicidal ideation, threatened suicide or self-harm, suicide behaviours, suicide attempts and a suicide death. A crisis may relate to the call maker, or another person, acknowledging that a call to emergency services may be made by a carer, friend, family or community member, or other person.

#### Responding to a crisis

'Response' was defined as including a range of actions, such as taking a call, attending on-scene, attending to a person in crisis or other affected persons, or coordinating service, dispatch, or other responses without direct contact.

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## Analysis

### Survey

Survey responses were entered into Excel, cleaned and reviewed for missing data using Stata v14.

Analysis presented is descriptive. Responses to 5-point and 6-point Likert items were grouped for analysis in terms of percentage agree (response 4 or 5 = Agree for 5-point scale, and response 4,5 or 6 = Agree for 6-point scale). For knowledge questions, the percentage who answered correctly is also provided.

Data were grouped into all police staff (All), police officers, and police recruits. Separate analyses were not undertaken for civilian call-takers, due to low numbers of this sub-group.

### Interviews

For the qualitative component, analysis began at the outset and occurred in tandem with data collection. Emergent themes were discussed between FD and CM as data collection progressed. Following completion of interviews, recordings were transcribed using a confidential transcription service. Transcripts were analysed thematically by FD to extract key concepts, themes and perspectives emerging from the interviews. The coding scheme was reviewed by CM following coding of six interviews. This review focussed on improving inter-rater reliability and comprehensiveness of the coding scheme. Differences and omissions were discussed and resolved through consultation prior to FD completing analysis.

# RESULTS

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## Survey and interview sample characteristics

Survey and interview sample characteristics are shown in Table 1. The median age of those surveyed was 37 years old. Almost two-thirds (63%) of those surveyed were male. Police staff across a range of ranks and positions were recruited, including 35% recruits, 29% Sergeants or Senior Sergeants, and 26% Constables or Senior Constables. Approximately two-thirds (36%) of those surveyed worked in predominantly Metropolitan districts and 25% worked in predominantly Regional districts.

Table 1 Survey and interview sample characteristics

|   | Survey     |    | Interview  |    |
|---|------------|----|------------|----|
|   | n (N=218)  | %  | n (N=21)   | %  |
| Age in years, median (range)  | 37 (19-59) |    | 41 (23-56) |    |
| Male  | 138        | 63 | 14         | 67 |
| Years of service, median (range)  | 8 (0-37)   |    | 15 (0-36)  |    |
| <b>Rank</b>   |            |    |            |    |
| Civilian  | 9          | 4  | 0          | 0  |
| Recruit   | 75         | 34 | 3          | 14 |
| Constable/Senior Constable  | 57         | 26 | 5          | 24 |
| Sergeant/Senior Sergeant  | 63         | 29 | 12         | 57 |
| Other   | 6          | 3  | 1          | 5  |
| <b>District</b>   |            |    |            |    |
| South Brisbane  | 25         | 12 | 4          | 19 |
| Sunshine Coast  | 24         | 11 | 0          | 0  |
| North Brisbane  | 16         | 7  | 3          | 14 |
| Townsville  | 13         | 6  | 0          | 0  |
| Gold Coast  | 12         | 6  | 1          | 5  |
| Moreton   | 12         | 6  | 3          | 14 |
| Logan   | 10         | 5  | 0          | 0  |
| Mt Isa  | 6          | 3  | 0          | 0  |
| Mackay  | 5          | 2  | 0          | 0  |
| Other [Wide Bay Burnett, Far North, Ipswich, Police Headquarters, Capricornia, South West, Darling Downs] | 18         | 7  | 5          | 25 |
| Not yet allocated   | 35         | 16 | 1          | 5  |
| Not specified/Other   | 42         | 19 | 3          | 14 |
| <b>Region</b>   |            |    |            |    |
| Metro [North Brisbane, South Brisbane, Gold Coast, Moreton, Logan, Headquarters]                          | 78         | 36 | 15         | 71 |
| Regional [Sunshine Coast, Townsville, Mackay, Wide Bay, Far North, Ipswich, Capricornia, Darling Downs]   | 55         | 25 | 3          | 14 |
| Remote [Mt Isa, South West]   | 8          | 4  | 3          | 14 |
| Not yet allocated   | 35         | 16 | 0          | 0  |
| Not specified   | 42         | 19 | 0          | 0  |

