V-VICTA®

VirTra - Virtual Interactive Coursework Training Academy®

MENTAL ILLNESS: A PRACTICAL APPROACH - SUICIDE

Training Manual

VirTra

DISCLAIMER

The attached documents, related digital media simulation and related course work material are provided to clients to assist in the training of their employees. Due to the variation in policies from agency to agency and regional differences in applicable laws, clients must ensure the appropriateness of the material for their personnel. VirTra assumes no liability in the use of the associated material that is produced to assist agencies in the training of their personnel.

The Customer shall implement and enforce the safety notices shown below for all users of the VirTra system and accessories.

- Do not attempt to open or service VirTra recoil kits while under pressure. VirTra recoil kits contain high-pressure which can cause severe injury or death. If a problem occurs with a VirTra recoil kit, contact VirTra immediately.
- Absolutely no live weapons or ammunition shall be allowed within the vicinity of the training simulator. Violation of live firearms mixing with non-live firearms could result in injury or death.
- Never activate a laser emitting device towards your eyes or another person's eyes. This equipment contains products that emit invisible laser energy that could, if misused, damage the user's eyes. Users must never point a training firearm (or any other laser emitting device) at their own eye or another's eye.
- Some VirTra products contain raised or elevated stages. Users shall be warned that falling off the stage could cause injury to person or property.
- Some VirTra products contain V-Threat-Fire® devices. V-Threat-Fire devices provide an electric impulse of up to 2.5 seconds in duration at the point of contact (do not connect or place V-Threat-Fire devices over the user's heart). Only VirTra trained instructors are authorized to activate or use V-Threat-Fire devices, and the use of V-Threat-Fire devices for punishment or to cause repeated pain to a user is strictly prohibited.

TRADEMARKS

VirTra, the VirTra logo are either registered trademarks or trademarks of VirTra in the United States and/or other countries. Product names used in this manual are ascribed to their respective owners and acknowledged.

AUTHOR

Nicole Florisi, M.S. - VirTra Subject Matter Expert; Investigative Focus

TRAINING COURSE CERTIFICATION

This "Mental Illness: A Practical Approach" training course has been certified by the IADLEST™ National Certification Program on 9/23/2022.
Certification number: 22505-2209

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

TOPIC

Mental Illness: A Practical Approach - Suicide

ESTIMATED TIME

1 hour

PERFORMANCE OBJECTIVE

(Slide 3) At the end of 1 hour of instruction in a video simulation the student will successfully be able to:

A. Understand the role of contact professionals
B. Recognize signs, symptoms, and behaviors associated with suicidal ideation or NSSI
C. Explain best practices for dealing with people who have suicidal ideation or perform NSSI

CLASS SIZE

Designed for pairs of officers with maximum class size of 8 (4 pairs). If class size is smaller than 8 (4 pairs) scenarios can be cycled through.

The following training plan and lesson plan is designed to be used with the VirTra simulator. Where as many of the techniques have been used over many years in LE, this training plan maximizes training time and leverages the strengths of the VirTra Training System.

The instructor shall first ensure that students are familiar with the presented material. The outline is provided to supplement and provide context to the use of the simulation scenarios.

The simulation scenarios are used as a tool to facilitate the understanding of the concepts. The first scenarios will be provided in a slower tempo with the use of the PLAY/PAUSE feature to elaborate on the training points. Once the first simulation is provided in this format the remaining scenarios will be provided to each pair of officers. The Socratic methodology should be used for event debriefing.

"What did you know?"
"What did you see or hear?"
"What did you do and the reason behind it?"
"What would you do differently in the future?"

All officers will be allowed to watch the other pairs participate in the exercise. This is done to maximize the benefit of modeling for adult learners. Students shall be given the opportunity to ask questions at the end of each section.

VirTra
© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

SAMPLE STUDENT GROUP SET UP

Non-test scenarios should be used with the concept of social learning theory and observation. The non-participating students should be watching their peers and be ready to answer what other options may have been available after the initial Socratic debrief.

