

Running head: ALL FOR ONE: SUICIDE PREVENTION

All for One: Suicide Prevention for Sweetwater County Fire District #1

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### Certification Statement

I hereby certify that this paper constitutes my own product, that where the language of others is set forth, quotation marks so indicate, and that appropriate credit is given where I have used the language, ideas, expressions, or writings of another.

Signed: \_\_\_\_\_

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## Abstract

The problem was that Sweetwater County Fire District #1 (Fire District #1) had no program to address suicide prevention within its ranks. The purpose of this research was to identify the components of suicide prevention programs, then develop and implement an appropriate suicide prevention program for Fire District #1.

Action research was conducted to identify the components of a suicide program, explore the efforts of other fire departments with respect to suicide prevention and identify the components and requirements to establish and maintain a suicide prevention program for Fire District #1.

A literature review was conducted to answer the research questions. Interviews were held with mental health professionals to help define the components of suicide prevention and identify the resources needed to sustain such a program. A request for information was sent out via two fire service forums in an attempt to discover the efforts of other fire departments with regards to suicide prevention. The request also asked what resources were required to sustain their programs, if any.

The results revealed that few agencies have instituted suicide prevention programs or efforts. A model was found which could be adapted to the needs of Fire District #1 in conjunction with a component developed in law enforcement to promote emotional resiliency. These were used to develop a suicide prevention/emotional resiliency curriculum for Fire District #1.

Recommendations were made and a program created to establish a suicide prevention/emotional resiliency program for Fire District #1. The recommended program

included initial and annual training for all members of the agency concerning the program. Additional recommendations advised that the program should include crisis management content, a means of referral for counseling, and that a source of funding be established for an annual mental healthcare checkup.

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## Introduction

The fire service in the United States has a noble history of camaraderie and brotherhood spanning more than 300 years. The challenges faced on the fire ground and during training pull the members of the department together, forging a bond which is as strong as it is invisible; few things are capable of penetrating this bond. Suicide is one of those actions by a member of the team which causes the bond to weaken or break. This act, whether completed or not, brings doubt and confusion to the agency where it occurs. Suicides from within a fire department cause members to leave or change professions, further weakening what was once a unified force of competent firefighters with a common mission and vision. The loss of these members is a loss to the fire service as a whole, but especially to the department where it occurs.

The problem is that Sweetwater County Fire District #1 (Fire District #1) has no system or program to address suicide prevention within its ranks. The purpose of this research is to identify the components of suicide prevention programs, then develop and implement an appropriate suicide prevention program for Fire District #1. This research effort will conduct action based research to answer the questions: What are the components of a suicide prevention program? What programs and activities have other fire departments implemented to address suicide prevention within their organizations? What details should be included in a suicide prevention program for Fire District #1? What long-term requirements and resources are necessary for the longevity and effectiveness of a suicide prevention program within Fire District #1?

## Background and Significance

Fire District #1 is a combination agency consisting of four career members and an authorized roster of up to 45 paid-per-call volunteer firefighters (volunteers); as of this writing there are 32 volunteers. The career staff is composed of the Fire Chief, Assistant Fire Chief/Training Coordinator, and two Battalion Chiefs. The volunteer contingent consists of six Fire Captains, four Fire Lieutenants, Volunteer Firefighters, and Fire Cadets – otherwise known as junior firefighters. The Fire Lieutenants' positions are officer training positions for Fire Captains. The volunteer contingent is divided into battalions, with each Battalion Chief being responsible for the personnel assigned to them.

Fire District #1 recruits new membership through two methods. Experienced firefighters with prior certification and background may join with credentials indicating a certification level of Firefighter I (FFI) or higher. Inexperienced recruits must attend a recruit academy which takes place over the course of four months, culminating in ProBoard Fire Service Professional Qualifications System (Pro-Board) accredited FFI certification. Fire District #1 also has a fire cadet program which allows youths age 14 years and older to participate in a support role until within six months of their 18<sup>th</sup> birthday. After that time they may begin testing for FFI Pro-Board accredited certification. The average longevity of the Fire District #1 volunteer membership roster is 5.3 years.

Fire District #1 operates out of a single fire station which is located within the municipality of Rock Springs, Wyoming. Most of the personnel of Fire District #1 live in

Rock Springs. There are minimum participation requirements for attendance at fire calls and regularly scheduled trainings.

Call attendance is required for 30% of those calls which occur while a member is not at work or on vacation. Those members who fail to meet this requirement must make up an equivalent of 100% of the calls for that month. This is accomplished through volunteer hours, and/or on-call hours. Volunteer hours are any activity which supports the mission of Fire District #1 from workout time at the fire station to volunteer work such as washing apparatus or participating in public education and fire prevention activities; on-call time is time which the individual agrees to be available for calls.

Regularly scheduled trainings are every Wednesday from 1800-2100 hours. All members are required to attend 50% of all regular trainings in any given three month period. Opportunities are provided for members to make up trainings after the fact as appropriate. The training participation requirement is also the minimum level of participation which qualifies the member for the Wyoming Volunteer Fireman's Pension. On average, the personnel of Fire District #1 log just over 7,000 hours of combined training each year.

Fire District #1 protects an area consisting of 2000 square miles of Sweetwater County in southwest Wyoming, and a resident population of approximately 7,500. Fire District #1 also contracts with the neighboring Reliance Fire District for their fire protection needs. Within these areas are approximately 70 miles of Union Pacific Railroad right-of-way, 65 miles of U.S. Interstate 80 (I-80), as well as several hundred miles of primary and secondary highways, and county roads.

Fire District #1 is funded through a maximum three mil tax levy of the assessed valuation of the district. The mil levy amount is defined by Wyoming state statutes. The annual budget for Fire District #1 for the most recent fiscal year is \$1,200,000 based on a mill levy of 2.95 mills of assessed valuation. Salaries and benefits account for just over 50%, with the remaining portion earmarked for operational costs, property and liability insurance, and capital expenses.

Fire District #1 responds to an average of 275 calls per year. The most frequent call type is crash-rescue on I-80, followed by medical assists for severe trauma and life-threatening illnesses, and wildland fire incidents. The balance of the call volume is vehicle and rubbish fires, service calls, hazmat incidents and structure fires. Although most of the residents of Fire District #1 are located within 4 miles of the fire station, the large response area of Fire District #1 often results in response times of 30 minutes or more. One such response in 2010 consisted of a 75-mile drive on state and county roads for a response time of 90 minutes for a ranch house fire.

The response model of the fire district requires that all available members respond when a call is toned out. Each member carries a radio or pager to alert them to the need for response. The required resources for a particular call are filled from first-arriving personnel and supplemented with personnel staged at the fire station as needed. All members respond to the fire station first; direct response is by direction of a chief officer, or pre-established protocols based on the location of the incident with respect to the residence of the individual. Strict standard operating procedures (SOP's) govern personally-owned vehicle response to the fire station; all traffic laws must be obeyed, with violators subject to reprimand and/or dismissal.

The time spent in training and incident response builds a sort of camaraderie among the members which is unique to the agency. Fire Cadets who have come up through the ranks and members with many years of service are pillars of the organization. These are the members who mentor new hires and help them adjust to the personality of the department. Social activities are a large part of the organization, pot-luck dinners on holidays and special occasions are frequently scheduled. Fire District #1 is a close-knit group which looks out for each other. This enhances retention, while building the spirit and camaraderie previously mentioned.

Unfortunately, suicide of two of the members has impacted Fire District #1 twice in the past three years. In June of 2009, one of the battalion chiefs attempted to take his own life by shooting himself in the chest with a handgun after a five-hour stand-off with law enforcement on a county road five miles outside of Rock Springs. At the time of this incident, the person had 12 years of service with Fire District #1 and had also worked as a full-time emergency medical technician (EMT) with one of the local private ambulance services. Although the suicide was not completed, the individual was unable to return to work after being discharged from the hospital.

The second instance occurred in October of 2011 involving a 20 year old member of the department who was on leave from the agency while she attended college. This individual had joined Fire District #1 as a Fire Cadet in 2006 and was known for her positive attitude and drive. She was a cross-country athlete and holder of several Wyoming State track records, and a recipient of a full-ride scholarship. Unfortunately, she did not survive her suicide.

