# Police and Suicide Prevention

## Evaluation of a Training Program

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**Abstract.** *Background:* Police officers are frequently the first responders to individuals in crisis, but generally receive little training for this role. We developed and evaluated training in suicide awareness and prevention for frontline rail police in the UK. *Aims:* To investigate the impact of training on officers' suicide prevention attitudes, confidence, and knowledge. *Method:* Fifty-three participants completed a brief questionnaire before and after undertaking training. In addition, two focus groups were conducted with 10 officers to explore in greater depth their views and experiences of the training program and the perceived impact on practice. *Results:* Baseline levels of suicide prevention attitudes, confidence, and knowledge were mixed but mostly positive and improved significantly after training. Such improvements were seemingly maintained over time, but there was insufficient power to test this statistically. Feedback on the course was generally excellent, notwithstanding some criticisms and suggestions for improvement. *Conclusion:* Training in suicide prevention appears to have been well received and to have had a beneficial impact on officers' attitudes, confidence, and knowledge. Further research is needed to assess its longer-term effects on police attitudes, skills, and interactions with suicidal individuals, and to establish its relative effectiveness in the context of multilevel interventions.

**Keywords:** police, gatekeeper, training, suicide, intervention



The importance of the police in recognizing and managing people at risk of suicide has become increasingly apparent (Department of Health, 2012). As part of their day-to-day duties police officers come into frequent contact with suicidal persons, not least because they are often the first emergency service to be alerted when an individual is suspected to be at risk of suicide (Matheson et al., 2005). They also regularly deal with crises related to mental health issues, estimated to be at least 15% of incidents dealt with by the police in the UK (Bather, Fitzpatrick, & Rutherford, 2008; for a recent international overview see Hansson & Markström, 2014). Furthermore, in a study from England almost a quarter of individuals who died by suicide had seen a police officer in the 3 months prior to their death, which was as many as had contact with a mental health professional in the year preceeding their suicide (Linsley, Johnson, & Martin, 2007). This included both victims of crime and alleged perpetrators as well as individuals likely to have ongoing police contact, such as those detained in police custody (Best, Havis, Payne-James, & Stark, 2006; Cox & Skegg, 1993) and persons with drug and alcohol addictions (Murphy, Hawton, & Van Heeringen, 2000).

These findings suggest that it is crucial for police officers to be able to recognize situations where a member of the public is at risk of suicide, ascertain their level of risk, and facilitate access to appropriate services. This particularly includes Railway Police officers, given that around 5% of all self-inflicted deaths occur on railways (Mishara, 2007) and the high lethality of rail suicide attempts, particularly at main line railways (Ladwig, Ruf, Baumert, & Erazo, 2009). In the UK, British Transport Police (BTP) deals with approximately 350 deaths on the rail system per year, of which at least 80% are believed to be suicides (Smith, 2013). In addition, BTP officers are thought to deal with over 20,000 incidents each year involving mental health issues, including 2,700 incidents of suicidal behavior (Smith, 2013). Their confidence and competence in dealing with such incidents are arguably key to providing appropriate care and support to individuals in crisis and for the staff's own well-being and job satisfaction in relation to this area of work.

Research has repeatedly shown that training gatekeepers – that is, people who have primary contact with those at risk of suicide and may therefore identify such risk and refer them for treatment – can be a potentially effective component of suicide prevention strategies; it can be successful in developing the knowledge, skills, and attitudes of trainees (Isaac et al., 2009) and decreasing stigma related to suicide and mental health care (Bean & Baber, 2011) as well as reluctance to intervene (Tompkins & Witt, 2009; Wyman et al., 2008). However, much of the literature in this area has focused on programs for clinicians, mental

*Table 1*. Training objectives

| Key areas covered in the training module: |
|---|
| • The extent of the suicide problem (including specifically on the rails) |
| • The role of police officers in suicide prevention (including legal duties and other responsibilities) |
| • Current advances and limitations in suicide risk assessment |
| • Common myths and misconceptions about suicide |
| • The main characteristics of individuals who engage in suicidal and self-harm acts, including a typology of high-risk groups and situations |
| • Demographic, psychosocial, psychiatric, and environmental risk and protective factors for suicide, including behavioral patterns, emotional problems, and other warning signs |
| • How to approach and question individuals suspected to be at risk of suicide |
| • How to ascertain the level of risk of individuals suspected to be suicidal or expressing suicidal ideation |
| • How to refer individuals at risk of suicide to the services most appropriate for their specific needs and level of risk |
| • Implementing force-specific suicide prevention procedures and relevant mental health legislation, in high, moderate, and standard risk situations |
| • Postincident procedures, including: |
| a. Dealing with individuals bereaved by suicide and referring them to available help and services |
| b. Dealing with the media following a suicide or attempted suicide |
| c. Sources of support and advice for police officers dealing with the aftermath of a suicide or attempted suicide, or experiencing suicidal thoughts |