A. Officer Yackley and Officer Emerson
B. Officer Danninger and Officer Ashley
C. Officer Bacon and Officer Adams
D. Officer Stephens and Officer Marks

First Scenario - Executed in "PLAY/PAUSE" methodology for all students - key concepts are applied and discussed
Second Scenario - Group A participates while Groups B, C, and D watch
Third Scenario - Group B participates while Groups A, C, and D watch
Fourth Scenario - Group C participates while Groups A, B, and D watch
Fifth Scenario - Group D participates while Groups A, B, and C watch
Sixth Scenario - (Practical skills test) Class is sequestered with students brought one at a time (not pairs) to evaluate performance.

SCENARIO BANK TO BE USED

A. Misery Mountain
B. Office Anxiety
C. Party Pooper

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

I. INSTRUCTOR INTRODUCTION

II. INTRODUCTION TO MENTAL ILLNESS FOR CONTACT PROFESSIONALS

A. WHAT IS MENTAL HEALTH?

B. MENTAL ILLNESS

C. WHO CAN DIAGNOSE?

D. THE ROLE OF CONTACT PROFESSIONALS

III. SUICIDAL BEHAVIOR

A. SUICIDAL THOUGHTS AND BEHAVIORS

B. FACTS

C. MYTHS

IV. RISK FACTORS

V. WARNING SIGNS

VirTra

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

VI. CRISIS INTERVENTION

VII. HOW TO TALK ABOUT SUICIDE

VIII. SUICIDE BY COP

A. STATISTICS

B. TYPOLOGY

C. INTEGRATED RESPONSE

IX. NON-SUICIDAL SELF INJURY

X. CONCLUSION

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

TABLE OF CONTENTS

I. INSTRUCTOR INTRODUCTION 7

II. INTRODUCTION TO MENTAL ILLNESS FOR CONTACT PROFESSIONALS 7

- A. WHAT IS MENTAL HEALTH? 7
- B. MENTAL ILLNESS 7
- C. WHO CAN DIAGNOSE? 7
- D. THE ROLE OF CONTACT PROFESSIONALS 8

III. SUICIDAL BEHAVIOR 8

- A. SUICIDAL THOUGHTS AND BEHAVIORS 8
- B. FACTS ABOUT SUICIDE 8
- C. MYTHS ABOUT SUICIDE 9

IV. RISK FACTORS 9

V. WARNING SIGNS 9

VI. CRISIS INTERVENTION 10

VII. HOW TO TALK ABOUT SUICIDE 10

VIII. SUICIDE BY COP 11

- A. STATISTICS 11
- B. TYPOLOGY 12
- C. INTEGRATED RESPONSES 12

IX. NON-SUICIDAL SELF INJURY 13

X. CONCLUSION 14

XI. QUESTIONS? 14

XII. REFERENCES 15

XIII. CONTACT VIRTRA 16

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

I. INSTRUCTOR INTRODUCTION

Instructor will introduce themselves to the class. This introduction should be no more than 2-3 minutes long and establish why they are qualified to teach the course and how long they have been with the organization. This not a moment to brag but to build confidence and trust from the attending students.

II. INTRODUCTION TO MENTAL ILLNESS FOR CONTACT PROFESSIONALS

A. WHAT IS MENTAL HEALTH?

(Slide 6) Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

B. MENTAL ILLNESS

(Slide 7) Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities. Many factors contribute to mental illness: biological factors, stress and trauma, life experiences, and long-lasting health conditions. Mental illness becomes problematic when daily activities, relationships, and work is affected. Mental illness can be very impactful in a person's life.