## Experience with suicide crisis

Over three-quarters of officers (88%) and 13% of recruits reported that they had some professional experience of a suicide or attempted suicide (Table 2). Forty-eight percent of officers and 32% of recruits reported that they had a personal experience of suicide or attempted suicide. Personal experience of suicide or attempted suicide was open to interpretation, with a text box provided for individuals to detail the nature of their experience. Responses indicated that personal experiences of suicide or attempted suicide were generally those of the police staff member’s friends, family or acquaintances. No respondent disclosed their own experience of suicidality.

Table 2 Self-reported experiences of suicide situations among police officers

| %   | Officers | Recruits |
|---|----------|----------|
| Professional experience of suicide or attempted suicide | 88       | 13       |
| Personal experience of suicide or attempted suicide     | 48       | 32       |

In interviews, officers reported that responding to suicide crisis events was a core component of policing. Experienced officers identified that responding to suicide crises was very common, and that officers could encounter three to four jobs each week.

Yeah, okay so I’ve attended quite a few completed suicides, for want of a better term. Then I would say on a weekly basis, attending or responding to persons in crisis or threatening suicide, there would be at least three to four jobs a week, if not more, depending on the week. But at minimum three to four. [#6, constable]

One new recruit identified that they had responded to three suicide crises in their first week on the job.

My experience is very limited, but it is growing. As of the last three days on station duty I’ve had three suicide crises. [#2, recruit with 3 days of field experience]

Police officers who performed the specialist role of negotiators indicated that they responded to suicide related calls on a regular basis with frequency ranging from every few days to once a month.

There’s a lot! [...] I wouldn’t say it’s small. It’s not the biggest but it is a fair proportion of the jobs we attend to. [#19, sergeant]

Officers also identified the range of suicide related call outs that they responded to.

I guess it varies, from people that generally have suicidal ideation or suicidal thoughts, through to people that are acutely suicidal. So there’s everything in between. There’s people that just ring up for a conversation or drop into the station because they’re not feeling like they can do life any more, through to people holding a knife to their own throat or sitting on top of a bridge and they are about to jump off. So that’s my experience. [#12, sergeant]

Officers predominantly described responding to suicide threats, attending situations where a death has taken place, and providing information to members of the public who have been bereaved by suicide (Table 3). Responding to calls related to self-harm was seldom specifically mentioned by respondents.

Table 3 type of suicide related events discussed in interviews

|   | n (N=18) <sup>1</sup> |
|---|-----------------------|
| Suicide threats                                       | 17                    |
| Suicide death   | 12                    |
| Responding to those who have been bereaved by suicide | 8                     |
| Responding to situations involving self-harm          | 3                     |

<sup>1</sup> Note that interviews with recruits were excluded from this analysis.

## Training

Table 4 provides details of the training received by police. Almost all officers (98%) reported that they had received some form of training in suicide prevention, mental illness or vulnerable persons training, and 61% reported that they had received suicide prevention training. In contrast, only 27% of recruits reported having received suicide prevention training, and only 36% of recruits reported having received any relevant training.

Table 4 Self-reported training experiences in suicide prevention, mental illness or responding to vulnerable persons

|   | All                 |    | Officers            |    |                       |     | Recruits           |    |
|---|---------------------|----|---------------------|----|-----------------------|-----|--------------------|----|
|   | Survey<br>n (N=218) | %  | Survey<br>n (N=126) | %  | Interview<br>n (N=18) | %   | Survey<br>n (N=75) | %  |
| Received previous suicide prevention training   | 105                 | 48 | 77                  | 61 | 8 <sup>1</sup>        | 44  | 20                 | 27 |
| Received previous mental illness or vulnerable person training                                  | 149                 | 68 | 113                 | 90 | 6                     | 30  | 23                 | 31 |
| Received other relevant training  | 61                  | 28 | 41                  | 33 | N/A                   | N/A | 13                 | 17 |
| Received any training: suicide prevention, mental illness, vulnerable persons or other relevant | 165                 | 76 | 124                 | 98 | 18                    | 100 | 27                 | 36 |

<sup>1</sup> Police negotiator training.