Both of these events shook Fire District #1 to the core. Critical incident stress debriefings were held for both incidents. Counseling was offered to all members of the agency, and all were admonished to speak with someone, preferably a chief officer, about any lingering emotional trauma from the events. No requests were made for counseling; few if any conversations were noted regarding ongoing issues with these instances.

Suicide is currently ranked as the 8<sup>th</sup> leading cause of death in the United States (U.S. Department of Health and Human Services, 2001). Sweetwater County has one of the highest suicide rates per 100,000 of population in the United States. (Center for Disease Control and Prevention, n.d) In the fire service, several instances of suicide clusters in larger metropolitan fire departments in recent years have provoked a closer look at suicide among firefighters. (National Fallen Firefighters Foundation [NFFF], 2011)

Gist, Taylor and Raak (2011) noted that there is very little empirical data regarding suicide in the fire service. Although the incidence of suicide among the firefighting community is suspected to be higher than the national, death statistics normally do not include information about occupation. The fact that the majority of the fire service in the United States is made up of volunteers makes it even more difficult to track the frequency of suicide in the fire service.

Gist et al. (2011) presented an opinion that fire service personnel are more acquainted with death and injury due to the nature of their occupation. The real possibility of death as a result of the firefighting occupation and the high incident of occupational injury may be factors which may increase the capability of suicide.

The experiences of Fire District #1 with regards to suicide indicate that there is a need for suicide prevention in the department. This applied research project will result in a suicide prevention program which corresponds to the particular needs and resources of Fire District #1 and its personnel – both career and volunteer. This research effort directly correlates to the National Fire Academy (NFA) course Executive Leadership goal of developing the “ability to conceptualize and employ the key processes and interpersonal skills used by effective executive-level managers” (Federal Emergency Management Agency [FEMA], 2011). This research additionally supports the U. S. Fire Administration’s (USFA) operational objectives of reducing “risk at the local level through prevention and mitigation improving” and “the fire and emergency services’ capability of response to and recovering from all hazards” (Department of Homeland Security, 2009, pp. II-2).

#### Literature Review

In 2001 the U.S. Department of Health and Human Services National Strategy for Suicide Prevention (NSSP) published a collaborative effort defining suicide prevention strategies at the national level (U.S. Department of Health and Human Services, 2001). In this effort eleven topics were outlined to guide national suicide prevention efforts. These eleven goals and objectives are found in Table 1. The themes considered address the various methods of suicide prevention including those aimed at society as a whole as well as those which seek greater understanding of both suicide and the means by which it might be reduced in frequency.

Those themes applicable to an individual entity’s suicide prevention program are summarized in the following paragraphs.

The first goal promotes the idea that suicide is a preventable health problem (U.S. Department of Health and Human Services, 2001). This amounts to an awareness campaign to change the general stigma associated with suicide. The basis of this thought process is the notion that as more people become aware of the fact that suicide is a treatable mental health issue, a corresponding reduction in suicide should be realized.

The second goal suggests the establishment of support for suicide prevention (U.S. Department of Health and Human Services, 2001). This goal is designed to be delivered across many different types of organizations including religious based organizations, the healthcare system and government. On a micro-scale this initiative could be applied to a single organization and those associated with it both directly and indirectly.

Those entities which might be directly involved with a given agency would be the department physician, other public safety disciplines and agencies, and professional organizations associated with the particular entity, such as unions and chiefs' associations. Those who might be indirectly involved would be the religious affiliations, fraternal organizations, and other entities where the individual might participate in activities unrelated to the fire service. (U.S. Department of Health and Human Services, 2001)

The third goal is related to the first in that it advances the notion that it is socially acceptable to seek professional treatment for mental health related problems (U.S. Department of Health and Human Services, 2001). This initiative in particular is relative to the fire service, with its tradition of self-reliance and bravado. The premise of this goal

is to encourage the individual in seeking professional assistance without fear of any negative stigma being applied to their situation. Through this initiative it is hoped that more people experiencing suicidal thoughts will seek help before taking action on those feelings.

Table 1

NSSP Goals and Objectives for Action (U.S. Department of Health and Human Services, 2001)

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Goal 1: Promote Awareness that Suicide is a Public Health Problem that is Preventable.

Goal 2: Develop Broad-based Support for Suicide Prevention.

Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services.

Goal 4: Develop and Implement Suicide Prevention Programs.

Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-harm.

Goal 6: Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment.

Goal 7: Develop and Promote Effective Clinical and Professional Practices.

Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services.

Goal 9: Improve Reporting and Portrayals of Suicide Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media.

Goal 10: Promote and Support Research on Suicide and Suicide Prevention.

Goal 11: Improve and Expand Surveillance Systems.

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The fourth goal is the creation and establishment of suicide prevention programs (U.S. Department of Health and Human Services, 2001). This initiative postulates that the frequency of suicide will be diminished through the development of programs within individual entities that are specifically aimed at preventing suicide before it occurs. This goal acknowledges that the public health framework is not specific enough to address all instances of suicide. Other considerations pertinent to this effort are the organization-specific details of a given program such as time and monetary resources which will need to be dedicated to support a continued effort to prevent suicide at the agency level.

The fifth goal addresses access to lethal means of self-harm (U.S. Department of Health and Human Services, 2001). The thought process driving this idea is that some instances of suicide are impulsive in nature and can be prevented by the simple act of reducing the opportunity to take one's life. Any efforts in this arena must be translated to the awareness portion of a suicide prevention program and communicated to the organization to which it pertains.

The sixth goal is the implementation of training for individuals in the recognition of "at-risk behavior" and referral of those exhibiting such behaviors to mental healthcare providers (U.S. Department of Health and Human Services, 2001). The recognition of suicidal behavior is paramount to early and effective treatment. In most cases, victims of suicide exhibit many signs and symptoms prior to actually attempting to take their own life. This goal espouses the practice of training those who come in regular contact with a specific group of people to detect the early warning signs of suicide.

The eighth goal suggests improved access to mental health services for those affected or potentially affected by suicidal thoughts. There are many barriers which obstruct access to mental health services. These may include the lack of insurance coverage or funding to receive mental health services. In the case of many volunteer and combination fire agencies, such services are rarely available except as promoted through critical incident stress management sessions associated with specific incident responses. (U.S. Department of Health and Human Services, 2001)

The eleventh goal is an improvement in surveillance of statistics regarding suicide at the national level to further define the knowledge base of suicide and mental health issues. From the perspective of this research effort this goal suggests periodic assessment of a suicide prevention program to ensure that it is both current and relative to the needs of the organization it serves. (U.S. Department of Health and Human Services, 2001)

The items outlined in the National Strategy for Suicide Prevention are very broad in scope by design. They were established to set forth a framework from which to address suicide prevention over the whole of society. However, they can be used as a guide for development of an agency-specific suicide prevention program. It should be noted that these goals and objectives address more than just clinical treatment programs, and that they advocate a holistic approach to suicide prevention. Although these objectives are now more than ten years old, they are still referenced in current reference works by the Center for Disease Control (CDC). (Center for Disease Control and Prevention, 2010)

The Suicide Prevention Resource Center (SPRC) has established a basic plan for suicide prevention (Jed Foundation and Suicide Prevention Resource Center, 2012). These guidelines also contain measures to promote mental health for the populations served. This approach is a cooperative effort between the Jed Foundation and the SPRC. It is based on the principles established in the United States Air Force Suicide Prevention Program. Although the comprehensive approach is aimed at colleges and universities, the basic principles can be applied to other institutions as well. The basic components can be found in Table 2. Information can be found the various tabs within the web page which provides guidelines and explanations for the individual topics. A discussion of the same follows below.

Table 2

SPRC Comprehensive Approach (Jed Foundation and Suicide Prevention Resource Center, 2012)

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Follow Crisis Management Procedures

Restrict Access to Lethal Means

Develop Life Skills

Promote Social Networks

Identify Students at Risk

Increase Help Seeking Behavior

Provide Mental Health Services

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Crisis management procedures are those protocols established by the entity that address the immediate needs of the institution and the suicidal person (Jed Foundation

and Suicide Prevention Resource Center, 2012). These protocols include measures to cope with the immediate threat of suicide and any danger to those associated with the suicidal person as well as postvention measures to help the agency recover in the aftermath of an attempted or completed suicide.