health staff (e.g., Gask, Dixon, Morriss, Appleby, & Green, 2006), and teachers (e.g., Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010). Although some gatekeeper training interventions have included police officers among wider community-based groups (Bean & Baber, 2011; Hegerl et al., 2006), we are not aware of any such programs aimed specifically at this group. Suicide and mental health awareness training appear to have been relatively neglected areas in police training (Bradley, 2009; Carey, 2001; Cummins, 2012; Norris & Cooke, 2000; perhaps with the exception of police custody settings) and poorly valued in traditional police culture (Husted, Charter, & Perrou, 1995).

Lack of awareness about suicide and associated mental health issues may contribute to stigmatizing attitudes and limit the support that suicidal individuals may otherwise receive (Dagnan, Trower, & Smith, 1998; Weiner, 1986), potentially exacerbating their distress and level of risk. Reports from across the globe have suggested that encounters with mentally ill individuals are, from a police perspective, not only frequent but often also sensitive and challenging (Chappell, 2013). In North America, Australia, and Europe, where most research on this topic has been conducted, studies have shown that some officers feel reluctant, and even resentful, when responding to people in crisis, a role that is not always recognized as within the remit of law enforcement (Borum, 2000), and for which they can feel unsupported and unprepared (Fry, O'Riordan, & Geanellos, 2002; Godfredson, Thomas, Ogloff, & Luebbers, 2011; Psarra et al., 2008). In addition, lack of training has been identified as contributing (a) to poor confidence and feelings of anxiety, irritation, and fear among police officers dealing with such situations and (b) to the perception that mentally ill individuals are challenging, difficult to manage, and potentially dangerous (Borum, 2000; Fry et al., 2002; Gofredson et al., 2011). In turn, this can lead to a disproportionate use of force and restrictive measures (Wells & Schafer, 2006) and to criminalization of individuals in severe distress (Lamb, Weinberger, & DeCuir, 2002). In the UK, the reportedly poor knowledge of relevant police powers and mental health legislation among officers (Lynch, Simpson, Higson, & Grout, 2002) may further exacerbate the problem.

Understanding suicidal behavior may therefore improve attitudes and increase helping behaviors, while enabling police officers to feel more confident and effective in this difficult area of work. In addition, having more positive and better informed views about suicide may assist police officers in dealing with people bereaved by suicide, who are themselves at increased risk of taking their own lives (Pitman, Osborn, King, & Erlangsen, 2014; Qin, Agerbo, & Mortensen, 2002), and when disclosing the details of a suicide or attempted suicide to the media, where sensationalized and overly detailed reporting is known to lead to imitative acts (Niederkrotenthaler et al., 2009).

Finally, providing adequate training with regard to suicidality may have secondary benefits for the officers themselves in terms of increasing awareness of mental health issues that might affect them personally, their colleagues, or their family members, and raise awareness about when and how to seek help. This may be particularly important in relation to BTP officers, for whom the pressure and distress of removing bodies (and body parts) from railway lines may be particularly traumatic (Mishara, 2007). Previous research has shown that police officers have a greater risk of suicide and suicidal ideation than comparable populations (see Violanti, Mnatsakanova, & Andrew, 2013). This has in turn been be linked to their increased exposure to traumatic work events and risk of developing symptoms of posttraumatic stress disorder (PTSD) and alcohol abuse (Violanti et al., 2013; Gershon, Lin, & Li, 2002), and cultural reluctance to seek help in relation to these problems (Violanti, 2007), even when experiencing severe suicidal thoughts (Berg, Hem, Lau, & Ekeberg, 2006). In spite of this, there is evidence that police suicide prevention programs can be well received among police workers and can be effective in reducing police suicides (Mishara & Martin, 2012), but remain relatively rare.

As part of wider efforts to reduce rail suicides by 20% (Rail Safety and Standards Board, 2012), we developed and evaluated a training resource for police officers to assist them in identifying and intervening in situations where an individual may be at risk of suicide. Using mixed (quantitative and qualitative) methods, we evaluated the impact of this resource on officers' self-reported attitudes, confidence, and knowledge in relation to suicide prevention, as well as their views of the resource and its perceived impact on practice.