Qualitative feedback indicated variability in police staff's ability to access specialist suicide prevention training. Officers who had undertaken specialist police negotiator training described this as a valuable experience which had assisted them in their confidence and ability to respond to people in suicide (and other types) of crisis. In contrast to this however, some officers interviewed (n=4) stated that they felt that they had experienced no training, or minimal training in the past.

Police officers who had had long careers within the QPS noted improvements in training available to QPS staff, specifically a shift in focus from a 'hands on' approach to methods which emphasise the use of effective communication to achieve a positive outcome.

I think training is certainly getting better. The problem I think is, as with all training, we don't do enough. I don't know if you could ever do enough [...]. So more training would be good, but I think it's certainly better than it used to be when I joined the job 30 years ago. It was probably non-existent really. But it's definitely improving. [#7, sergeant]

Several officers (n=7) highlighted the value of experiential learning to improving their ability and confidence in handling suicide crisis situations. Valuable experiences included witnessing others in the field, and other life experiences outside of the QPS. One officer described the value that they derived from observing a mental health clinician, who was part of a co-responder team, respond to someone in crisis:

So it was interesting definitely, and good to see it from different points of view. Just working with the [co-responder] nurse and seeing how she worked and how she spoke to people. Yeah, definitely a good learning curve for me. [...] Also certainly working with that mental health nurse and seeing the way she approached people just, I don't know, talking to them normally I guess. Talking about how they were feeling and that sort of thing. [#7, sergeant]

## Knowledge

Police knowledge of suicide prevention was assessed quantitatively, based on their responses to ten knowledge questions included within the Police and Suicide Prevention survey. The average score was seven out of ten, indicating a good overall degree of knowledge. As shown in Table 5, less than half of officers answered the questions “Most people who attempt suicide have a mental health problem” and “All people at high risk of suicide should be subject to an Emergency Examination Authority, Examination Authority or Treatment Authority” correctly.

Table 5 Police knowledge of suicide prevention

|   | Agree % | Correct responses % |                   |                  |
|---|---------|---------------------|-------------------|------------------|
|   |         | All<br>N=218        | Officers<br>N=126 | Recruits<br>N=75 |
| Suicide rates are similar in men and women. (F)   | 7       | 72                  | 71                | 69               |
| Most people who attempt suicide have a mental health problem. (T)   | 44      | 44                  | 48                | 39               |
| People who have lost a family member due to suicide are less likely to attempt suicide themselves. (F)  | 5       | 72                  | 76                | 64               |
| People with a history of suicide attempts and self-harm are at increased risk of suicide. (T)   | 85      | 85                  | 83                | 89               |
| People who are about to attempt suicide are always distressed and agitated. (F)   | 3       | 86                  | 90                | 77               |
| Asking someone directly about suicide can give them ideas or encourage them to end their life. (F)  | 5       | 80                  | 86                | 69               |
| Daring a person to carry out a suicidal threat will discourage them from attempting suicide. (F)  | 1       | 90                  | 90                | 88               |
| Most suicides happen without warning. (F)   | 24      | 55                  | 62                | 44               |
| Police should only intervene when a person is at high risk of suicide. (F)  | 17      | 74                  | 73                | 73               |
| All people at high risk of suicide should be subject to an Emergency Examination Authority, Examination Authority or Treatment Authority. (F) | 62      | 13                  | 15                | 11               |

## Skills

Contrasting with the emphasis of the survey on assessing content knowledge, interviews with police officers focussed on the types of skills that they found valuable. In particular, police identified communication strategies as a key skill requirement in responding to suicide crises. Secondly, police identified the coping strategies and self-care strategies that they employed, in relation to responding to suicide related events.

## Communication

Officers described a range of specific communication approaches which they had found to be useful in responding to suicide situations. Table 6 below lists each of these, notes the number of officers who mentioned each approach, and includes a quote which illustrates each concept.