C. WHO CAN DIAGNOSE?

(Slide 8, 9) Psychiatrists, psychologists, counselors, clinicians, therapists, clinical social workers, psychiatric nurse practitioners, physicians, and nurse practitioners. This can vary by state, licensing requirements, and master's level program requirements. Only psychiatrists, physicians, physician's assistants, psychiatric nurse practitioners, and nurse practitioners (state dependent) can prescribe medication.

A mental health professional will conduct a full mental health assessment before diagnosing a person with a mental illness. The assessment may consist of:

1. Physical Exam
2. Lab Tests
3. Mental Health History
4. Personal History
5. Mental Evaluation
6. Cognitive Evaluation

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

D. THE ROLE OF CONTACT PROFESSIONALS

1. Contact professionals are not trained to diagnose nor should they. Familiarization and recognition of behaviors are critical in deciding an intervention response. The intervention response should be as safe and effective as possible for all parties involved.
2. Behavioral health response and/or crisis intervention should be a coordinated effort that is as safe and effective as possible for everyone involved.
3. The focus should fall in recognizing indicators and signs associated with behaviors.
4. Safety is paramount and should not be compromised situationally for a behavioral health response or crisis intervention. Crisis intervention, behavioral health intervention, and de-escalation tactics are integrated responses based on the totality of circumstances.
5. Refer to department policies and legal department mandates for behavioral health or crisis response.

III. SUICIDAL BEHAVIOR

A. SUICIDAL THOUGHTS AND BEHAVIORS [1, 2]

(Slide 11) Suicide is death caused by injuring oneself with the intent to die. A suicide attempt is when someone harms themselves with the intent to end their life, but they do not die as a result of their actions. Suicidal thoughts and behaviors can be the result of many factors and vary by age, culture, sex, and other population characteristics. From 2008-2017, suicides outnumbered homicides every year and the suicide rate continues to increase yearly as well.

The National Institute of Mental Health says "suicidal thoughts or actions are a sign of extreme distress and alert that someone needs help. Any warning sign or symptom of suicide should not be ignored. All talk of suicide should be taken seriously and requires attention. Threatening to die by suicide is not a normal response to stress and should not be taken lightly."

The act of suicide is often an attempt to control deep, painful emotions and thoughts an individual is experiencing. Once these thoughts dissipate, so will the suicidal ideation. While suicidal thoughts can return, they are not permanent. An individual with suicidal thoughts and attempts can live a long, successful life.

B. FACTS ABOUT SUICIDE [1, 2, 3, 4, 5]

(Slide 12)

1. In 2016, suicide was one of the top four causes of death from ages 10-44 and the second leading cause of death from ages 10-34.
2. Overall, suicide is the 10th leading cause of death with 44,965 suicides in 2016. That is 1 death every 12 minutes. Worldwide: 1 death every 40 seconds.
3. In 2016, 9.8 million adults thought about suicide, 2.8 people made a plan, and 1.3 million attempted suicide.
4. Suicide rates have gone up more than 30% in half of the states since 1999.
5. Teens and older adults are at a higher risk for suicide.
   i. Teenage suicide is a growing and serious problem. The teenage years can be emotionally turbulent and stressful. Teenagers face pressures to succeed and fit in. They may struggle with self-esteem issues, self-doubt and feelings of alienation. For some, this leads to suicide. Depression is also a major risk factor for teen suicide.
   ii. Suicide in the elderly population is a concern as well as depression in the elderly that is undiagnosed and untreated.
6. 54% of people who died by suicide did not have a known mental illness.