Restricting access to lethal means involves identifying means which facilitate suicide (Jed Foundation and Suicide Prevention Resource Center, 2012). This requires that the facility and surrounding areas be assessed for a variety of factors that may allow the suicidal person to more easily attempt or complete suicide. This may include restricting access to firearms, chemicals, drugs, and other agents commonly used in suicide. Other considerations may include preventative measures such as high fences around bridges, buildings and other environmental factors that might be used as lethal means.

Developing life skills involves teaching the individual to cope with life stresses which may lead the individual down the road of despair and suicide (Jed Foundation and Suicide Prevention Resource Center, 2012). This component of the comprehensive approach identifies four areas for personal development to help establish resiliency and develop skills to help one cope with the rigors of life. These four areas include: (a) “interpersonal communications/human relations,” (b) “problem solving/decision-making,” (c) “physical fitness/health maintenance,” and (d) “identity development/purpose on life” (Jed Foundation and Suicide Prevention Resource Center, 2012). These life skills are drawn from an earlier document titled “Life-skills Development Inventory-College Form: An Assessment Measure,” authored in 1998 by B.K. Picklesimer and T. K. Miller. The posted link to that resource was invalid at the time of this research.

The concept of promoting social networks advances the idea of decreasing loneliness and isolation, both of which are demonstrated risk factors for suicide (Jed Foundation and Suicide Prevention Resource Center, 2012). By reinforcing the connectedness of the individual with the group, the person develops a network through which other coping mechanisms are strengthened. This gives the individual another tool to cope with life stresses by being part of a community where they may feel more comfortable voicing their concerns and sharing their anxieties and grief. On a more positive note, the person has the opportunity to learn other interests and share their own, developing life-long bonds with their colleagues. This principle also facilitates leadership involvement with the individual.

Identifying students at risk seeks to single out those who might be experiencing thoughts of suicide (Jed Foundation and Suicide Prevention Resource Center, 2012). This is accomplished through several different means including gatekeeper training for those with whom students at risk routinely associate, such as faculty and peers. Other means of identifying students at risk include pre-screening at the time of application to the school, and screening of those who access student mental health services for suicidal thoughts. Awareness events highlight the risk factors for suicide and web-based self-assessment programs are also part of this component.

Increasing help seeking behavior encompasses activities and initiative that make students under stress more likely to seek out assistance (Jed Foundation and Suicide Prevention Resource Center, 2012). This is accomplished by increasing awareness of available support services and programs as well as providing anonymous, on-line self-

initiated screening. This part of the program assumes that an increased awareness of the need for treatment increases the likelihood that such persons will seek help.

Providing mental health services includes the use of existing campus counseling services as well as referral to long term care if needed (Jed Foundation and Suicide Prevention Resource Center, 2012). Although a quick, knee-jerk approach might be to hire additional staff to provide more potential for treatment, there are other measures which can be taken within the scope of existing resources. These may include the aforementioned voluntary self-screening tools found online, or the use of quick referral programs similar to employee assistance programs as found in private industry. Making the best with what is currently available is the main focus of this component of the comprehensive approach.

In 2001 the United States Air Force (Air Force) (2001) published their suicide prevention program. The Air Force identified eleven initiatives for suicide prevention within that organization. These are listed in Table 3.

The themes from the Air Force (2001) suicide prevention program are discussed in the following paragraphs. All of the topics are detailed because this particular source is an existing, operational program for suicide prevention within an organization.

The Air Force (2001) considered that leadership involvement was paramount to the continued success of any efforts for suicide prevention. Also, the normal command structure could be used to efficiently transmit program updates and information down through the ranks. By these means, suicide prevention goals such as reducing stigma, encouraging airmen to seek help, and keeping abreast of program progress and updates are easily facilitated. One effect of this program feature was that commanders

in the Air Force viewed suicide prevention as important. This was taken as evidence to support the idea that leadership support is essential to the continued success of the suicide prevention program of the Air Force.

Table 3

Air Force (2001) Suicide Prevention Initiatives

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Leadership Involvement

Assessing Suicide Through Professional Military Education

Guidelines for Commanders: Use of Mental Health Services

Community Prevention Services

Community Education and Training

Investigative Interview Policy (Hand-off Policy)

Critical Incident Stress Management (CISM)

Integrated Delivery System (IDS) for Human Services Prevention

Limited Patient Privilege

Behavioral Health Survey

Epidemiology Database and Surveillance System

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One issue that became clear during the development phase of the Air Force Suicide Prevention program was the lack of knowledge regarding suicide prevention (Air Force, 2001). Although supervisors and managers were managing difficult situations on a daily basis due to the nature of the service, in many cases they felt ill-equipped to cope with suicidal individuals. To this end, suicide prevention and the details of the program were inserted into the rank and station specific professional military education

curricula. It is worth noting that initial resistance due to robust curriculum content was overcome by direct order to make room for the specific suicide prevention content.

The next initiative addressed the reluctance of managers and supervisors to recommend or order that an individual seek mental health services (Air Force, 2001). It promoted the idea that it is ok to seek out these services as an individual. By encouraging self-referral and eliminating any recourse to the professional status of the individual using mental health services, the stigma of mental health treatment was reduced. This edict also removed any barriers to accessing treatment which may have existed prior to the program's inception.

Community preventative services for mental health were an area identified for improvement (Air Force, 2001). Historically, the existence of persons staffed specifically in preventative health service had been penalized by directives that denoted those personnel as excess to the regular manpower contingent of Air Force installations. Although two recommendations were made to augment the compliment of preventative mental health staffing, ultimately these services were incorporated into existing job descriptions. The directive did specify that time spent in preventative mental health activities would be tracked and used to establish needs for prevention activities.

The fifth initiative identified the need for greater community education regarding suicide (Air Force, 2001). Air Force statistics regarding suicides indicated that only 30% of suicide victims had sought assistance with mental health issues. To better enhance awareness of suicide and assist in both self-referral and referral of those exhibiting signs of suicidal thoughts, the LINK program was developed. LINK stands for (a) "Look

for possible concerns,” (b) “Inquire about concerns,” (c) “Note level of risk,” and (d) “Know referral resources and strategies.” (Air Force, 2001, p. 18)

The LINK program originally consisted of four levels of action, but has since been refined to include only two levels. The first level is buddy care and consists of annual training regarding risk factors and other early warning signs of suicide (Air Force, 2001). This training is mandatory for all members of the Air Force and encourages early recognition and early referral of individuals exhibiting signs of suicide.

The second level of LINK is for immediate supervisors of individuals at risk of suicide (Air Force, 2001). This level introduced the concept of gatekeepers, supervisors who “identify, triage, and mentor” personnel in need of mental health services (Air Force, 2001, p. 19). Referrals from this level are routed either through the next immediate level of care – that of community preventative resources, or directly to medical healthcare providers in emergent situations.

The original third and fourth levels of the LINK concept were removed due to the presence of resources that already existed or care that was already provided through traditional means. The elimination of those two parts of the Air Force program was due to the assumption that the groups and professionals targeted were already in possession of this training. For the purposes of identifying all possible aspects of a suicide prevention effort the original last two items are discussed below. (Air Force, 2001)

The third level of the LINK process continued the concept of gatekeepers, extending the network beyond the peer level into community prevention resources. These resources occupy a variety of community services, including wellness programs,

faith-based counseling, social services, and other informal and formal programs. (Air Force, 2001)

The fourth level of LINK community education initiative was referral to direct care (Air Force, 2001). The training at this level provided education to medical providers with identification, referral, and treatment of those at risk to suicide.

The sixth initiative identified legal problems as a suicide risk factor (Air Force, 2001). This initiative addresses the impact of being investigated for criminal or other military charges on the emotional and mental well-being of the individual under indictment. The process specifies the hand-off requirements for those who have been informed of being under investigation or being charged with a crime.

Initiative seven addresses critical incident stress management (CISM) (Air Force, 2001). This item mandates the existence and implementation of CISM teams and critical incident stress teams (CIST) at each installation of the Air Force. The intent of this particular initiative is aimed at preventing post-traumatic stress disorder (PTSD), which has been identified as a long-term result of exposure to traumatic events.

The eighth initiative revamped the manner through which suicide prevention services were accessed by those in need of them (Air Force, 2001). Previous to this effort, access to those services was conducted by any of several entities within the Air Force. This created harmful competition between those entities in some cases, and limited access in others.

