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Preventing Suicide in Policing

What the Evidence Means for Policy and Practice

Author: David Marshall, Lecturer in Criminology, University of the West of Scotland
Doctoral Researcher, University of Strathclyde

Executive Summary

Suicide among police personnel is a serious workforce and organisational concern, but the evidence does not support a simple conclusion that policing itself creates a uniformly elevated risk. Suicide mortality varies considerably between countries, historical periods and comparison populations.

More consistent evidence points to an interaction between clinical, interpersonal, occupational and organisational factors. Depression, anxiety and post-traumatic stress symptoms feature prominently, alongside relationship difficulties, poor social support and adverse life circumstances. Organisational experiences can compound these pressures, while concerns about confidentiality, stigma and career consequences may prevent personnel from seeking help.

Crucially, factors associated with suicidal thoughts are not necessarily the same as those associated with progression towards suicidal behaviour. Prevention should therefore move beyond reliance on single interventions or periodic screening.

The practical message

The evidence supports a layered approach: accessible and trusted support; organisational practices that minimise avoidable distress; early responses to psychological difficulty; and individualised intervention where there is evidence of planning, previous suicidal behaviour or access to highly lethal means.

Why it Matters Now

Police services increasingly provide wellbeing, occupational-health and psychological support. The key question is no longer simply whether support exists, but whether personnel trust it enough to use it.

Stigma, confidentiality concerns and fears about occupational consequences can inhibit disclosure. In policing, where seeking psychological support may be perceived as affecting deployment, firearm status, reputation or career progression, the perceived safety of support can be as important as its availability.

Suicide prevention is therefore not simply a mental-health service issue. It is an organisational responsibility involving leadership, culture, management practice and appropriate clinical provision.

Context and Evidence Base

Police-suicide research spans several decades and multiple countries. The final evidence map contained 77 unique retrieved reports, encompassing mortality and administrative records, surveys, longitudinal and retrospective studies, qualitative research, case investigations and a smaller body of intervention research.

The evidence does not demonstrate a single level of suicide risk applicable to all police populations. Mortality varies by jurisdiction, historical period, comparator population and methodological approach. Claims that police officers universally experience elevated suicide mortality should therefore be treated cautiously.

More consistent patterns emerge around vulnerability. Suicidality is repeatedly associated with depression, anxiety, PTSD symptoms, relationship disruption, poor social support and other adverse circumstances. Organisational stress and barriers to accessing support also emerge as potentially important factors. However, the available evidence largely identifies associations rather than demonstrating that these factors directly cause suicidal thoughts or behaviours.

A major evidence gap

Research is much better at identifying factors associated with suicidal thoughts than explaining why some individuals progress to planning, attempts or death. That distinction has direct implications for prevention.

Methods

This briefing draws on an updated systematic review and narrative synthesis of the international empirical evidence concerning suicide and suicidal thoughts and behaviours among police personnel, building on an earlier published systematic review (Krishnan et al., 2022). Included studies were critically appraised for methodological quality, with findings synthesised across clinical, occupational, organisational, interpersonal and prevention domains. Suicidal ideation, planning, attempts and deaths were considered separately rather than treated as a single outcome.

Five Things the Evidence Tells Us

1. There is no single 'police suicide risk'.

Suicide mortality varies substantially across police populations. Policing is better understood as a context within which risk and protection operate than as a single causal explanation for suicide.

2. Vulnerability is multidimensional.

Mental-health difficulties, trauma-related symptoms, relationship problems, poor social support and occupational or organisational adversity can coexist. Prevention focused exclusively on either the individual or the workplace is too narrow.

3. Support must be trusted, not simply provided.

Stigma, confidentiality concerns and anticipated career consequences can inhibit disclosure. The existence of counselling or occupational-health provision does not mean personnel necessarily experience it as accessible or safe to use.

4. Suicidal thoughts and suicidal action are not the same problem.

Evidence explaining progression towards attempts or death is considerably weaker than evidence concerning suicidal ideation. Acute assessment should therefore look beyond general distress to planning, previous suicidal behaviour and access to highly lethal means.

5. Prevention should operate as a system, not a single programme.

Comprehensive organisational approaches show promise, but intervention research remains limited. No single programme or screening approach can currently be identified as the solution to police suicide.

Key Evidence at a Glance

In a nationwide Norwegian study,

fewer than one in ten

officers reporting anxiety or depressive symptoms or serious suicidal ideation had contacted a psychologist or psychiatrist (Berg et al., 2006).

***The message:** even significant psychological distress or suicidal ideation does not necessarily translate into seeking specialist mental-health support.*

In one US study, **35%** of surveyed officers did not feel their agency supported officers' mental wellness.

Almost one in four did not know whether their agency had suicide-prevention or mental-wellness programming, even though almost all participating agencies reported providing access to some form of counselling (Thoen et al., 2020).

***The message:** providing support is not enough if personnel are unaware of it or do not experience their organisation as supportive of mental wellness.*

Following Montreal's organisation-wide Together for Life programme, the observed police **suicide rate fell from 30.5 to 6.4** deaths per 100,000 during the subsequent 12 years (Mishara & Martin, 2012).

***The message:** comprehensive organisational approaches show encouraging potential.*

***Montreal caveat:** Longer-term follow-up found 8.8 per 100,000 compared with 23.2 per 100,000 among police serving elsewhere in the province of Quebec. The observational, multicomponent design means the programme cannot definitively be credited with causing the reduction or reveal which elements were most effective (Mishara & Fortin, 2022).*

What Police Organisations Should Do

- 1. Test whether support is genuinely trusted.** Assess whether personnel know where to seek help, understand confidentiality arrangements and believe they can access support without disproportionate occupational consequences. Service availability alone is an inadequate measure of accessibility.
- 2. Create several routes into support.** Do not rely on personnel self-identifying as high risk during periodic screening. Provide multiple pathways into support, including confidential clinical provision, with supervisors and peers appropriately equipped to recognise distress and signpost or facilitate access to care.
- 3. Treat organisational processes as part of prevention.** Ensure fairness, timely communication and appropriate support during potentially high-stress processes such as investigation or suspension. This can minimise avoidable amplification of distress without weakening legitimate organisational accountability.
- 4. Distinguish wellbeing support from acute-risk management.** Where suicidal ideation is identified, separately consider planning, previous suicidal behaviour, escalating distress, substance misuse and access to highly lethal means. Decisions concerning access to potentially lethal means should be proportionate and individualised.
- 5. Measure outcomes, not just activity.** Training attendance, referral numbers and staff awareness do not demonstrate suicide prevention. Where feasible, evaluate whether interventions affect suicide-relevant outcomes, including ideation, planning, attempts and mortality.

Conclusion and Next Steps

There is unlikely to be a single intervention that prevents police suicide.

The evidence instead supports a layered system combining trusted support, good organisational practice, early responses to distress and individualised management of acute risk.

Research must now move beyond identifying additional risk factors towards understanding when and why suicidal thoughts become suicidal actions, and which interventions can alter those trajectories.

Key References

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Evidence Notes

The review synthesises a broad but methodologically uneven international evidence base. Formal critical appraisal identified variation in study quality and methodological robustness. Much of the literature is observational or cross-sectional, so recurring associations should not be interpreted as evidence of causal pathways. Intervention evidence remains comparatively limited, and even the stronger intervention studies do not permit definitive causal attribution.

Contacts

David Marshall

Lecturer in Criminology, University of the West of Scotland
David.marshall@uws.ac.uk