 

# Method

## A Suicide Prevention Resource for Police Officers

The resource consisted of a training module designed to be delivered over a 4-hr session (see Table 1), with the aid of a training manual and a PowerPoint presentation, as well as case vignettes and reflective questions to encourage group discussions and learning. We also produced an abbreviated version of the resource, to be used following successful completion of the training as a memory aid and easy-to-consult suicide risk assessment and referral tool.

### Resource Development

The training module and associated aide-mémoire were developed in consultation with frontline police officers and experts in the police, the health service, and suicide research, and following a review of the academic literature on comparable gatekeeping interventions (e.g., Gask et al., 2006; Isaac et al., 2009) and suicide risk assessment and referral tools (e.g., Bryan & Rudd, 2006), as well as on risk factors (Hawton & van Heeringen, 2009) and warning signs for suicide (Rudd et al., 2006), in the general population. From an operational perspective, accurate assessment of suicide risk and referral to appropriate services (based on suicide risk) were identified from the outset as key priorities, based on concern that police response to individuals at low or moderate risk of suicide may not differ sufficiently from actions taken in situations of high and immediate risk of suicide. In turn, the tendency to treat all potentially suicidal individuals as being *high-risk* was said to have placed additional strain on already stretched mental health services and resources. For this reason, and because operational needs meant that the module could be no more than 4-hr long, training focused primarily on suicide risk categorization and taking appropriate action based on individual needs and level of risk, with case vignettes designed to help trainees practice these skills in small groups.

*Train the trainers* sessions were carried out to ensure that the trainer delivering the module, a qualified regional police trainer with several years' experience, was satisfied with its content and format.

### Piloting and Implementation

A slightly modified version of the resource was concurrently piloted with police in the Kent Medway area of the South of England (evaluated and reported separately). Between autumn 2010 and summer 2011, 168 BTP frontline staff from London North area were trained using the resource, having been selected by rostering (i.e., based on officer availability on specific training days). All sessions were led by the same trainer, with additional input from a subject matter expert from the BTP Suicide Prevention and Mental Health Team, in relation to force policies and procedures and BTP-specific experiences of managing and preventing suicide.

## Evaluation

### Questionnaire

All officers who participated in the training program were asked to complete a brief questionnaire before (Time 1), immediately after (Time 2), and 6 months after (Time 3) undertaking training, to measure changes in knowledge, confidence, and attitudes regarding suicide prevention. All three questionnaires included a modified 13-item version of the Attitude to Suicide Prevention Scale (ASPS; Herron, Ticehurst, Appleby, Perry, & Cordingley, 2001), a scale with good internal reliability ($\alpha = 0.77$) that has been used in earlier evaluations of suicide prevention programs for frontline staff (Gask et al., 2006; Hayes, Shaw, Lever-Green, Parker, & Gask, 2008). As the original scale was developed with health professionals, we removed references to "health services" (from Item 1), deleted Item 6 ("It is easy for people not involved in clinical practice to make judgements about suicide prevention"), and amended other items to avoid using the term *commit* in relation to suicide (since this is now generally regarded as inappropriate). To reflect operational need and priorities, we also developed a measure of confidence in suicide prevention (four items; e.g., "I feel I can accurately identify situations where a person is at risk of suicide") and knowledge about suicide (10 items based around prevalent suicide myths, e.g., "Most suicides happen without warning"; "Asking someone directly about suicide can give them ideas or encourage them to end their lives"). Both groups of questions were primarily – but not exclusively – focused on categorization of suicide risk and appropriate referral paths. Ratings on the attitudes and confidence scales were made on a 5-point Likert scale (ranging from 1 = *strongly agree* to 5 = *strongly disagree*), while participants were asked to either agree or disagree with each knowledge question or to declare themselves unsure. Basic demographic information was also collected, alongside details of rank, length of service, specialism, previous relevant training, and personal and professional exposure to suicide and attempted suicide. The second and third questionnaires also included questions about officers' experiences of the training and the extent to which this had influenced their practice.

### Focus Groups

We also conducted two focus groups with 10 officers who had participated in the training program, to discuss in greater depth their views and experiences of this. Potential participants were randomly selected by rostering. A semi-structured interview schedule (available on request) was developed based on a review of the literature, expert consultation, and emerging findings from the questionnaire study. The focus groups were led by one of the authors



 

(L. M.), who is an experienced qualitative researcher and interviewer. They each lasted between 60 and 90 min, and were tape-recorded to enable subsequent verbatim transcription.

## Data Analyses

All quantitative data analyses were conducted using SPSS 15.0. Paired differences were assessed using Wilcoxon signed ranks tests. In the results, denominators for some variables vary because of missing information. For consistency and comparability with past research using the ASPS, all negatively worded items on the ASPS were reversed, so that higher scores would be indicative of more negative attitudes. Also, means and standard deviations are reported for scores on each item of the ASPS, even though these data were not normally distributed (and were therefore analyzed accordingly).