This clouded the issue for those in need of suicide prevention services, denying the care they most urgently needed. The new procedure is aimed at providing better understanding of available services for all facets of one's personal life, including factors

identified by the Air Force (2001) as major contributors to mental health. These factors include relationships, job performance, finances, the legal system, and substance abuse, mental health, and depression.

The ninth initiative addresses the patient confidentiality issues of airmen by establishing a provider-client privilege (Air Force, 2001). This limiting of patient privilege helped as a suicide prevention factor by reducing the stigma associated with the use of mental care services. It mandates that records of those who seek mental health service may not be publicly criticized for such, nor may the fact that such services were sought be reflected in the individual's discharge records. It does allow the commander access to pertinent information in order to continue the basic mission of the unit.

The tenth initiative created a behavioral health survey to be conducted periodically to assess the mental well-being of both the unit and the individual (Air Force, 2001). This survey seeks to identify the top items of concern regarding the mental health of those in their command. This behavioral health survey is a tool for commanders to use that allows them to detect suicidal thoughts and risk factors among their troops. Suicide was identified as the top concern for most Air Force commanders.

The eleventh initiative establishes a surveillance program to identify and track self-injury and suicide in the Air Force (2001). This piece of the Air Force Suicide Prevention Program is used as a tool to assess the effectiveness of the program as a whole. Although it is noted that this is not verifiable due to the lack of a control group, statistics show a reduction in the instance of suicide in the Air Force between 1994 and 1999; data for subsequent years was not included in the document.

In a summary of the program, the Air Force (2001) concluded that the factors most crucial to its success in the area of suicide prevention are: “leadership involvement, education at all levels, re-engineering helping services, unity behavioral assessment, and surveillance.” (Air Force, 2001, p. 33)

The United States Army (Army) (2010) also has a suicide prevention program. The basic focus of the Army initiative classifies efforts as prevention, intervention, and postvention. The Army suicide prevention effort is designed to address suicide risk factors to help prevent suicide from occurring and mitigate the effects of the same should suicidal behavior or attempts at suicide occur. The characteristics of the Army program are discussed below.

The prevention aspect of the Army (2010) suicide prevention program endeavors to prevent suicidal behaviors from occurring and to stop thoughts of suicide from progressing to actual suicidal behavior. Preventative measures are those activities and practices which prevent stresses from becoming unbearable. The Army program indicates that leadership involvement is among the most essential influences of suicide prevention. Familiarity with personnel and their families, personal knowledge of the personnel within their sphere of influence and the development of skills to cope with life stressors are all part of the prevention aspect of the Army suicide prevention program.

The intervention approach of the Army (2010) program for suicide prevention is directed towards intervening with personnel who might be suffering from thoughts of suicide, displaying suicidal behaviors or other mental health issues which may progress to suicide. This portion of the program requires that individuals who are experiencing a mental health crisis or displaying suicidal behaviors be either requested or required to

seek treatment by a mental health professional as the severity of the condition indicates.

The intervention facet of the Army (2010) suicide prevention program introduces the gatekeeper concept, whereby individuals with additional training are able to provide more informed crisis intervention at a personal level. In the intervention phase more restrictive means may also be employed, such as restriction from lethal means, or being placed under the watchful eye of a fellow soldier.

The gatekeeper education provided via the Army (2010) suicide prevention program is known as ACE. The ACE acronym represents the concepts: (a) "Ask," (b) "Care," and (c) "Escort" (Army, 2010, p. 15). The *ask* concept directs the gatekeeper to inquire about any suspicions of suicidal thoughts, to directly confront the individual about any suspicions, and to discuss those suicidal thoughts openly and without bias or prejudice. The *care* component guides the gatekeeper to provide a sort of emotional first aid for those who may be contemplating suicide. Care may include removal of lethal means and frank discussion about the benefits of mental health care. The *escort* concept indicates that the person in distress must not be left alone, but that they should be escorted to appropriate care or counseling. Individuals may be escorted to a chaplain, person of higher authority, or emergency care as is deemed appropriate. The key to the ACE program is that no force is used in meeting its objectives.

The postvention aspect of the Army (2010) program addresses the needs of the individual and others around them after a suicide has been attempted or completed. Postvention seeks to prevent the suicidal person from inflicting greater harm upon themselves, as well as preventing harm to those around the individual in distress.

Postvention also addresses the needs of the unit after the event. During postvention, counseling and psychological services may be provided for the unit to keep the suicidal behavior from spreading to others. This aspect also seeks to maintain the integrity and readiness of the unit.

The substance of the Army suicide prevention program is “suicide risk reduction” (Army, 2010, p. 2). The intention is to mitigate any risk factors for suicide in order to decrease the chances that suicide will occur. Leadership is an important facet of the program, to the extent that the Army Suicide Prevention Program requires commanders to ensure that activities are in place which facilitate the mental, social, psychological, and spiritual well-being of those under their purview.

The Badge of Life organization was formed by a group of retired law enforcement officers who saw the need for more than just a traditional suicide prevention model (Levinson, O'Hara, & Clark, 2010). The intent of the program is to help prevent suicide among the ranks of law enforcement by teaching the individual how to cope with job stresses and emotional trauma occurring in conjunction with the rigors of law enforcement. The concept which forms the basis of the Badge of Life philosophy is called “Emotional Self Care” (ESC) (Levinson et al., 2010, p. 98). The ESC concept is designed to build emotional resiliency in the public safety officer.

The Badge of Life program consists of two core principles, (a) peer support and (b) ESC (Levinson et al., 2010). Peer support involves assigned formal and informal leaders within the agency or among retirees from with the law enforcement discipline who have had training specific to the mental health and welfare of law enforcement personnel. The training provides information to the peer support officer regarding the

warning signs of PTSD, emotional stress, or other signs and symptoms of job related mental health issues.

The ESC training begins when the new recruit first enters the basic law enforcement academy (Levinson et al., 2010). Recruits are taught the difference between stress – the normal things that impact our daily lives such as keeping up with the rent, and trauma – the emotional injury which occurs when officers encounter abnormal situations such as horrific injuries and deaths, abuse, etc. This concept continues through the career of the officer. Annual training is given on the subject of mental health, coupled with a non-mandatory annual emotional personal mental health inventory per the recommendation of the Badge of Life Program.

The mental health inventory asks the officer to voluntarily schedule a visit with a counselor or mental health provider of their choosing. These mental health professionals may be part of an established agency employee assistance program (EAP), or they can be any other provider that the individual prefers. (Levinson et al, 2010)

Levinson et al. note that this is not a substitute for suicide prevention programs, but rather a component of the basic skillset to help the individual learn to maintain mental health fitness in much the same way as one might maintain physical fitness. In this manner the individual acquires skills which will sustain their mental health throughout their careers and during retirement. A key part of this concept is endorsement of the program by agency leadership, including leading by example. A lesson plan outline is included in Appendix A.

The efforts of other fire departments with regards to suicide prevention programs were researched through the Bing search engine and the Learning Resource Center of the National Fire Academy. Key words included suicide, suicide prevention, firefighter suicide prevention, and fire department suicide prevention programs. One Executive Fire Officer (EFO) Applied Research Paper (ARP) was found with relevancy to this effort.

Wayne Zigowicz (2008) of Littleton Fire Rescue (LFR) conducted research regarding the establishment of a suicide prevention program for the community of Littleton, CO. The research was prompted by several situations wherein LFR personnel were confronted either by emergency response to suicide or by having the attempted suicide occur on the property of LFR at one of the fire stations.

The LFR research effort showed that a majority of fire department personnel had not received suicide prevention training in any form. It was noted that although the state of Colorado did have certain suicide prevention efforts in place, most emergency responders were unaware of such programs. This trend was reflected throughout the emergency response community of the United States. Overall, most public safety members had received no formal training at any level regarding suicide prevention, and were unaware of local, state, or national efforts for suicide prevention. (Zigowicz, 2008)

Zigowicz (2008) addressed the problem of suicide prevention in the community from a dual perspective. One recommendation focuses on the needs of crews during emergency response to suicide and suicidal situations, while the other provides suicide prevention training for LFR personnel. These recommendations built upon the

guidelines established by the NSSP goals (U.S. Department of Health and Human Services, 2001).