Table 6 Police reported communication approaches in responding to suicide situations

| Communication approaches                            | Officers n (N=18) | Quote  |
|---|-------------------|--|
| Convey empathy and caring                           | 17                | “[Empathy] plays a part in responding to any job, where police don’t have hierarchy influence. Police generally turn up somewhere and the police are great at telling people to do stuff and put certain stuff down. As soon as that doesn’t work, then you are going to need empathy, otherwise you’ll never gain influence. That’s getting back to that behavioural influence stairway model. Empathy is at number two, so actively listening. Having the good skills to actively listen is one thing. But then if you can’t show empathy – showing empathy can be as simple as acknowledging their distress.” [#14, negotiator] |
| Listen  | 10                | “It’s about getting people to do the talking [...] – because communication’s about listening, communication’s not about talking.” [#13, sergeant/negotiator]   |
| Develop rapport                                     | 9                 | “But what you can do is develop a rapport and develop a relationship so to speak with that person enough to influence their behaviour, to at least have an element of trust in you to come out and say, well I’m not going to kill myself today, I am going to come out and surrender myself to police or to whoever and seek some help.” [#20, senior investigator]   |
| Show your human side                                | 6                 | “So, then that’s the way I try to speak to people and I find that that works really well. Because I also think that a lot of people don’t see us as people either, they just see a uniform. They don’t expect us to be human. I think that once you open up and actually show that you have a human side, people respond really well to that as well.” [#6, constable]   |
| Be aware that it’s not about ‘fixing their problem’ | 5                 | “But basically with suicide intervention we really focus on not problem solving. But getting that person past where they’re at. [...] it’s not about finding out what’s the matter with someone. It’s more about finding out what matters to someone. Basically when I say not problem solving, [...] we’re not about figuring out what their problems are. We are more focussed on consequences.” [#14, negotiator]   |
| Be authentic/genuine                                | 5                 | “It has to be genuine, or they don’t respond but for me, as long as someone knows that I’m listening and I’m trying to understand, I think that will get you further than any other sort of communication technique.” [#17, constable]   |
| Be patient/take time                                | 4                 | “I think the biggest thing with police, [...] because they’re so heavily under the pump, jobs and responding times and that sort of thing. A lot of the time they feel rushed to try and get through a job whereas – dealing with someone in a crisis incident, you’ve got to give them time. It’s all about time and slowing things down and taking a breath and that sort of thing. As opposed to trying to rush through any job. [...] It takes time. It really does. So you can’t rush it.” [#13, sergeant/negotiator]   |
| Create a calm environment                           | 3                 | “It’s very much trying to slow the process down, as in really calming the matter.” [#15, sergeant]   |
| Act respectfully                                    | 2                 | “Always remembering too, to treat people the way you would want your own family members treated. [...] I think if that were my family member, if that was my mum or my brother or my sister and I was – there was a copper dealing with them, how would I want the copper to speak to them? So, then that’s the way I try to speak to people and I find that that works really well.” [#6, constable]  |

Police officers described the importance of specific approaches that were important when communicating with families and significant others following a death by suicide. These included the need for empathy and rapport – which were seen as particularly important in the context of situations where police had certain formal duties to carry out to investigate a death – to help lessen blame, answer questions and facilitate further support.

They're really difficult. [...] I just show a lot of empathy. I'm very empathetic in general and just that – manage that whole scene and the family and move in the right direction. Because it can be quite distressing having police there, because it's quite formal. We have to do certain things and examine a scene and have forensics in and it can be quite confronting. I generally like to speak to them, get that rapport first and then explain everything to them and see if they've got questions and all the rest of it. Because it's so traumatic for them and then you've got police in there as well and it's a very difficult situation. It's probably different each time. [#22, constable]

### Coping strategies

Responding to suicide crisis was acknowledged by participants to be a potentially stressful situation with a variety of impacts on officers at the scene. These after effects were described in cases where traumatic events took place but also where the outcome was positive, with a life being preserved.

[...] if you have a win on the job, well it's not hard to feel good about what you've done. So you don't walk away with any residual effects and – that didn't go well because we've had a win essentially. We've saved someone. [...] I actually find when I go home, I'm actually on quite a buzz. I actually find it hard to sleep because I'm on a high still, I have the – that – I'm on a – like a euphoric feeling that this is – what a great result and we've got someone some help. It's usually the second day or third day where I feel a little bit flat. [#13, sergeant]

Interview participants were asked to describe any strategies that they used to cope with stress that might result from responding to suicide crises. Approaches to dealing with stress that were mentioned by officers are summarised in Table 7.