Qualitative data from the questionnaires and focus groups were transcribed and anonymized. Transcripts were read at least twice, summarized, and major themes recorded by one of the authors (L. M.), following the analytical steps recommended by Braun and Clarke (2006). A coding frame was developed to facilitate coding of focus group transcripts using NVIVO (Version 8.0; QSR, 2008). In relation to open-ended questionnaire responses, some of the thematic categories originally constructed were further collapsed for quantitative analyses of content.

The evaluation received ethical approval from the Oxford University Central Research Ethics Committee (reference MSD/IDREC/C1/2010/58).

# Results

Of the 168 officers who participated in the training program, 101 (60%) completed a pretraining questionnaire, 118 (70%) a posttraining questionnaire, and 21 (12.5%) a 6-month posttraining measure. In all, 53 participants (31.5% of those who received training) completed a questionnaire before and shortly after the training. As shown in Table 2, the sample varied in age (range: 20–55 years), gender, grade and years of service (range: 1–36 years), but the majority of participants were male Police Constables, with an average of around 3 years of service.

Almost half the sample reported having dealt with suicide and attempted suicide in their professional lives, despite only a minority having previously received training in suicide prevention or other relevant subjects. A third of the sample had personal experience of suicide and attempted suicide, including in family and friends.

## Impact of Training on Attitudes Toward Suicide Prevention

Attitudes toward suicide prevention were mostly positive, particularly following the training (Table 3). Only a minority of participants felt that suicide prevention is not police responsibility, or reported resenting this area of work, or feeling defensive about it. Compared with pretraining scores, fewer officers identified those surviving a suicide attempt as attention seekers, and at least half the sample recognized that those who are serious about suicide do not necessarily conceal their suicidal intentions.

Matched comparisons revealed that, with the exception of responses to Item 12 (“There is no way of knowing who will kill themselves”), posttraining scores were always lower than pretraining ones. This is indicative of improved attitudes to suicide prevention. In relation to three items (“If people are serious about suicide they do not tell anyone,” “If a person survives a suicide attempt then this is a ploy for attention,” “I do not feel comfortable assessing someone for suicide risk”), differences between pre- and posttraining scores were statistically significant (all $p < .01$; see Table 3).

However, despite the majority of officers appearing confident in their ability to assess suicide risk, a third of

*Table 2.* Sample characteristics ($N = 53$)

| | *n* | % |
|---|---|---|
| Age, median (years; $N = 49$) | 30 | |
| Male gender | 41 | 77.4 |
| Rank | | |
| Police Constabulary (PC) | 30 | 56.6 |
| Police Community Support Officer (PCSO) | 20 | 37.7 |
| Police Sergeant (PS) | 3 | 5.7 |
| Years of service, median | 3 | |
| Received previous suicide prevention training | 4 | 7.5 |
| Received other relevant training | 7 | 13.2 |
| Professional experience of suicide or attempted suicide ($N = 50$) | 24 | 48.0 |
| Personal experience of suicide or attempted suicide ($N = 50$) | 17 | 34.0 |



 

*Table 3.* Comparisons between pre- and posttraining attitudes to suicide prevention

| | Pretraining | | Posttraining | | Wilcoxon signed rank test | *p* |
|---|---|---|---|---|---|---|
| | *N* | *M*[a] (*SD*) | *N* | *M*[a] (*SD*) | | |
| I resent being asked to do more about suicide (*N* = 52) | 53 | 2.02 (0.80) | 52 | 1.96 (0.63) | –0.35 | .724 |
| Suicide prevention is not police responsibility (*N* = 52) | 53 | 2.16 (0.99) | 52 | 2.02 (0.73) | –1.30 | .193 |
| Making more funds available to the appropriate services would make no difference to suicide rates (*N* = 52) | 53 | 2.55 (0.95) | 52 | 2.33 (0.98) | –1.29 | .198 |
| Dealing with suicidal persons is rewarding (*N* = 51) | 51 | 2.80 (0.78) | 51 | 2.71 (0.88) | –1.09 | .275 |
| If people are serious about suicide, they do not tell anyone (*N* = 50) | 51 | 3.16 (0.90) | 51 | 2.33 (0.77) | –4.69 | **< .0001** |
| I feel defensive about suicide prevention (*N* = 49) | 50 | 2.46 (0.71) | 51 | 2.27 (0.87) | –1.66 | .097 |
| If a person survives a suicide attempt, then this is a ploy for attention (*N* = 51) | 51 | 2.41 (0.78) | 52 | 2.0 (0.71) | –2.96 | **.003** |
| People have the right to take their own lives (*N* = 50) | 51 | 3.18 (0.91) | 51 | 3.04 (0.96) | –1.10 | .273 |
| Since unemployment and poverty are the main causes of suicide there is little that an individual can do to prevent it (*N* = 47) | 51 | 2.22 (0.73) | 51 | 2.08 (0.69) | –0.86 | .392 |
| I do not feel comfortable assessing someone for suicide risk (*N* = 49) | 51 | 3.06 (1.01) | 50 | 2.26 (0.75) | –4.72 | **< .0001** |
| Suicide prevention measures are a drain on resources that would be more useful elsewhere (*N* = 50) | 51 | 2.33 (0.86) | 51 | 2.24 (0.76) | –0.43 | .665 |
| There is no way of knowing who will kill themselves (*N* = 48) | 51 | 3.04 (1.04) | 49 | 3.27 (1.09) | –1.30 | .208 |
| What proportion of suicides do you consider preventable? (none – all; *N* = 47) | 48 | 3.17 (1.14) | 49 | 2.84 (0.96) | –1.620 | .105 |