Emergency response to suicide included surveillance efforts to coincide with national reporting databases regarding suicide and quality control (Zigowicz, 2008). Suicide responses were recommended to be tracked and submitted to a national database to assist with defining the problem of suicide at the national level.

Zigowicz (2008) also recommended that emergency responders be monitored via an internal support network to determine any impact through response to suicide and suicidal situations. The intent of this particular recommendation is to reduce the stigma associated with seeking the services of mental health professionals.

Suicide awareness training for all emergency responders is also advanced by Zigowicz (2008). The content of this recommendation includes a presentation to be given to all members of LFR. Included in the curriculum are items such as identification of risk factors, facts and myths regarding suicide, and information regarding local and national suicide prevention programs. In this vein, Zigowicz advances the concept of public safety personnel as gatekeepers for suicide prevention.

Other tenets of the LFR program include standard operating procedures (SOP's) for response to suicides and suicidal situations, brochures containing information about suicide and suicide prevention, recommendations that LFR participate in community suicide prevention efforts, and education of LFR personnel regarding community risk reduction efforts pertaining to the health and welfare of the community. (Zigowicz, 2008)

The SOP's developed by Zigowicz (2008) provided direction for LFR personnel at emergency scenes involving suicidal individuals. These include personal and team safety components, review of risk factors, and specific information for dispatch personnel when dealing with suicidal callers. The intent is to ensure consistency of action when dealing with suicide during incident response.

The brochures are for both suicidal individuals and the survivors of suicide victims. The first brochure is a referral resource providing information for mental health services and resources to help the suicidal person in their hour of crisis. The survivor's brochure aids in recovery after the fact for the family and friends of the victim. Both of these resources encourage access to mental health treatment for those contemplating suicide as well as those left behind in the wake of suicide. (Zigowicz, 2008)

Zigowicz's (2008) last two recommendations focus on the participation of LFR in local suicide prevention efforts and the education of LFR personnel regarding their role in the health and welfare of the community in which they serve. Zigowicz discovered existing suicide prevention programs which aided the cause of such efforts within his own agency. Coupled with the awareness training previously mentioned for all LFR personnel, these newly discovered programs would prove a valuable asset to the suicide prevention efforts of LFR within the community of Littleton, Colorado.

A document was found via the Bing internet search engine which is attributed to personnel from the San Jose Fire Department of San Jose, California (Suicide Prevention and Crisis Intervention Guidebook, n.d.). The San Jose Fire Department web page had no mention of the document; it is included in this effort due to the relevance of content with regards to research question two: What programs and

activities have other fire departments implemented to address suicide prevention within their organizations?

The Suicide Prevention and Crisis Intervention Guidebook is a manual which individual agencies can download and customize for their own use. The contents include information regarding signs and symptoms of suicide and depression as well as checklists for resilience and relationship problems. Additional information is provided for those suffering in the wake of suicide. (Suicide Prevention and Crisis Intervention Guidebook, n.d.)

The National Fallen Firefighters Foundation (NFFF) addressed the issue of mental health for emergency responders in their 2004 Firefighter Life Safety Summit (Gist et al., 2011) Firefighter Life Safety Initiative 13 (FLSI 13) states that counseling and behavioral health services should be available for firefighters and their families. Subsequent summits expanded on the original framework of FLSI 13 to encourage best practices, further research, and the implementation of evidence-based behavioral health programs for the benefit of the fire service.

A series of 25 recommendations emerged from the most recent summit of 2011. These recommendations are categorized into four groups: (a) defining the incidence of suicide among firefighters, (b) job related factors which contribute to suicide risk for firefighters, (c) current, validated best practices with regards to suicide prevention, and (d) the establishment of long range goals and objectives. (Gist et al., 2011)

Defining the prevalence of suicide in the fire service is addressed in the first five recommendations. Main thoughts regarding suicide in the fire service are based on the goals of the NSSP, such as surveillance and reducing stigma associated with seeking

mental health services. Other ideas advance the concepts of determining risk factors specific to fire service personnel, examining military efforts toward suicide prevention, and incorporating applicable elements of those programs into fire service programs. It is strongly recommended that current proven research is employed to avoid paradoxical impacts such as so-called cluster suicides. (Gist et al., 2011)

Recommendations three through six explore risk factors specific to those in the fire service. The third recommendation advances Thomas Joiner's (2009) Interpersonal Theory of Suicide as a possible means of determining propensity for firefighter suicides. Joiner indicates that there are three factors which contribute to suicide in the general population: (a) thwarted belongingness, (b) perceived burdensomeness, and (c) capability for suicide.

Gist et al. (2011) place particular emphasis on the use of Joiner's Theory as an instrument by which to assess the individual for suicide potential, noting that both belongingness and personal contribution form the basic culture of the fire service. When a person perceives that they are becoming a burden for whatever reason, or they begin to feel isolated from their fellows, the possibility of suicidal thoughts increases.

The concept of capability for suicide explains the circumstances which authorize the individual to actually attempt suicide – the transition from thought to deed (Gist et al., 2011). Gist et al. highlight the fact that firefighters are subjected to death and injury at a much higher frequency than any other occupation. Coupled with the fact that firefighters experience a greater incident of occupational injury and accept the possibility of death as part and parcel of the job, the capability for suicide is a much smaller step for fire service personnel than the general population. In light of both the simplicity and

applicability of Joiner's Theory of Suicide, Gist et al. advocate further research and testing of the model for fit, utility and applicability to fire service suicide prevention efforts.

The seventh recommendation builds on Joiner's (2009) theory, suggesting that the concepts of belongingness and personal contribution deserve greater assessment for impact to the mental health of fire service personnel. The eighth recommendation advocates the development of suicide prevention screening and intervention strategies for the fire service as a whole. (Gist et al., 2011)

Recommendations nine through fourteen focus on ensuring that all suicide prevention efforts are based in current, sound, proven theory. Gist et al. mention the idea that suicide prevention should be broadly focused, being part of a wellness program for the individual as a whole. These efforts should address a broad range of risk and protective factors present or suspected within a given agency. These recommendations further suggest that mental healthcare professionals treating firefighters should have access to free instruction relative to fire service mental health issues and concerns. Peer counseling should also be addressed by providing the appropriate training and support prior to implementation.

The remaining recommendations establish priorities and actions for future efforts regarding suicide prevention activities of the NFFF. It is recommended that suicide prevention be integrated into FLSI 13, and that all department efforts follow a consistent, proven blueprint for suicide prevention such as the Public Health Approach to Prevention advanced by the SPRC. Although generic in nature as presented by the

authors, the SPRC model applies a regimen for periodic evaluation as well as the inclusion of tested and proven elements. (Gist et al., 2011)

The incorporation of peer support elements into FLSI 13 and the cooperation among fire service organizations is also recommended. Recommendations also include suggestions that protocols be developed to help agencies address high profile and series suicides. (Gist et al., 2011)

Through all of the action and priority-based recommendations, a strong current is present advocating fiscal support, availability of information, and continued research for suicide prevention and mental health issues in the fire service. (Gist et al., 2011)

### Procedures

This research topic was chosen in the wake of a second suicide by a member of Fire District #1 within as many years. A problem statement was developed to define the needs of Fire District #1 regarding internal suicide prevention efforts. A purpose statement was constructed to guide the research effort. The research questions were identified to allow proper evaluation of existing suicide prevention efforts in the mental health community, other occupations and the fire service. These research questions further sought to define what components should comprise a suicide prevention program for Fire District #1, as well as identifying the resources needed to sustain suicide prevention efforts for the foreseeable future.

A literature review was conducted from November 2011 through April 2012 to acquire information regarding suicide prevention programs and suicide prevention. The USFA's Learning Resource Center online database was searched using the search terms suicide prevention, suicide prevention programs, firefighter suicide, and firefighter

suicide prevention programs. The literature review continued via the internet using the Bing search engine with the same search terms. The internet search was expanded to include terms relating to law enforcement and military occupations for information pertinent to this effort.

The literature review was conducted to answer the following research questions:

- What are the components of a suicide prevention program?
- What programs and activities have other fire departments implemented to address suicide prevention within their organizations?
- What details should be included in a suicide prevention program for Fire District #1?
- What long-term requirements and resources are necessary for the longevity and effectiveness of a suicide prevention program within Fire District #1?