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

C. MYTHS ABOUT SUICIDE [6, 7]

(Slide 13)

1. Myth: People who talk about suicide want attention.
   Fact: People who die by suicide usually talk about it first.
2. Myth: Suicide only affects people with a mental health condition.
   Fact: Many individuals who attempt or die by suicide do not have a mental illness. Many people with a mental illness are not affected by suicidal thoughts.
3. Myth: Suicide happens without warning.
   Fact: Warning signs usually precede the majority of suicides. Knowing risk factors and warning signs is imperative.
4. Myth: People who complete or attempt suicide take the easy way out.
   Fact: People who die by suicide want to end their suffering. They feel hopeless and are not thinking rationally.
5. Myth: Talking about suicide encourages a person to complete suicide.
   Fact: Talking about suicide reduces the stigma and also allows a person to get help, share their story and reconsider the situation and thought process.
6. Myth: Once an individual is suicidal, they will remain suicidal.
   Fact: Active suicidal ideation is often short-term and situation-specific. Studies have shown that approximately 54% of individuals who have died by suicide did not have a diagnoseable mental health disorder. For those with mental illness, the proper treatment can help reduce symptoms.

IV. RISK FACTORS [8, 9]

(Slide 15)

A. Prior suicide attempt(s)
B. Misuse and abuse of alcohol or drugs
C. Mental disorders (especially untreated disorders), particularly depression and other mood disorders
D. Access to lethal means
E. Crisis within the past 2 weeks
F. Job or financial problems
G. Loss of housing
H. Knowing someone who died by suicide, particularly a family member or close friend
I. Social isolation
J. Physical health problems
K. Chronic disease and disability
L. Lack of access to behavioral health care
M. Criminal or legal problems
N. Antidepressants
   For some, antidepressant medication causes an increase in depression and suicidal thoughts and feelings. Because of this risk, the FDA advises that anyone taking antidepressants should be watched for increases in suicidal thoughts and behaviors. Monitoring is especially important if this is the person's first time on depression medication or if the dose has recently been changed. The risk of suicide is the greatest during the first two months of antidepressant treatment. This is especially noted for adolescents and the elderly.

V. WARNING SIGNS [9]

(Slide 17, 18)

A. Talking about wanting to die or wanting to kill themselves.
B. Talking about feeling empty, hopeless or having no reason to live
C. Planning to look for a way to kill themselves, such as searching online, stockpiling pills or newly acquiring lethal items (e.g., firearms, ropes)

VirTra
© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

D. Talking about great guilt or shame
E. Talking about feeling trapped or feeling that there are no solutions
F. Feeling unbearable pain, both physical or emotional
G. Talking about being a burden to others
H. Using alcohol or drugs more often
I. Acting anxious or agitated
J. Withdrawing from family and friends
K. Changing eating and/or sleeping habits
L. Showing rage or talking about seeking revenge
M. Taking risks that could lead to death, such as reckless driving or other reckless behavior
N. Talking or thinking about death often
O. Displaying extreme mood swings, suddenly changing from very sad to very calm or happy
P. Giving away important possessions
Q. Saying goodbye to friends and family
R. Putting affairs in order, making a will
S. Posting thoughts about death or dying on social media

VI. CRISIS INTERVENTION

(Slide 20) Crisis intervention is critical for a suicidal person as well as asking the questions that determine the level of suicidality to provide the person with the appropriate level of services. Be direct and ask the following questions:

1. Are you thinking about killing yourself?
2. Are you having thoughts of suicide?
3. Do you have a plan to kill yourself?
4. If so, what is your plan?

Saying the word(s) suicide or killing yourself will not put that idea into a person's thoughts. A person talking about suicide can be reaching out for help and serious about completing the act. The only way to determine if a person wants to kill themselves is to ask directly.[10]

VII. HOW TO TALK ABOUT SUICIDE

(Slide 22-24))

A. Be direct. Talk openly and ask questions
B. Be willing to listen
C. Allow expression of feelings. Emotions and feelings are energy and have to go somewhere
D. Accept the feelings
E. Be non-judgmental
F. Don't debate whether suicide is right or wrong, or whether feelings are good or bad
G. Don't lecture on the value of life
H. Don't call them a coward or weak
I. Be cautious about saying you "understand." That can be inadvertently inflammatory. More appropriate would be, "help me understand what you're feeling or going through."
J. Be cautious about saying "you'll feel different tomorrow," "things will change" or "think about your family and friends." Individuals considering suicide are operating from an emotional standpoint and not thinking rationally. Certain statements can trigger additional negative thoughts. More appropriate would be, "in the past, what prevented you from killing yourself or going through with it?" This helps identify personal strengths.