Table 7 Police self-reported coping strategies

| Specific coping strategies    | Officers n (N=18) | Quote  |
|-------------------------------|-------------------|--|
| Talking with peers/debriefing | 12                | <p>“If you would have asked me this two years ago I would have gone oh no, I process it well and talk, whatever, you know, where now I see the massive importance of a debrief.” [#15, sergeant]</p> <p>“There's always a team around you. Supporting you and helping you and assisting you and coming up with aims, objectives and strategies and how we're going to go about certain things within brackets of conversation or what we're hoping to achieve. [...] probably we're very similar as people. And we always after every job, we'll always have our own debrief. Where we'll check up on each other, we'll go and have a coffee, we'll talk about the job. Everyone okay? What do we feel good about it? What do we feel bad about it? As a team leader what I normally do now. Usually in the coming days or like a week later, I'll just touch base with my team again. Make sure they're travelling all right and are they okay and are they good? [...] Yeah look I'll always make sure – I'll always be checking on the welfare of my team.” [#13, sergeant]</p> |
| Time with friends/family      | 12                | <p>“So look I have a fairly good support base there of friends, both within and outside of the job, and my family's very, very supportive of what I do as well so it's – always nice to go and get a cuddle from the kids and that sort of thing when you've had a good job and obviously a not so good job.” [#13, sergeant]</p>  |

|                        |   |   |
|------------------------|---|---|
| Professional support   | 9 | “I [laughs] – for me, [...] I treat my mental health exactly like I treat my physical health. For me, personally, I will go and speak to a counsellor, just because. Just to offload. Just to vent. Just to exercise my mental muscle a little bit. [...] I would prefer to take preventative measures rather than reactive. I do, quite regularly just engage with a counsellor of my own accord just to talk through things and keep my mental health up to speed I guess.” [#6, constable] |
| Exercise               | 8 | “I’m aware from the job that I’m doing that exercise is an important part of life. Exercise helps relieve stress and all of that sort of stuff.” [#14, negotiator, rank unknown]  |
| No specific strategies | 7 | “I just do. I just cope with things. [...] Maybe, yeah. I’ve seen some pretty horrific things and it doesn’t seem to bother me. I suppose I can detach myself. [...] I don’t know why, it just doesn’t seem to affect me. [...] I don’t really think about incidents after they’ve happened, once it’s been dealt with.” [#19, sergeant]  |
| Distraction            | 6 | “As far as self-care sort of things, I just find time to just read a book or – I don’t like to hide, I’ll just escape in the sense I’ll read – watch a good movie or read a good book or something like that. I just give myself time; it’s probably the best way I deal with things. I stay busy driving my kids around and doing all that sort of stuff you’ve got to do.” [#21, district duty officer, rank unknown]   |
| Humour                 | 3 | “In regards to the mental health side or the suicide crises, I think there’s always been that – I think they call it the dark humour or the black humour where being very careful of the crowd around but sometimes there’s a funny thing that the average person wouldn’t think is funny, but it’s part of the process of dealing with situations.” [#15, sergeant]  |
| Relaxation/ meditation | 1 | “I’ve recently been introduced to – well, introduced better to meditation, which is something that I never thought I’d do. But now that I understand it better I have sort of done a little bit of that. Not a lot, but a little bit. I think that that’s certainly got possibilities of being something I’d do more of.” [#7, constable]   |

Several officers expressed some concern, or at least an awareness, that traumatic events during their career may result in challenges to their personal wellbeing in the future (n=6).

[...] the strategies that I employ and that’s sort of hopefully what sees me in good stead. I’m not going to sort of fall in a heap, but you never know. I think that you – I sort of think that no matter what the strategy is, you do develop and you start to carry more and more baggage in a way. [#9, sergeant]

## Attitudes

Attitudes towards suicide and people who experience suicidality or mental health problems were assessed quantitatively. Additionally, perceptions of organisational and self-stigma were assessed using items of the Mental Illness Clinicians Attitudes scale.

Table 8 provides police responses to attitudinal questions contained in the Police Suicide Prevention survey. Overall, police attitudes indicated a level of comfort and destigmatising attitude in handling suicide situations. Fewer than one in five (19%) police staff agreed that they were uncomfortable assessing someone for suicide risk.