An interview was conducted with a local mental healthcare professional to determine what formal suicide prevention programs, if any existed in the local area. Mike Bauer of Southwest Counseling Services was selected due to prior experience in critical incident stress debriefings with Fire District #1 and his efforts with the local suicide prevention coalition. The interview also attempted to acquire information concerning EAP's offered by other local employers. Information such as basic benefit structure, frequency of usage, and associated costs per session for access were discussed.

The interview attempted to answer the following research questions:

- What are the components of a suicide prevention program?

- What details should be included in a suicide prevention program for Fire District #1?
- What long-term requirements and resources are necessary for the longevity and effectiveness of a suicide prevention program within Fire District #1?

A request for information regarding suicide prevention programs in the fire service was sent out via electronic means. The responses were requested through the Training Resources and Data Exchange Network (TRADENET) hosted by the UFSA, and the mailing list of the National Society of Executive Fire Officers (NSEFO). The information request as distributed is found in Appendix B. Responses to the information request were directed to be submitted by email or traditional postal service as the respondent desired. Contact information including phone, mailing address, email, and web address information was provided in the message.

The information request was developed and sent out to answer the following research questions:

- What programs and activities have other fire departments implemented to address suicide prevention within their organizations?
- What details should be included in a suicide prevention program for Fire District #1?
- What long-term requirements and resources are necessary for the longevity and effectiveness of a suicide prevention program within Fire District #1?

Limitations encountered during this research were limited access to suicide prevention efforts already in existence in the fire service. This limitation was noted from

the small number of respondents to the request for information and the limited availability of information regarding suicide prevention.

Another limitation was the generic nature of most available information for the development of an individual suicide prevention effort. The results indicated that development of a program to prevent and reduce suicide within a given entity required the developer to find a generic model and then incorporate elements from existing individual programs.

## Results

Through this research, the author was able to compile data to answer the four research questions. In addition, a proposed implementation plan was developed to establish an emotional resiliency/suicide prevention plan for Fire District #1.

Research question one: What are the components of a suicide prevention program?

The literature review noted several resources which define the components of a suicide prevention program. The NSSP Goals and the SPRC Comprehensive Approach both assist in establishing the contents of an individual suicide prevention program. The Air Force (2001) and Army (2010) suicide prevention programs serves as models to draw from for the development phase of such programs. An additional component includes the Badge of Life (Levinson et al., 2010) ESC concept. A suicide prevention and crisis intervention manual by San Jose Fire Department (Suicide Prevention and Crisis Intervention Guidebook, n.d.) was also discovered.

The NSSP, in its 2001 effort set forth 11 goals for reducing suicide in the United States. Although they do not provide a framework for development of an individual

suicide prevention program, the goals do provide guidance to define such programs within an organization. Table 4 outlines those goals which are applicable to individual suicide prevention programs and help ensure that the components of such a program coincide with national efforts. Each component of a given suicide prevention program should address one of these goals. (U.S. Department of Health and Human Services, 2001)

The SPRC Comprehensive Approach provides a more compact set of guidelines for development of a suicide prevention program, including components which expand on some of the NSSP goals as well as providing guidance for the more minute details of a specific program. The SPRC system was developed for college campuses; however the basic blueprint may be applied to other situations as well. The seven components all correspond to at least one of the NSSP's goals for suicide prevention. The SPRC Comprehensive Approach can be reviewed in Table 2. (Jed Foundation and Suicide Prevention Resource Center, 2012)

The Air Force (2001) Suicide Prevention Program has longevity on its side, having been in existence since 2001. The basic principles of the NSSP goals can be found in all of its initiatives. Additionally, the Air Force initiatives also correspond to the SRRC Comprehensive Approach (Jed Foundation and Suicide Prevention Resource Center, 2012). The Air Force (2001) Suicide Prevention Program places special emphasis on the involvement of leadership in suicide prevention efforts.

The limitations of the Air Force (2001) Suicide Prevention Program are that it is designed for a resident population who are subject to a command authority for the entire term of their enlistment or commission. Some of the characteristics of the Air Force

program directly correlate to base and community situations which are under direct control of the base administration. These conditions are not present in normal civilian life and would be difficult to establish or maintain outside of a military environment.

Table 4

Pertinent NSSP Goals and Objectives for Action (U.S. Department of Health and Human Services, 2001)

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Goal 1: Promote Awareness that Suicide is a Public Health Problem that is Preventable.

Goal 2: Develop Broad-based Support for Suicide Prevention.

Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services.

Goal 4: Develop and Implement Suicide Prevention Programs.

Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-harm.

Goal 6: Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment.

Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services.

Goal 11: Improve and Expand Surveillance Systems.

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The Army (2010) Suicide Risk Reduction Program also places strong emphasis on leadership involvement. The Army categorizes all suicide prevention efforts into three basic areas: prevention, intervention, and postvention. The Army establishes the requirements for a suicide prevention program to be in place at all installations;

however, there is no single program outlined, and the details of each installation's suicide prevention efforts are left to the discretion of the commander and staff.

The applicability of the Army (2010) Suicide Risk Reduction Program lies in the three-pronged approach of prevention, intervention, and postvention. These are concepts familiar to the risk reduction community as a whole and provide known ground from which to work during the initial design of a suicide prevention program.

The Badge of Life ESC program falls in line with the prevention aspect of risk reduction. ESC teaches firefighters how to provide for their own mental health resilience, and then following up with a voluntary visit with a mental healthcare professional on a yearly basis. The continuation of this ESC throughout their career and into retirement continues to promote mental health throughout the life of the firefighter. (Levinson et al., 2010)

An interview was scheduled with Mike Bauer of Southwest Counseling Services in Rock Springs to discuss suicide prevention efforts on March 1, 2012. Bauer recommended many of the resources found in the literature review. Gatekeeper training as part of a crisis intervention model was discussed. Bauer noted that he had conducted gatekeeper training in the past for other entities. Bauer stated that all suicide prevention efforts should consider a personal aspect with regards to how suicide has or could affect the individual, their family, friends, and the community.

With regards to leadership involvement in a suicide prevention program, Bauer suggested that the efforts should be *firefighterized* to make them as effective and acceptable as possible. The adaptation to a fire service specific program might be more effective if terminology related to the industry were used. This could include such terms

as *incipient* for the early stages of depression, and similar use of industry vernacular. Bauer further suggested that the program should identify what the responsibilities should be for each level of the command structure of Fire District #1.

The summary, the components of a suicide prevention program should address all of the seven components of the SPRC's Comprehensive Approach (Jed Foundation and Suicide Prevention Resource Center, 2012); the eight goals of the NSSP found in Table 4 would also serve as a guide to ensure that the program is on track (U.S. Department of Health and Human Services, 2001). An outline of the components of a suicide prevention program is shown in Figure 1.

It is important to note that suicide prevention efforts are an ongoing effort. Figure 1 is shown in a circular fashion to indicate the need for continued evaluation and support of suicide prevention efforts.

Research question two: What programs and activities have other fire departments implemented to address suicide prevention within their organizations?

Data regarding the suicide prevention activities of other fire departments was initially sought through the literature review. Only two sources were located through the literature review, an EFO research effort by Wayne Zigowicz (2008) of LFR and a suicide prevention handbook (Suicide Prevention and Crisis Intervention Guidebook, n.d.) attributed to the San Jose, California fire department.

Zigowicz' (2008) efforts are aimed at reducing suicides within the community of Littleton, Colorado and reducing the danger to LFR personnel when responding to suicides and suicidal situations. The recommendations of his effort included a suicide

awareness education slideshow for all responders in the LFR, and an SOP for response to suicidal situations.

A document attributed to the San Jose Fire Department of San Jose, California titled *Suicide Prevention & Crisis Intervention Guidebook* (n.d.) was found on the Fire Nuggets web page. The manual contains information regarding suicide and depression, also addressing prevention, intervention, and postvention aspects of suicide prevention. The manual is customizable for the needs of an individual agency and is free from the Fire Nuggets web site.

There are disclaimers about the use of the manual as a self-help guide and the manual advises readers to seek out a mental health professional for any questions or concerns. However, the manual is a pre-designed resource for suicide prevention programs due to its completeness and customizable format. (Suicide Prevention and Crisis Intervention Guidebook, n.d.)