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

Things to ask or say to someone who is thinking of suicide:[9]

A. I'm glad you told me you're thinking about this (suicide or killing yourself).
B. I'm sad to hear you're hurting.
C. What's happening that makes you want to die?
D. When do you think you will act on your thoughts or plan?
E. What can I do to help?
F. You're not alone
G. We can get through this together.
H. Have you felt this way before? What helped get you through it?

VIII. SUICIDE BY COP [11, 12]

(Slide 26-29) Suicide by cop (SBC) is when an individual is actively suicidal and engages in life-threatening or criminal behavior directed at police to elicit use of lethal force. Response to SBC calls can be harrowing and difficult. There are two victims of a SBC incident; the suicidal subject and the officer.

Factors that influence SBC:

A. Critical family issues
B. Suicidal ideation
C. Past suicide attempts
D. Acute crisis
E. History of mental illness
F. Substance use
G. IPV/domestic violence incident

A. STATISTICS

1. 95% were male
2. Mean age of 35 years
3. 41% were Caucasian, 26% Hispanic and 16% African American
4. 37% were single
5. 29% had children - 18% of these were currently experiencing issues related to the child
6. 54% were unemployed
7. 29% did not have housing
8. 62% had confirmed or probable mental health history
9. 80% were armed - of these 60% possessed a firearm (80% loaded, 7% unloaded, 4% inoperable) and 48% of those with a loaded firearm fired the weapon. 26% possessed knives.
10. 19% feigned or simulated weapon possession - 46% did so by reaching or placing their hand in their waistband.
11. 87% of individuals made suicidal communications prior and/or during the incident
12. 36% were under the influence of alcohol
13. Of the 5% of females who committed SBC:
    - i. Mean age of 40 years
    - ii. 50% Caucasian, 25% Hispanic
    - iii. 42% single
    - iv. 50% had children
    - v. 100% armed with weapons
    - vi. 50% had a firearm (33% loaded) and 50% had a knife
    - vii. 100% had confirmed or probable mental health history - 67% suffered from depression or other mood disorders

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

B. TYPOLOGY

1. Direct confrontation: individual plans attacks ahead of time
    - i. Kamikaze attack: Use of deadly force on police with no immediate provocation
    - ii. Controlled attack: Confrontation where individual escalates situation to use of lethal force
    - iii. Manipulated confrontation: Orchestrated situation for police investigatory response
    - iv. Dangerous confrontation: Deliberately orchestrates a serious crime with a higher level of danger
2. Disturbed intervention
    - i. Suicide intervention: Suicide attempt that appears ambivalent but was not a tactic to elicit police response. However, attempts at prevention are rejected or the police provide an alternative route.
    - ii. Disturbed domestic: Domestic incident where an individual chooses death over arrest
    - iii. Disturbed person: A person under the influence of alcohol, drugs, or is mentally ill, who is acting in a dangerous manner.
3. Criminal intervention
    - i. Major crime: Unwillingness to go to jail, person may be on parole or probation
    - ii. Minor crime: Individual resists police intervention in a minor crime or incident and the situation escalates

C. INTEGRATED RESPONSES

1. Assess the situation and take the call seriously
2. Secure the scene and assess safety threats for everyone involved
3. Obtain background information on the individual if possible
4. Evaluate suicide risk
    - i. Suicidal intent
    - ii. Suicidal plan
    - iii. Suicidal means in terms of availability and lethality
5. Establish contact
    - i. Establish rapport
    - ii. Use crisis intervention and active listening skills
6. Determine the main problem
7. Talk the subject down
    - i. Provide reassurance
    - ii. Comply with reasonable requests
    - iii. Offer alternative, realistic optimism
    - iv. Avoid being baited and dropping your guard
    - v. Consider non-lethal containment
    - vi. Consider limited walk-away containment
    - vii. Employ appropriate follow-up after situation has been resolved