However, fewer than half of those surveyed (42%) considered that responding to those in suicide crisis was a rewarding aspect of their job.

Table 8 Attitudes towards suicide prevention, based on Police Suicide Prevention survey

| Agree %  | All<br>N=218 | Officers<br>N=126 | Recruits<br>N=75 |
|--|--------------|-------------------|------------------|
| I resent being asked to do more about suicide.   | 5            | 6                 | 3                |
| Suicide prevention is not a police responsibility.   | 9            | 14                | 3                |
| Making more funds available to the appropriate services would make no difference to suicide rates.                     | 11           | 12                | 11               |
| Dealing with suicidal persons is rewarding.  | 42           | 41                | 44               |
| If people are serious about suicide, they do not tell anyone.  | 38           | 35                | 45               |
| I feel defensive about suicide prevention.   | 3            | 5                 | 1                |
| If a person survives a suicide attempt, then this is a ploy for attention.   | 5            | 6                 | 4                |
| People have the right to take their own lives.   | 28           | 28                | 29               |
| Since unemployment and poverty are the main causes of suicide there is little that an individual can do to prevent it. | 3            | 2                 | 5                |
| I do not feel comfortable assessing someone for suicide risk.  | 19           | 16                | 25               |
| Suicide prevention measures are a drain on resources that would be more useful elsewhere.                              | 6            | 9                 | 3                |
| There is no way of knowing who will kill themselves.   | 28           | 36                | 15               |
| What proportion of suicides do you consider preventable?   | 4            | 3                 | 4                |

Survey respondents provided an indication of their attitudes regarding mental illness, their attitudes towards people with mental illness, and how they thought that their colleagues or friends might perceive them, if they had a mental illness (Table 9). Eight-five percent of those surveyed agreed that they felt as comfortable talking with a person with mental illness as they did in talking with someone with a physical illness. Nearly all (94%) police staff reported that they would want to work with a colleague even if they told them they had a mental illness. However, in contrast over one-half (53%) of police staff agreed with the statement that they would never admit having a mental illness to colleagues for fear of being treated differently.

Table 9 Selected items from the Mental Illness Clinicians Attitudes (MICA-4) Survey

| Agree %   | All<br>N=218 | Officers<br>N=126 | Recruits<br>N=75 |
|---|--------------|-------------------|------------------|
| People with a severe mental illness are dangerous more often than not.  | 26           | 25                | 31               |
| People with severe mental illness can never recover enough to have a good quality of life.  | 8            | 7                 | 8                |
| I feel as comfortable talking to a person with a mental illness as I do talking to a person with a physical illness.                        | 85           | 87                | 83               |
| I just learn about mental health when I have to and would not bother reading additional material on it.                                     | 35           | 36                | 33               |
| If a senior colleague instructed me to treat people with a mental illness in a disrespectful manner, I would not follow their instructions. | 92           | 93                | 91               |
| If a colleague told me they had a mental illness, I would still want to work with them.   | 94           | 94                | 96               |
| If I had a mental illness, I would never admit this to my friends because I would fear being treated differently.                           | 44           | 51                | 36               |
| If I had a mental illness, I would never admit this to my colleagues for fear of being treated differently.                                 | 53           | 58                | 45               |

## Confidence

Confidence in responding to suicide situations was assessed both qualitatively and quantitatively. Overall, officers reported higher degrees of confidence than did recruits. The lowest level of confidence reported by police was in relation to knowing how to refer people at risk of suicide to the services most appropriate to their needs and levels of risk.

As Table 10 shows, while most officers indicated a level of confidence in identifying situations where a person was at risk of suicide, in establishing the level of risk of a suicidal person, and in knowing how to approach and question people at risk of suicide, police appeared on the whole to be more confident in establishing risk than in approaching someone at risk.