An email requesting additional information about the suicide prevention manual was sent to the San Jose, California fire department. Battalion Chief Colleen Mulholand of the San Jose Fire Department, who replied, indicated that the development of the manual was in response to several suicides within their agency. Battalion Chief Mulholand explained that the manual has been a great resource since its development and is part of a three hour course on suicide prevention required for all new hires. The manual and course are combined with an EAP program and an Employee Assistance Committee comprised of San Jose Fire Department members who help facilitate access to the EAP benefits and program. Battalion Chief Mulholand also mentioned that San

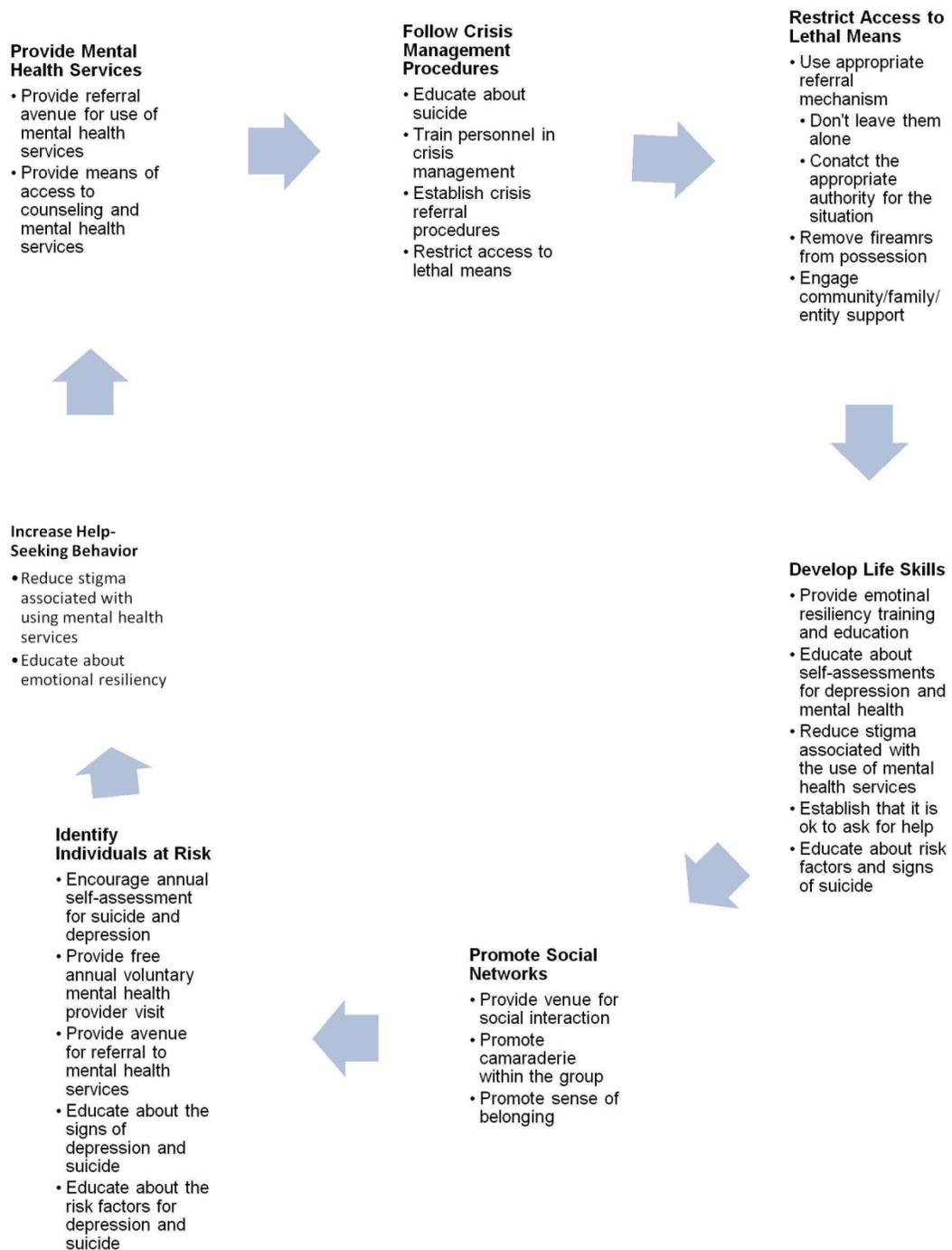
Jose Fire Department has an active CISM team for stress management in the wake of difficult incidents.

A request for information regarding the efforts of suicide prevention in fire departments was sent out via two means: (a) TRADENET of the U.S. Fire Administration, and (b) the NSEFO email list. Although it is unknown how many individuals were reached through the TRADENET effort, the NSEFO mailing list included the 786 members of the organization. Of the four responses to the request, it is unknown from which venue the response originated. The text of the request for information can be found in Appendix C.

In response to the inquiry about suicide prevention programs, only one respondent belonged to an agency with a suicide prevention program. This agency was also the only agency other than the San Jose Fire Department to have a suicide prevention handbook, which was also their suicide prevention policy. Captain Horace R. Talley of Chesterfield Fire and EMS (Chesterfield) of Chesterfield, Virginia provided an electronic copy of their manual/program titled *Courage to Save Ourselves: Chesterfield Fire and EMS Suicide Prevention and Crisis Intervention Guide*.

Talley indicated that the manual was based on a variety of resource material including the Army and Air Force Programs as well as reports from the World Health Organization, the International Critical Incident Stress Foundation, and material from the Houston Fire Department resources for fire, police and other first responders. Talley also noted that chaplaincy is an integral part of the stress management program of the agency.

Figure 1 Suicide Prevention Plan Components



The Chesterfield manual is a basic resource similar to the San Jose document (Suicide Prevention and Crisis Intervention Guidebook, n.d.). It provides information regarding suicide facts and myths, information about depression and suicide, and information for crisis intervention. The manual also provides information about stress management and coping with grief. The Chesterfield manual briefly alludes to declaring a personal mayday in the resources section, which also provides other mechanisms and sources for support and help during times of grief and crisis.

From a demographics standpoint, the agencies represented were predominantly combination fire departments, with one being entirely career. The size of the entities ranged from a total agency strength of 10/25 ratio of career to volunteer personnel to a 460/120 ratio of career to volunteer firefighters.

Although all of the respondents indicated that their agency did have an EAP, no information was available about the percentage of employee usage of the EAP. None of the departments represented by the responses had any funding budgeted specifically for suicide prevention activities. Only one agency indicated that they had experienced a firefighter suicide – a former employee who had been terminated took his own life three months after leaving the department. One respondent indicated that a family member had committed suicide several years ago.

As far as additional information, Chesterfield provided two of their internal *Safety Zone* bulletins regarding mental health issues. One respondent indicated that their department had taught stress management classes during the fall of 2011. Another respondent added that they had a CISM program in place, but nothing directly related to suicide prevention.

Research question three: What details should be included in a suicide prevention program for Fire District #1?

The SPRC has established the *Comprehensive Approach* to assist with the development of suicide prevention activities on college campuses (Jed Foundation and Suicide Prevention Resource Center, 2012). As a developmental tool for use at a variety of campuses, all with their own unique circumstances, this template would serve as a model upon which to build an individual program for a given entity. The elements of Figure 1 are all within the support capabilities of Fire District #1.

In addition, the goals established by the NSSP provide additional considerations for further fine-tuning of the program for a given agency (U.S. Department of Health and Human Services, 2001). The template found in Figure 1 represents a very rough outline of what might constitute a suicide prevention program for Fire District #1.

Other components of a suicide prevention program would be leadership involvement and initial and ongoing education and training. The involvement of leadership is crucial to the success of any endeavor; suicide prevention is no different. Leadership involvement was a consistent theme in the Army (2010), Air Force (2001) and Badge of Life (Levinson et al., 2010) suicide prevention and emotional resilience programs.

Education and training provide orientation to the subject and program. An old adage says that you expect what you inspect meaning that if a given area of concern is revisited with regularity, then it can be expected to be a prevalent concern to everyone within the organization. Education and training are consistent topics among the various sources both in the literature review and the responses to the request for information.

Research question four: What long-term requirements and resources are necessary for the longevity and effectiveness of a suicide prevention program within Fire District #1?

With the details of a suicide prevention program developed, resources must be identified and allocated to ensure the longevity of the effort. These resources include time, funding and commitment of staff to the program.