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

IX. NON-SUICIDAL SELF INJURY

(Slide 31-34) Non-suicidal self injury (NSSI) refers to self injury that is not suicidal in nature and there is no intent to complete suicide. NSSI is defined as a deliberate, self-inflicted destruction of body tissue without suicidal intent for purposes not socially sanctioned. NSSI can be both a mental health crisis and a physical health crisis dependent on severity of injury. NSSI can be a very effective strategy to reduce negative thoughts and emotions, but it is simultaneously unhealthy and harmful. In the past, NSSI was primarily associated with other psychiatric disorders. The DSM-5 now includes NSSI as a "condition for further study" to obtain more information and diagnostic criteria.[14 17]

A. NSSI is also known as self-mutilation, self-harm or self-injury

B. NSSI is more common in adolescents and young adults than in other populations

C. There is a link between NSSI and suicidality even though that is not the primary cause for self-injurious behavior. One study showed that 70% of teens who engage in self-harm had at least one previous suicide attempt. 55% had multiple attempts.

D. Common behaviors associated with NSSI:[16]
   1. Cutting
   2. Burning
   3. Interfering with wound healing (picking or reopening wounds)
   4. Punching or hitting oneself or other objects
   5. Inserting objects into the skin
   6. Purposely bruising or breaking one's bones
   7. Certain forms of hair pulling
   8. Ingesting toxic substances

E. Reasons individuals engage in NSSI:[19 20]
   1. Regulate and manage distressing thoughts and emotions
   2. Gain a sense of control
   3. Feel excitement and release
   4. Stop dissociative experiences
   5. Gain relief and self-soothe
   6. Self-punishment
   7. Stop suicidal ideation

   A component of self-harm is the cyclical nature of the experience. Pain can stimulate endorphins or other mood-changing hormones. The individual may also self-harm to "feel" something instead of numbness or emptiness. The cycle becomes dangerous and habit-forming as after the release occurs, the aspect of guilt and shame reoccurs at the behaviors which can lead to additional negative cognitions, and so the cycle repeats. Self-harm may become ritualistic and more addictive as time progresses.

F. How to engage and help an individual who self-injures:
   1. Express concern
   2. Provide reassurance
   3. Ask if the individual wants to kill themselves or complete suicide. You will not know the motivation until you ask.
   4. Express empathy
   5. Be cognizant of both the mental health crisis and potential physical health emergency dependent upon the wounds inflicted.
   6. Ask what you can do to help
   7. Engage with behavioral health partners

VirTra
© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

X. CONCLUSION

As it is of utmost importance, below is a reiteration of the role of the contact professional.

A. Contact professionals are not trained to diagnose nor should they. Familiarization and recognition of behaviors are critical in deciding an intervention response. The intervention response should be as safe and effective as possible for all parties involved.
B. Behavioral health response and/or crisis intervention should be a coordinated effort that is as safe and effective as possible for everyone involved.
C. The focus should fall in recognizing indicators and signs associated with behaviors.
D. Safety is paramount and should not be compromised situationally for a behavioral health response or crisis intervention. Crisis intervention, behavioral health intervention, and de-escalation tactics are integrated responses based on the totality of circumstances.
E. Refer to department policies and legal department mandates for behavioral health or crisis response.