Table 10 Police self-reported confidence in establishing suicide risks and responding to suicide situations

| Agree %  | All<br>N=218 | Officers<br>N=126 | Recruits<br>N=75 |
|--|--------------|-------------------|------------------|
| I know how to approach and question people at risk of suicide.   | 57           | 73                | 29               |
| I feel I can accurately identify situations where a person is at risk of suicide.                                | 70           | 82                | 48               |
| I don't feel comfortable establishing the level of risk of a suicidal person.                                    | 20           | 20                | 23               |
| I know how to refer people at risk of suicide to the services most appropriate to their needs and level of risk. | 55           | 64                | 39               |

Interviews corroborated the quantitative findings. Recruits suggested that they had low levels of confidence in responding to suicide situations, while more experienced officers described moderate to high levels of confidence. One officer distinguished between confidence and comfort level, when describing their discomfort in communicating with families who had been bereaved.

If it's occurred, the aftermath, I'm fairly confident because I've done it enough times. I know the process. I'm never confident dealing with families, but that's my personal perspective. I don't like having to pass on death messages. ... I'm confident doing it, but I still don't like it." [#4, sergeant]

## Organisational factors

All interviewees identified that responding to suicide crises was a part of their role within the QPS and that it formed part of what they understood to be policing core business. Several officers indicated that they saw responding to people experiencing suicide crises as consistent with the oath that they take to protect life.

Yeah, I do. Any time a threatening or attempting suicide job gets called in, it's pretty much given – it'll be allocated a priority code two, which is lights and sirens, so it is a priority. We will attend those jobs over other jobs that are in the queue waiting to attend to, so it is a priority. [t's reasonable because] it is preservation of human life, which is our core duty, or one of our core duties. [#19, sergeant]

I just enjoy being able to help people and that's just my little – one little part I can do. I can't provide the actual help they need to get them out of the crisis. But quite often I can give them the help they need to get them past that crisis point. I may not stop them from suiciding, but if I can stop them from suiciding that day at that time, that's a win. [#14, negotiator]

## Organisational strengths and challenges

As summarised in Table 11, a range of organisational strengths and challenges were highlighted by interview respondents. While noting that improvements could be made, police identified that there had been improvements in training, and shifts in processes towards more communication oriented approaches, overtime. Many noted that this was occurring alongside broader cultural change within the QPS.

However, officers indicated some frustrations, which included lack of support for officers in rural and remote districts. Officers also voiced frustrations in interfacing with the health system, in terms of their experiences of repeated encounters with people at risk. These discussions underscored different organisational imperatives on police and health, with police identifying that they fostered ‘worst case scenario’ planning, with respect to people who may be at risk of suicide.

Table 11 Police identified organisational strengths and challenges

|   | Officers<br>n (N=18) | Quote  |
|---|----------------------|--|
| <b>Strengths</b>                            |                      |  |
| Increased access to high quality training   | 10                   | “On the QPS side – I don’t want to sound like I’m bagging what I do. But for a long time a lot of our on the job training, our [...] training has been really tactically driven. You see this situation. This is what you do in this situation. I’ve been fairly critical of that for a long time [...]. There are two things that coppers do the most. One is drive cars and the other is talk to people. They’re probably two of the things that we do the least amount of training on, outside of the negotiator world. That’s changing now with our Australia yearly tactical training. They’re doing a lot more communication-based scenarios in it. It’s really, really good. If you’re talking about am I happy with the amount of training that we get as a non-negotiator police officer, I think there is a lot more scope for a lot more training to be done, as difficult as that can be in a large organisation. But communication with people is very, very important. It’s the most important thing we do for a whole heap of reasons.” [#10, sergeant] |
| Changing the culture                        | 9                    | “I think they’re slowly changing. The QPS is a pretty big [organisation] to shift and it’s slowly moving that way. There is a unit set up now, a vulnerable persons unit, that these types of things will really contribute long term towards making sure that we do provide a good service to people. Another [factor] to that will be a big cultural change away from the stigma that suicide probably has [...] I think there are things like setting up units that specifically deal with those things and equipping them with skills and education is pretty much the key in my opinion for a lot of this sort of stuff. I think that it’s really what needs to happen, information sessions and education about that type of thing. I think there is definitely room for improvement. But I think also they’re probably slowly on that road too.” [#10, sergeant]  |
| Communication                               | 7                    | “In terms of just that de-escalation instead of confrontation, I think that a lot more people are employing that training in their day to day dealings with people, which has had a massive reduction in those violent confrontations, which I think is a great thing.” [#6, constable]<br><br>“I think we do quite well. I think it would be a fair call, a very high percentage of police have good communication skills. There’s always going to be the low percent, but it wouldn’t matter what role they’re in, like trouble with communications, but I think we do it well.” [#15, sergeant]   |
| Co-responder models and health partnerships | 6                    | “So, because we get tied up a lot with just mental health problems, it’s not always suicide attempts but the mental health. Obviously, suicides will have a mental health aspect to it. So, instead of others turning up and being the – we’re not qualified psychiatrists or doctors, so we try and send this co-responder car there first, so they’re sort of doing those jobs for us now. Because they’ve got them on board – I don’t know what they’re called, just for mental health, they’ve got access to these patient’s histories and things. So, it just means they’re getting probably a better intervention.” [#4, sergeant]   |
| Prioritisation of suicide responses         | 6                    | “I think they correctly prioritise the jobs. I think they understand the urgency of [attending] so they allow us that ability to make it an urgent [duty] driving matter or something like that where you have to get there as a quick response.” [#5, sergeant]   |

