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# The Forensic Forum Series

## Police Responses to "Suicide by Cop"


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## Part One – The Dynamics of Suicide

Author's Note: This three part series concerns the phenomenon of officer assisted suicide, or "Suicide by Cop" – SBC. The material in this series was presented by the author at the 2009 International Conference of the International Law Enforcement Educators & Trainers Association (ILEETA) in Chicago.

***"What are you gonna do if I come at you with this knife?!"*** the young man screamed from inside of the residence the pair of officers standing outside. ***"We'll shoot you if you do."*** was the response. Following a moment of eerie silence the disheveled and agitated young man quickly emerged from the doorway and ran towards the closest officer with a knife. In an instant there was a hail of gunfire and the young collapsed mortally wounded. As the involved officers were removed from the scene, one clearly despondent officer sat down at the curb and muttered, ***"Why us? Why couldn't he have just killed himself?"***

What the average street officer and supervisor lack in knowledge about suicide and specifically SBC intent behavior can fill volumes. Yet "Suicide by Cop" or "SBC" is one of the most serious officer and citizen safety issues facing law enforcement today. This series of articles, will attempt to acquaint you, the first responding street officer or patrol supervisor with the dynamics of suicide, SBC and the SBC intent subject. This series concludes with some tactical tips on how best to respond to situations where it is suspected that the subject you encounter is intent upon choreographing his death by your hands.

### SBC Factoids

- A study of 430 officer-involved shootings by Los Angeles Sheriff's Department deputies from 1987 – 1997 found that SBC accounted for 11% of all OIS's and 13% of OIS justifiable homicides; in 1997, 27% of OIS's were classified as SBC's. [1]

- A 2008 study using the latest empirical sample of Officer – Involved Shootings (OIS's) to examine the issue of SBC revealed that 36% of 707 OIS's from 1998 – 2006 could be categorized as "SBC." [2]

- A study published earlier this year showed that 97% of the SBC intent subjects that encountered police were subsequently injured or killed by them. [3]

### Mental Illness Factoids

- Law enforcement officers are more likely to be killed by a person with mental illness than by an assailant with a prior arrest for assaulting a peace officer, or for resisting arrest. [4]

- People with mental illnesses are killed by police in justifiable homicides at a rate of nearly four times greater than the general public. [5]

- In 1998, people with mental illnesses killed law enforcement officers at a rate 5.5 times greater than the general population. [6]

- In a 2000 study on mental illness, nearly one third of all people shot and killed in Officer-Involved Shootings (OIS) in New York City were classified as mentally ill. [7]

## Mental Illness

Part of our society's failure to properly address and care for people with mental illness are ineffective treatment laws that require someone to be a danger to themselves or others before they can be treated over their objection. As of the most recent documentation of 2005, eight states still had no mechanism to mandate treatment for the mentally ill in a community setting.

## Suicide Dynamics and Risk Assessment

To best respond to a potential SBC incident, officers must first understand forensically the basic psychological dynamics of suicide, suicidal ideation and suicidal behavior. Remember that because you, the peace officer, are not a doctor or a certified psychologist, you do not make diagnosis. Rather, you are "assessing" suicidal risk based upon a preponderance of evidence and a "totality of circumstances" presented, observed and experienced at the time your decisions are made.

Most SBC incidents can be resolved without the use of deadly force. Learning how to intervene in suicidal situations is as important as learning CPR or basic first aid techniques since both may deal with life and death situations. While CPR is "physical" first aid, suicide and SBC intervention can be seen as "psychological" first aid.

Although law enforcement officers are not trained psychologists, best police practices and the "reasonable officer doctrine" dictate that as "First Responders" officers should at least be knowledgeable in some basic psychology and cues of suicidal behavior sufficient to quickly assess a subject's current state of suicidality and potential lethality. The assessment of verbal communication and behavioral indicators and stressors that might be impacting the stability of the suicidal subject encountered is referred to as a "Suicide Risk Assessment" or 'SRA'. The objectives of an SRA are: (1) to see the warning signs when they are being communicated; and (2) to judge how close the person is at risk of suicide. Suicidal ideations and behaviors are alarms that sound out to First Responders, *"Notice me!" "I'm in trouble!" "I need help!"* [8] It is important to remember that the method of suicide is determined by both availability to a means and the personality of the individual.