*Note*. [a] Scores range from 1 to 5. Higher scores are indicative of more negative attitudes. Bold indicates statistically significant results.



participants felt that "there is no way of knowing who will kill themselves" and almost three-quarters considered only 50% or less of all suicides to be preventable.

## Impact of Training on Confidence in Suicide Prevention

Following the training most participants said they were confident about their skills in various aspects of suicide prevention. Establishing the level of risk of suicidal individuals was the area in which fewer officers (albeit still the majority) reported feeling confident. No respondents reported difficulties in identifying suicidal individuals or referring them to the services most appropriate to their needs, and only one participant reported having little confidence in approaching and questioning people at risk of suicide.

Among officers who completed both the pretraining and posttraining questionnaires, there were statistically significant improvements in all confidence domains following the training (all $p < .01$; see Table 4).

## Impact of Training on Knowledge About Suicide Prevention

Following the training, all suicide prevention knowledge questions were answered correctly by at least half the participants, with the exception of Item 2 ("Most people who attempt suicide have a mental health problem"). Over 80% of the sample (85/102, 83.3%) answered at least seven items correctly, and the proportion of *unsure* responses was lower than before training (see Table 5).

In matched comparisons, the median number of correct responses increased significantly following the training – median pretraining score ($n = 50$) = 6/10 vs. median posttraining score ($N = 48$) = 8/10; $z = -5.18$, $p < .0001$.

## Feedback About Training

Immediately following the training, participants ($n = 110$) were asked to rate several elements of their training experience. All aspects of the training, including its content,

 

*Table 4.* Comparisons between pre- and posttraining confidence in suicide prevention

| | Pretraining | | Posttraining | | Wilcoxon signed rank test | *p* |
|---|---|---|---|---|---|---|
| | *N* | *M*[a] (*SD*) | *N* | *M*[a] (*SD*) | | |
| I feel I can accurately identify situations where a person is at risk of suicide | 53 | 2.91 (0.69) | 52 | 2.17 (0.47) | –4.96 | **< .0001** |
| I know how to approach and question people at risk of suicide | 53 | 3.15 (0.69) | 52 | 2.08 (0.44) | –5.56 | **< .0001** |
| I don't feel comfortable establishing the level of risk of a suicidal person | 53 | 3.08 (0.85) | 52 | 2.54 (1.02) | –2.95 | **< .0001** |
| I know how to refer people at risk of suicide to the services most appropriate to their needs and level of risk | 53 | 3.06 (0.86) | 52 | 2.19 (0.60) | –5.04 | **.003** |

*Note*. [a] Scores range from 1 to 5. Higher scores are indicative of lesser confidence. Bold indicates statistically significant results.

*Table 5.* Knowledge about suicide prevention (pre- and posttraining)