## Challenges

|  |   |  |
|--|---|--|
| Frustration with the health system         | 5 | “Where police often are let down is by a lack of understanding of health or a perception of health, don’t take this person seriously. They work under different guidelines, different risk. We have a large-scale response to a higher risk incident, only to see that person out walking around a short time later. It’s sometimes frustrating for police. [...] we look at that worse case and we look at the possibilities and that. Quite often the problem is the police are the ones that are picking up the pieces. That’s why we tend to be a bit cynical, when we’ve seen it all before. Where they get let out and then they’re just back up on the bridge or back somewhere else the next day or two days later. [...]. I guess police sometimes are feeling let down by how health prioritise things in comparison to police.” [#14, negotiator, rank unknown] |
| Rural and remote resourcing                | 4 | “So, it’s very hard [...] especially in these remote areas. We don’t have the luxury of having negotiators and those kinds of people around. We’ve just got to deal with it. We just manage out here. What they do in the high dense areas like [Brisbane] and the big cities and stuff like that, they’ve got the capability for multiple units to respond. Out here it could just be two people. Sometimes it’ll only be one. So, we’ve just got to manage.” [#5, sergeant]  |
| Professional consequences – accountability | 3 | “I actually think police have a better attitude towards people that are suicidal than the [health service] because, basically, if we fail to do our job and said person kills themselves, [...] we’ll get the sack. So, police are very careful about what they say [...] and doing the thing that’s most essential to keep that person safe.” [#12, sergeant]   |

# CONCLUSIONS

Surveys and interviews with QPS staff identified overall high levels of knowledge, skills, attitudes and confidence in responding to suicide crisis situations. There are opportunities to support police in making best use of Emergency Examination Authorities and in facilitating the use of emerging alternative care pathways. Ongoing initiatives to foster collaboration, knowledge exchange and mutual support between police and health services, are important to improving knowledge and confidence among police staff in responding to suicide crisis situations. Additionally, the support needs of police responders and their families need to be addressed. QPS should continue to invest in initiatives to destigmatise mental illness.

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### NEED HELP?

Suicide can be a difficult topic for many people. If you would like to talk with someone, find support, or locate more information, you can contact:

Lifeline 13 11 14  
[www.lifeline.org.au/gethelp](http://www.lifeline.org.au/gethelp)

Suicide Call Back Service  
1300 659 467  
[www.suicidecallbackservice.org.au](http://www.suicidecallbackservice.org.au)

MensLine Australia  
1300 789 978  
[www.mensline.org.au](http://www.mensline.org.au)

Beyond Blue Support Service  
1300 224 636  
[www.beyondblue.org.au](http://www.beyondblue.org.au)

SANE Australia Helpline  
1800 187 263  
[www.sane.org](http://www.sane.org)

QLife (LGBTI)  
1800 184 5270  
[www.qlife.org.au](http://www.qlife.org.au)

Kids Helpline  
1800 551 800  
[www.kidshelpline.com.au](http://www.kidshelpline.com.au)

Defence Family Helpline  
1800 624 608  
[www.defence.gov.au/dco/defence-helpline.asp](http://www.defence.gov.au/dco/defence-helpline.asp)