There are many distinct types of suicide. They include: teenage suicide; euthanasia; murder-suicide; suicide bombing; ritual suicide; suicide pacts; internet suicide; copycat suicide; forced suicide and "Suicide by Cop." People view the act of suicide differently. The most common views of the act of suicide are based on cultural, religious, medical, legal, philosophical differences including, for example, "Right to Die" advocates.

## Suicide Factoids [9]

- Suicide is the 8th leading cause of death in the U.S.;
- The U.S. suicide rate is approximately 10.6 per 100,000;
- On an annual basis, there are more suicides (31,484) than homicides (17,732) in the U.S.;
- Firearms are used in 58% of all suicides in the U.S.;
- Women attempt suicide more frequently than men, but men are 4X more likely to be successful than women;
- Suicide is the 3rd leading cause of death in persons between the ages of 15 – 24 years;
- 90% of suicide completers had either a diagnosable mental illness, or substance abuse disorder;
- 69% of suicide completers expressed suicidal communication prior to their suicide; between 33% - 55% did so within one month of their suicide.[10]

## Suicide Risk Factors

The risk factors associated with suicide intent behavior include, but are not limited to:

- Age (adolescents/elderly)
- Alcohol/drug dependence
- Depression
- Social isolation
- Impulsivity
- Psychosis – Mental Illness
- A precipitating event
- •Feelings of hopelessness
- •Poor coping skills
- •Family history of suicide
- •Recent loss of an intimate relationship
- •Suicidal ideations
- •Presence of a lethal means
- •Presence of an organized plan

Several recent studies identified characteristics that should be evaluated in the psychiatric assessment of people suspected of suicide intent behavior. [11] Among these are:

- Suicidal or self-harming thoughts, plans, behavior and intent;
- Specific methods considered for suicide, including their lethality and their expectation of success;
- Evidence of hopelessness, impulsiveness, panic attacks, or anxiety;
- Absence for reasons for living, or plans for their future.
- Thoughts, plans, or intentions of violence towards others

## Suicidal Behavior – The Psychiatric/Mental Illness Nexus

The psychiatric professional or law enforcement First Responder conducting an SRA of a suspected suicide intent subject should pay attention to the subject's presentation of signs and symptoms of psychiatric disorders, with particular attention to mood disorders such as: primary major depressive disorders; mixed episodes; schizophrenia; severe anxiety with panic and agitation; and personality disorders.

Proactive questioning of the suspected suicide intent subject or post-incident forensic analysis of the suicide completer's mental health background should include evidence of the following:

- Previous psychiatric diagnosis and treatments;
- Voluntary and involuntary mental health hospitalizations;
- Treatments for substance abuse disorders;
- Severe psychic anxiety, agitation, or panic episodes;
- Current and past history of episodes of psychotic behavior.

A recent study of suicide completers indicated that 79% of suicide completers presented evidence of severe anxiety or agitation and 41% presented positive evidence of psychosis within one week of suicide. [12]

## Suicide "attempters" vs. "completers" – Motivation for Suicide

In a 1922 study on suicidal behavior, R.W. Maris compared the motivations behind suicidal ideation, attempts and completion' finding that the reasons that "completers" killed themselves were the loss of a spouse, children, or a job. The motivations behind non-fatal suicide attempts were identified as mental illness, alcohol/drug abuse and interpersonal problems. [13]

## Suicide Completion – The Intentional Loss of Control

Important in forensically analyzing the dynamic of suicide is the understanding that the suicide completer accomplishes his/her ultimate goal by using/selecting an instrument or method of lethality that removes all aspects of personal control from the "death act" at the ultimate moment. This explains why the suicide completer will jump from extreme elevations (high building/bridge); will suddenly jump in front of a speeding train; or will orchestrate a circumstance where they force multiple armed police officers to deploy deadly force upon them. Once the subject feels that lethality is assured and initiates their final action, they have no control to change their minds or "take it back."