| | Pretraining | | | Posttraining | | |
|---|---|---|---|---|---|---|
| | Agree *n* (%) | Disagree *n* (%) | Unsure *n* (%) | Agree *n* (%) | Disagree *n* (%) | Unsure *n* (%) |
| Suicide rates are similar in men and women (F) | 4/96 (4.1) | 44 (45.4) | 48 (49.5) | 5/109 (4.6) | 97 (89.0) | 7 (6.4) |
| Most people who attempt suicide have a mental health problem (T) | 27/97 (27.8) | 49 (50.5) | 21 (21.6) | 44/109 (40.4) | 53 (48.6) | 12 (11.0) |
| People who have lost a family member due to suicide are less likely to attempt suicide themselves (F) | 0/97 (0.0) | 69 (71.1) | 28 (28.9) | 6/107 (5.6) | 95 (88.8) | 6 (5.6) |
| People with a history of suicide attempts and self-harm are at increased risk of suicide (T) | 69/96 (71.1) | 12 (12.4) | 16 (16.5) | 99/109 (90.8) | 6 (5.5) | 4 (3.7) |
| People who are about to attempt suicide are always distressed and agitated (F) | 6/97 (6.3) | 70 (72.9) | 20 (20.8) | 9/108 (8.3) | 91 (84.3) | 8 (7.4) |
| Asking someone directly about suicide can give them ideas or encourage them to end their lives (F) | 6/97 (6.2) | 67 (69.1) | 24 (24.7) | 5/107 (4.7) | 95 (88.8) | 7 (6.5) |
| Daring a person to carry out a suicidal threat will discourage them from attempting suicide (F) | 1/97 (1.0) | 78 (80.4) | 18 (18.6) | 2/108 (1.9) | 102 (94.4) | 4 (3.7) |
| Most suicides happen without warning (F) | 24/96 (24.7) | 31 (32.0) | 41 (42.3) | 24/107 (22.4) | 66 (61.7) | 17 (15.9) |
| Police should only intervene when a person is at high risk of suicide (F) | 12/96 (12.5) | 67 (69.8) | 17 (17.7) | 6/107 (5.6) | 98 (91.6) | 3 (2.8) |
| All people at high risk of suicide should be sectioned under the Mental Health Act (F) | 26/96 (27.1) | 41 (42.7) | 29 (30.2) | 36/107 (33.6) | 54 (50.4) | 17 (15.9) |

*Note*. T = true. F = false.



trainer, and environment, were rated positively by at least 95% of respondents. Overall ratings of the training were consistently very positive (only 0.8% of trainees rated the training as poor; 4.2% as average; 22.9% as good; 56.8% as very good; and 15.3% as excellent).

## Most Helpful Aspect of Training

In all, 101 participants commented on the training element (or elements) they found most helpful. An especially common theme, mentioned by over half of those who provided feedback ($n = 52$, 51.5%), was that the course had increased their understanding of the police force's suicide prevention policies and procedures (including suicide management plans and related policy). Some trainees commented that all aspects of the training had been useful and informative ($n = 22$, 21.8%) and relevant to an officer's professional role ($n = 6$, 5.9%), whereas others were especially positive about the group discussions and exercises undertaken as part of the training ($n = 17$, 16.8%), including the opportunity to work through different case scenarios ($n = 8$, 7.9%) and reflect on past incidents with colleagues ($n = 7$, 6.9%). Other participants highlighted the benefits of learning about different aspects of risk assessment ($n = 8$, 7.9%) and risk management ($n = 10$, 9.9%), including how to identify and question persons at risk of suicide, "more options for dealing with everyday situations I might encounter", and "dos and don'ts for dealing with suicidal persons".

### Least Helpful Aspect of Training

Although a considerable majority of respondents said there was nothing in the training they found unhelpful ($n$ = 45, 70.3%), 19 officers (16.1%) identified one or more negative aspects of the course they attended. Specific comments were made about the format of the course ($n$ = 5, 7.8%) and the policy/procedural input ($n$ = 8, 12.8%), which for some was "mostly already known" and/or "not helpful in its entirety." Some participants, albeit a minority, also commented on a potential mismatch between academic research/knowledge and what officers observe in their everyday practice and interactions ($n$ = 4, 6.3%).

### Participants' Suggestions for Improving Training in Suicide Prevention

A fifth of participants commented that the training received did not necessitate any changes ($n$ = 24, 35.8%). Others, however, put forward some suggestions for improving training in suicide prevention. The most frequent of these was to incorporate the input of an outside speaker, for example a Samaritans worker ($n$ = 4, 6.3%), someone who had previously considered and/or attempted suicide ($n$ = 2, 3.1%), a mental health professional ($n$ = 1, 1.6%), or the representative of a support service ($n$ = 1, 1.6%). (Samaritans is a charity with branches across the UK and Ireland, offering confidential support to individuals in distress.)

Further suggestions were to provide more information about the force's suicide prevention procedures and management plans ($n$ = 6, 9.4%), more practical exercises (e.g., "scenarios in communication with the possible suicidal person"), relevant video clips, and other useful information. Although some participants called for longer training sessions ($n$ = 4, 6.3%), others expressed a preference for shorter sessions ($n$ = 3, 4.5%) and/or PowerPoint presentations ($n$ = 3, 4.5%), potentially to be delivered as part of new recruits' initial training ($n$ = 3, 4.5%).