XI. QUESTIONS?

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

XII. REFERENCES

1. National Institute for Mental Health. (n.d) Suicide. Retrieved from https://www.nimh.nih.gov/health/statistics/suicide.shtml
2. Centers for Disease Control. (n.d.). Preventing suicide. Retrieved from https://www.cdc.gov/violenceprevention/suicide/fastfact.html
3. Centers for Disease Control. (n.d.). Suicides rising across the US. Retrieved from https://www.cdc.gov/vitalsigns/suicide/
4. American Foundation for Suicide Prevention. (n.d.). https://afsp.org/about-suicide/suicide-statistics/ Retrieved from https://afsp.org/about-suicide/suicide-statistics/
5. American Academy of Child and Adolescent Psychiatry. (2017). Suicide in Children and Teens. Retrieved from https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx
6. National Institute on Mental Health. (n.d.) 5 Common Myths about Suicide Debunked. Retrieved from https://nami.org/Blogs/NAMI-Blog/September-2018/5-Common-Myths-About-Suicide-Debunked
7. Office of Suicide Prevention. (n.d.) Myths and facts of youth suicide. Retrieved from http://suicideprevention.nv.gov/Youth/Myths/
8. National Mental Health Alliance. (n.d.). Risk of suicide. Retrieved from https://www.nami.org/suicide/
9. National Institute for Mental Health. (n.d.) Suicide Prevention. Retrieved from https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml
10. Freedenthal, S. (2017). 10 things to say to a suicidal person. Retrieved from https://www.speakingofsuicide.com/2017/10/03/10-things-to-say
11. Kennedy, D. & Homant, R. (2000). Suicide by police: a proposed typology of law enforcement officer assisted suicide. Policing: An International Journal of Police Strategies & Management, Vol. 23 No. 3, 2000, pp. 339-355.Retrieved from https://pdfs.semanticscholar.org/a693/ef533e4fdaa17e86b7a62a5d2d92336bed8b.pdf
12. Miller,L. (2006). Suicide By Cop: Causes, Reactions, and Practical Intervention Strategies. International Journal of Emergency Mental Health, Vol. 8, No. 3, pp. 165 – 174. Retrieved from https://www.psychceu.com/miller/Miller_Suicide_by_Cop.pdf
13. Nock MK, Favazza AR. Nonsuicidal self-injury: definition and classification. Understanding Non-Suicidal Self-Injury: Origins, Assessment, and Treatment. Washington, DC: American Psychological Association; 2009:9–18
14. American Psychiatric Association. Diagnostic and statistical manual of mental disorders fifth edition (DSM-5). American Psychiatric Association; 2013, p. 783
15. Barrocas, A. L., Hankin, B. L., Young, J. F., & Abela, J. R. (2012). Rates of nonsuicidal self-injury in youth: age, sex, and behavioral methods in a community sample. Pediatrics, 130(1), 39–45. doi:10.1542/peds.2011-2094
16. Whitlock J, Eckenrode J, Silverman D. (2006). Self-injurous behaviors in a college population. Pediatrics. 117(6)1939–1948
17. Kahng, S., Iwat, B., Lewin, A. (2002). Behavioral treatment of self-injury, 1964 to 2000. Am. J Ment. Retard. 107(3)212–221
18. Peterson, J., Freedenthal, S., Sheldon, C., & Andersen, R. (). Nonsuicidal Self injury in Adolescents. Psychiatry, 5(11), 20–26.
19. Nixon M., Cloutier P., Aggarwal S. (2002). Affect regulation and addictive aspects of repetitive self-injury in hospitalized adolescents. J Am Acad Child Adolesc Psychiatry. 411333–1341
20. Gratz K. (2003). Risk factors for and functions of deliberate self-harm: an empirical and conceptual review. Clin Psychol Sc Pract. 10(2)192–20

VirTra

© 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

XIII. CONTACT VIRTRA

If you have any questions/issues with any part of this manual, please see contact below:

VirTra Training Department

295 E. Corporate Pl
Chandler, AZ 85225 USA

Office: 480.968.1488
Email: training@virtra.com

VirTra © 2024 BY VIRTRA INC. ALL RIGHTS RESERVED

VirTra

295 E. Corporate Pl
Chandler, AZ 85225 USA