## "Cues" Indicate Potential for Suicide

## Communication Cues

Risk assessors observing the suspected suicide intent person should pay particular attention to any communication "cues" presented by the subject. Studies of suicide completers indicate that 69% of completers expressed verbal or written suicidal communication sometime prior to their suicide. The same study documented that within one month of suicide, 33% made direct threats of suicide and when less direct communications were considered, this figure rose to 55%. [14]

## Mental State Cues

As previously discussed, suicide intent subjects present with a variety of psychological cues which indicate psychiatric/mental illness, and/or severe emotional/psychological distress. Along with those symptoms mentioned earlier, risk assessors should be alert to observations and evidence of the subject presenting with:

- Poor focus
- Rage
- Insomnia
- Acute depression
- Loss of rational thinking
- A lack of concentration and being easily distracted
- Self-hatred
- Humiliation
- Feelings of abandonment
- Hopelessness
- Indifference (at final stage)

## Remember the "SAD PERSON" Pneumonic in your SRA Evaluations [15]

While certified mental health professionals conduct Suicide Risk Assessments on a regular basis, the task for law enforcement First Responders is a less frequent occurrence that is often made more difficult by circumstances that are frequently time compressed, rapidly evolving, dynamic and which rarely take place within a controlled environment.

As is increasingly the case in today's economically distressed climate, the First Responder(s) already difficult assessment task is exacerbated by a an armed suicide intent subject presenting with "Suicide by Cop"

symptoms. The SBC intent subject will threaten the police and perhaps others in seeking to choreograph their death act at the hands of law enforcement who may not initially be aware of the subject's lethal design. In such instances (as will be discussed in Part Three of this series) it is imperative to conduct a rapid assessment by using the "Kiss (Keep It Simple Stupid) Principle." The following pneumonic provided by G.E. Juhnke, will serve this purpose.

- **S**ex
- **A**ge (adolescent/elderly)
- **D**epressed
- **P**revious suicide attempt
- **E**thanol (alcohol/drug abuse)
- **R**ational think loss (psychotic/mental illness)
- **S**ocial support lacking (isolation)
- **O**rganized suicide plan
- **N**o spouse (single, estranged, divorced, widowed)

**Part Two** of this series discusses the phenomenon of "Suicide by Cop" and the challenges this often lethal behavior presents to the law enforcement First Responder. *Be Safe Out There!*

**End Notes**


1. Houston, H. Range, M.D. and Angina, Deidre, M.D. ET. Al, "Suicide by Cop," Annals of Emergency medicine, Vol. 32, No. 6; American College of Emergency Physicians, Dec., 1998

2. Mohan die, Kris, Ph.D., Melody, Reid, Ph.D., Collins, Peter, M.C.A., M.D., "Suicide by Cop Among Officer – Involved Shooting Cases," Journal of Forensic Science, March, 1009, Vol. 54, No. 2

3. Wiley – Blackwell, "Suicide by Cop" Phenomenon Occurring in Over a Third of North American Shootings," Science Daily, 04-19-09

4. Treatment Advocacy Center (www.psychlaws.org) Briefing Paper, "Law Enforcement and People with Severe Mental Illness, Feb., 2005

5. Ibid.,

6. Brown, Jodi M., Lagan, Patrick A., "Policing Homicide: 1976 – 1998: Justifiable Homicide by Police; Police Officers Murdered by Felons, Bureau of Justice Statistics © 2001

7. Frye, James, J., "Policing the Mentally Disturbed," Journal of the American Academy of Psychiatry, 28:345 (2000)

8. Brown, Hal, Suicide and Mental Health International (SMHAI), "Suicide by Cop Results in Police Stress," (article), www.geocites/halbrown/suicide_by_cop1.html (2006)

9. U.S. Center for Disease Control Statistics, Suicide Statistics – United States, 2004

10. Parent, R.B. and Verdun – Jones, S., "Victim Precipitated Homicide: Police Use of Deadly Force In British Columbia," Policing: An International Journal of Police Strategies and Management, Vol. 21, pp. 432-448, 1998

11. Bush, Katie A., M.D., Fawcett, Jan, M.D., Jacobs, Douglas, G., M.D., "Clinical Correlations of Inpatient Suicide," Journal of Clinical Psychiatry, 125: pp. 355-373, 1974

12. Ibid.

13. Morris, R.W., Methods of Suicide: Assessment and Prediction of Suicide, pp. 362-380, Guilford Press, N.Y., 1992

14. Bush, Katie A., M.D., Fawcett, Jan, M.D., Jacobs, Douglas, G., M.D., "Clinical Correlations of Inpatient Suicide," Journal of Clinical Psychiatry, 64:1, 2003

15. Juhnke, G.E., "The Adapted SAD PERSONS: An assessment scale designed for use with children," Elementary School Guidance & Counseling, 1996, pp. 252-258

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