

Protecting Those Who Serve

POLICE MENTAL HEALTH & SUICIDE PREVENTION

One-page policy brief | J. Bruce Townley | Revised October 5, 2026

Police suicide prevention is a government and employer duty of care. Reform requires protected treatment, safer workplaces, accountable leadership and measurable results.

Scope: Canadian police members, retirees and families; adapt for other public-safety sectors.

Who must do what

Federal	Five-year strategy; protected, de-identified national reporting; fund CIPSRT, PSPNET and research; proposed police/public-safety 9-8-8 pathway; grants tied to enforceable standards.
Provincial / territorial	Confidential clinician-led baselines and reassessment; annual or twice-yearly check-ins agreed with associations, without employer clinical disclosure; care during claims; no arbitrary treatment interruption; independent inspection.
Indigenous / funding partners	Co-develop culturally grounded care with stable, equitable support, including remote services.
Municipal / police boards	Safe staffing, overtime limits, backfill and graduated returns; chief accountability; fund civilian crisis capacity; publish protected, de-identified results.

Essential safeguards

- Independent care.** Self-referral outside command, HR and fitness-for-duty systems; qualified, regulated clinicians with suicide-risk competence and recent police/public-safety experience. Non-clinicians route only.

Legal protection. Proposed jurisdiction-specific privilege for voluntary treatment; narrow lawful exceptions. Fitness-for-duty assessments remain separate and purpose-limited. These are proposals, not guaranteed current rights.

Humane risk management. Clinician-guided firearm safety; promptly reviewed, non-punitive temporary restrictions; family crisis access; timely, fair discipline.
- Clinical authority.** Command governs operations, not acute diagnosis, treatment or fitness. Return orders, treatment overrides and claim-denial recommendations require independent written clinical input.

Prevention, not surveillance. Baselines and reassessment guide confidential care, never hiring, promotion or discipline.

Independent oversight. Clear communication, dignity and timely, procedurally fair investigations for all participants; clinical support, including for investigators, without weakening scrutiny or consequences.

Prevent avoidable exposure; make the handoff work

Fund risk-appropriate clinical co-response and non-police crisis services with after-hours capacity. Retain police for immediate safety. Require receiving services, named contacts, confirmed handoffs and follow-up between response, hospital, custody and community care. Share only necessary, lawful information with required consent; inadequate capacity never authorizes unlawful detention.

Measure repeat crises; handover waits and officer-hours; completed treatment connections and continuity at 30/60/90 days; workload, equity, unmet need and displaced demand. Grande Prairie’s announced custody monitoring, care and outreach is emerging, not proven to reduce crises or injury. Monitoring supplements physical checks.

Define success safely

Prioritize qualified care, trust, confidentiality, continuous treatment, adequate benefits, sustained recovery and safe returns at 6 and 12 months. Fewer claims, shorter leave or lower spending alone can mask discouraged claims, premature returns or unmet need. Track retention, failed returns, presenteeism and total workforce cost, not benefit cost alone.

Evidence and complete framework

44.5% of 5,813 Canadian public-safety personnel screened positive; screening is not diagnosis [1]. Occupational suicide data remain inconsistent [2]. Montreal’s approximately 71% reduction over 22 post-program years is observational [3]. Co-response evidence is context-dependent [4–5]; injury benefits require longitudinal evaluation.

[1] Carleton et al. (2018) | [2] CIPSRT / ICRTSP | [3] Mishara & Fortin (2022) | [4] Lowder et al. (2024) | [5] Parry et al. (2026)

Read the full framework and references →

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