Focus group participants also highlighted the importance of formal officer training in delivering sympathy messages to individuals bereaved by suicide, as part – or instead of – training in suicide prevention. Some also reiterated the need for suicide prevention training to be delivered earlier in an officer's career, ideally by someone with "real experience" in the job.

> After a few years in this job everyone has pretty much got a story about someone being dragged off the tracks. So if you had someone who had 10 years as a copper [police officer] or what have you, and they, you know, they could give you a couple of these old war stories … and you know that they've been there, they've done it.

Another suggestion was to (also) deliver training in suicide prevention to control room staff who deploy officers to deal with incidents, so that they may guide officers on the scene. Partly for the same reasons, and partly because they are "basically in control," two participants added that it "would also be good for the duty governors to be trained." Finally, some suggested a refresher course, possibly involving service users with experiences of self-harm.

## Six-Month Follow-Up

Of the overall sample, 23 officers (12.5%) completed a questionnaire 6 months after undertaking training in suicide prevention (of these, 11 had previously completed questionnaires at both Time 1 and Time 2). During this period, the majority of respondents had contact with a person at risk of suicide at least once ($n$ = 14, 66.7%; in most cases two to four times, $n$ = 9, 42.9%).

There was insufficient power to carry out matched comparisons, but it appears that posttraining improvements in attitudes, confidence, and knowledge were maintained over time, at least in this subgroup of officers (data available upon request). Six months after the training, participants' attitudes toward suicide prevention remained mostly positive, over half the sample (12/21, 57.1%) answered correctly at least eight of ten suicide prevention knowledge questions, and confidence in relation to this area was high, particularly with regards to identifying, approaching, and questioning persons at risk of suicide. Establishing the level of risk of suicidal individuals remained the area in which fewer officers felt confident. A further and perhaps related area of concern was fear of being held accountable should "things go wrong," particularly at a time of budget cuts. As explained by a focus group participant:

> If we generally err on the side of caution, then we keep our jobs. That's kind of what it comes down to. You'd end up putting everyone down as high risk, because if you put anyone down as low risk, and they go and do it tomorrow, then it will be "Oh, you've categorized him wrong…"

# Discussion

The results of this study confirm the important role of the police in suicide prevention. Although by virtue of their rank and specialism not all rail police have regular contact with individuals at risk of suicide, our findings suggest that at least 50% will have dealt with suicide or attempted suicide in their professional lives. We developed training to better equip BTP officers for such situations, and assessed its effects on officers' attitudes to suicide prevention, confidence, and knowledge, as well as their satisfaction with the course and associated aide-mémoire.

Against a difficult backdrop of financial cuts and fear of accountability in case of a death, it is encouraging that pretraining attitudes toward suicide prevention were mixed but mostly positive. Also, despite only a minority of officers having previously received training in suicide prevention or other relevant subjects, their knowledge about risk factors for suicide and risk management was relatively good, with some exceptions. However, before the training program many participants reported low pretraining con-



 

fidence in assessing someone for suicide risk and in other suicide prevention skills.

Confidence in all suicide prevention domains increased significantly after the training, as did officers' overall knowledge about suicide prevention. Participants' attitudes toward suicide prevention also improved following the course, particularly in relation to specific domains. These positive changes were seemingly maintained at the 6-month follow-up, although it was not possible to verify this statistically owing to a lack of power. Similarly, while the numbers involved are too small to draw any firm conclusions, it is notable that 70% of those who had dealt with a suicide risk situation following the training reported that this had positively influenced their practice.

## Training Feedback and Suggestions for Improvement

The success of the training program was further corroborated by the excellent feedback received from officers who undertook the course – notwithstanding some criticisms and suggestions for improvement. Also, although there are important links and overlaps between dealing with the aftermath of a self-inflicted death and suicide prevention, some participants described the former as a more pressing issue than suicide prevention per se, especially in relation to delivering sympathy messages and receiving adequate postincident support from superiors and human resources.

Further suggestions to improve the suicide prevention training undertaken were to incorporate the input of an outside speaker, notably a Samaritans worker, someone who has considered or attempted suicide, a veteran officer with experience of dealing with suicidal behavior, or a mental health professional. Involving speakers and/or participants from other frontline services may also contribute to improved inter-agency communication, information flow, and working relations, for example, by clarifying – to all concerned – the roles, responsibilities, and powers of each service in relation to suicide prevention. This may be especially important at present, as police (including railway police) in several countries are increasingly moving toward multiagency partnership/crisis intervention team models of suicide prevention (Watson, Morabito, Draine, & Ottati, 2008) and of dealing with mental health and substance misuse issues more generally (Department of Health, 2014). Since this study was carried out, police in the UK have established a National Suicide Prevention Strategy Group, which has led to improvements in training, multiagency working, and local planning (All-Party Parliamentary Group on Suicide and Self-Harm Prevention, 2013).

## Limitations

While questionnaire response rates at Times 1 (60%) and 2 (70%) were similar to those reported in comparable studies (e.g., Appleby et al., 2000; Hayes et al., 2008), the number of officers who completed both questionnaires was relatively small and questionnaire responses at Time 3 were too low to establish the longer-term effects of the training program.

Further issues are the lack of a control group, the use of self-report data, which are open to self-presentation biases, and the exclusive focus on the perspectives of frontline officers, which are likely to reflect wider occupational concerns and cultural factors. Nevertheless, seeking the opinions of those trained using the resource, and at the frontline of suicide prevention, is arguably the best method of evaluating the utility of the training and associated aide-mémoire. Our approach had the additional advantage of combining quantitative data from the questionnaire study with qualitative data from the focus groups, thus providing a richer picture of the training's impact on policing practice. However, to fully evaluate this, it would be beneficial to also seek the views of other services involved in suicide prevention and of individuals at risk of suicide who have come into contact with the police.

More research is also needed to determine whether and how the effects of suicide prevention training for police officers may be sustained over time (see Shtivelband, Aloise-Young, & Chen, 2015), both in relation to suicide-specific attitudes and skills (Cross, Matthieu, Lezine, & Knox, 2010) as well as to directly measured behaviors (Krameddine, DeMarco, Hassel, & Silverstone, 2013). Other potential impacts might be on perceived discrimination from the police of those suffering with mental health problems or the use of force in mental health calls (for a more comprehensive list of possible outcome measures see Krammedine & Silverstone, 2015). Owing to time constraints on training delivery and evaluation, it was not possible to include within the program observation and supervised simulation learning (e.g., video-taped role-playing of de-escalation and empathy skills) – as in longer gatekeeper training interventions (see, e.g., Gask et al., 2006; Krammedine & Silverstone, 2015), or to subsequently test these skills using observational methods (see, e.g., Cross et al., 2010). Nonetheless, the program we designed incorporated all recommended components of gatekeeper trainings programs (i.e., preparing, connecting, understanding, assisting, and networking; see Isaac et al., 2009) and included small and large group discussions of case vignettes devised to help trainees practice and improve their suicide assessment and referral skills (the latter being the main aims of the training from an operational perspective).

## Further Research

Further studies could usefully include direct observation of these and related skills to measure posttraining changes in actual competency over time. Following evidence that e-learning modules can be an effective strategy for enhancing gatekeepers' knowledge, self-confidence, and skills in adolescent suicide prevention (Ghoncheh, Kerkhof, & Koot, 2014), the feasibility and effectiveness of delivering

 

online suicide prevention training to police officers may also benefit from further investigation.

Finally, notwithstanding the importance of suicide-specific attitudes, knowledge, confidence, and skills, future studies could systematically investigate the role of other potential barriers to police-led suicide prevention, including cultural and practical factors, both within and across different gatekeeping/frontline agencies. As remarked by some focus group participants, a particular problem might be that of implementing a risk-based, stepped-care approach to suicide prevention in what is often a risk-averse and blame-fearing environment.



## Conclusion

Training in suicide prevention appears to have been generally well received by officers, and to have had a beneficial impact on suicide prevention attitudes, confidence, and knowledge. This is consistent with previous research on mental health training initiatives for police officers (Loucks, 2013; Norris & Cooke, 2000; Pinfold et al., 2003) and evaluations of gatekeeper training interventions in other settings and professional groups (Coppens et al., 2014; Isaac et al., 2009; Tsai, Lin, Chang, Yu, & Chou, 2011). Nevertheless, as highlighted by officers participating in this study, a brief training intervention is unlikely to have a significant impact on suicide prevention or on the role that police officers (with relatively limited mental health training) may be able or willing to play in suicide prevention – unless part of a wider, multilevel and multiagency strategy to support individuals in crisis as well as other staff and first-responders involved in this difficult work. Indeed, while this resource was developed as a separate initiative, it was implemented alongside a number of other local and national initiatives aiming to reduce rail suicides and self-inflicted deaths more generally (Department of Health, 2012). More research is needed to increase understanding of potential synergistic effects of multiple interventions applied together (van der Feltz-Cornelis et al., 2011), and to guide further development of evidence-based multilevel interventions.

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