The time requirements of the program detail the amount of time required for initial implementation of the program and ongoing training and education necessary to maintain the program.

Initially, the time required to implement the program will include the hours necessary to establish the various facets of the program. Time will be necessary for the education of the career staff regarding the need for a suicide prevention program and the intent of the program.

With the preliminary introduction of the program begun, other members of the officer cadre and department personnel can be introduced to the program and initial education and training implemented. This initial training and education will include the same background information regarding the need, purpose and intent of the program. Gatekeeper and crisis intervention training will also be part of the initial program orientation. Remaining time requirements for the implementation of the suicide prevention program will be defined by the initial, department-wide training, annual training and education for the personnel of Fire District #1. Time will also need to be provided to orient all new hires of Fire District #1 to the suicide prevention and emotional resiliency program.

The preliminary time requirements for training and education would be approximately three hours for the initial orientation of the staff and gatekeepers. The expansion of the program into the general membership would require at least one training evening, with an annual session to reinforce the concepts of emotional resiliency and suicide prevention. The recruit academy training and education would also occupy one evening lesson in its entirety during the annual recruit academy.

There will be costs incurred during the initial phase of the suicide prevention program of Fire District #1, as well as costs to maintain the program. This funding will need to be defined.

The start-up costs associated with program implementation will include those for services of professionals who provide the initial gatekeeper training and the cost of any printed materials. Mike Bauer of Southwest Counseling Services in Rock Springs indicated that their agency has provided gatekeeper training in the past, although he did not specify a cost. Both the initial and the ongoing training costs would be absorbed in the annual training budget. This program would be considered firefighter training due to the safety and health aspect of its nature.

The continuing costs of a suicide prevention program for Fire District #1 would include funding for materials such as printed documents, funding to bring in outside instructors, and costs associated with mental healthcare services for those who choose to take advantage of the program.

Fire District #1 currently issues a USB flash drive (flash drive) to all personnel with the SOP's and other important information saved to it in electronic PDF format. The flash drive is updated annually to keep the information current. With the next update

cycle, the suicide prevention program documents could be placed on it for the use of all personnel. This will greatly reduce the costs associated with producing and distributing the program materials. A limited amount of printed materials will be produced for reference; however, the costs to print the material will be small and easily absorbed into the existing office supplies budget.

Potentially the most significant cost of the program would be that associated with providing access to mental healthcare professionals. Mike Bauer indicated that the cost of a one-hour counseling session was \$170 in the March 1, 2012 interview. The discussion continued regarding employee usage of EAP programs by area employers. Bauer indicated that the usage figure consistently amounted to about 5-7% of the employees from a given employer. Of that 5-7%, approximately 5% of those individuals attended more than one session. Although an EAP would be cost-prohibitive for Fire District #1, these usage figures are useful for inferring access to such a benefit by department personnel.

These usage figures reflect earlier phone surveys of local employers regarding usage of fitness-pass benefits of area employers' personnel. In 2009, Fire District #1 budgeted to provide a fitness reimbursement for all personnel desiring to purchase a membership at a local fitness club. A survey of the industrial facilities and other local employers who provided similar benefits to their employees indicated that 5-7% of the workforce consistently took advantage of the benefit.

After adoption of the fitness benefit by Fire District #1, the usage of the benefit has been consistent with the results of that survey. Bauer indicated that these would be accurate budget figures to use when establishing a budget for the suicide prevention

program at Fire District #1. Considering that the average roster of Fire District #1 is 40 personnel, and a usage of 6%, the annual budget would need to allot \$408 for mental health and counseling services. This represents only the minimum usage of an annual mental health fitness checkup. Although cost prohibitive at current budget levels, it would be prudent to consider allotting the entire potential amount required to provide a voluntary mental healthcare visit for each member of Fire District #1 every budget year.

These types of costs can be borne by Fire District #1 by two methods, (a) the annual physicals and drug testing budget, and (b) an insurance policy with a mental health benefit provided by Fire District #1 for all personnel. The physicals and drug tests budget is a combined \$7,000 over the career and volunteer categories. The annual budget for physicals is \$3,000 to be shared with the drug testing policy. If all employees were to take advantage of an annual mental health inventory as espoused by the Badge of Life, the annual expenditures would exceed the budget.

The other funding source for access to mental healthcare would be the stress management benefit provided by the insurance policy provided by Fire District #1. Those benefits are up to \$25,000 per person, per incident. Although family members are not covered, the policy covers care for the firefighter for PTSD, mental stress related illness, and traumatic stress debriefing and defusing.

The funding for a suicide prevention program at Fire District #1 would need to be evaluated over the course of the first three years to allow a proper determination for pertinent budget requirements. One way of mitigating the costs of providing an annual mental health check-up would be to negotiate a reduced price structure with the local mental healthcare provider.

The potential annual costs associated with the annual mental healthcare visits must be assumed to be the maximum as of this writing; however, it is hoped that they can be reduced. The cost of this program would still need to be tracked and incorporated into future revisions and updates of the program and annual budget.

Commitment is the last resource required to sustain a suicide prevention program at Fire District #1. Commitment dictates that all of the leadership and administration of Fire District #1 not only buy into the program, but also provide their continued support and belief in its value. Commitment to this endeavor will require that all personnel embrace the program and understand its intent. The commitment of the administration of Fire District #1 will be demonstrated through annual training and education, including the use of outside instructors. If this program is perceived to be important to the staff and administration of Fire District #1, it will also become important to the rank and file of the agency.

Based on the information found via the literature review and the original research, a suicide prevention and emotional resiliency program for Fire District #1 is warranted. The full version of the program can be found in Appendix D of this effort. The program should be considered as circular in nature, continually cycling through the various components of the program. In this fashion any one of the areas of concern regarding the mental health and emotional well-being of an individual can be addressed from the aspects of prevention and intervention. It is the sincerest hope and intention that postvention can be avoided through the application of the principles of the program.

## Discussion

The suicide of a close friend or family member is one of the most traumatic events a person can experience. The disbelief, grief, and anguish brought on in the wake of such a loss are as difficult to imagine as they are to ignore. The problem of suicide in the fire service although not quantified, is a bona fide issue, as the firefighters of Fire District #1 have lamentably discovered by their own brother and sister who have taken, or attempted to take their own lives.

It is mentioned in many, if not all of the references regarding suicide and suicide prevention, that one cannot hold themselves emotionally liable, or personally responsible for the suicide of another person. As chief of Fire District #1 the author understands this fact – however difficult a pill it might be to swallow. What remains after all is said and done is the fact that suicide has occurred not once from within the ranks of the department, but twice. These events may represent the pure coincidence of lightning striking the same place twice, but it would be irresponsible to allow these tragedies to pass without addressing the need to prevent such trauma from making a return visit to Fire District #1. This is an issue which cannot be left in the dark shadows of the agency's history, waiting to show its colors again.

The concept of suicide prevention must be considered to be unique to the circumstances of the individual entity. Unlike the basic professional standards which establish requirements for basic firefighter skills, fire officer qualifications, and other facets of the fire service, there are no boilerplate templates to be used for suicide prevention. Programs such as the Air Force (2001) and Army (2010) suicide prevention programs display some basic components of a suicide prevention program. Most public

agencies are unable to exert the same influence over agency personnel and the community that the military structure provides.

The SPRC Jed Foundation Model (Jed Foundation and Suicide Prevention Resource Center, 2012), taken in context with the NSSP goals for suicide prevention provide (U.S. Department of Health and Human Services, 2001) the foundation upon which a suicide prevention program could be designed for the needs of Fire District #1. This approach allows the individual suicide prevention program to be tailored to the specific needs and resources of a given agency. At the same time, the basic attributes of a proven blueprint for suicide prevention can be retained.

The concept of emotional resiliency is also important, too important to ignore. By teaching the individual how to recognize the need for emotional first aid, perhaps suicide prevention will indeed be a last resort. The Badge of Life concept and curriculum provide a means to equip individuals with the ability to recognize their own emotional trauma and depression and take steps to reach out for help long before suicide becomes a viable option. (Levinson et al., 2010)

All of this would be for naught however, if leadership involvement and commitment is absent from the picture. The Air Force (2001) recognized early on the importance of leadership sponsorship and participation to the success of suicide prevention. These thoughts are echoed by Ron Clark of the Badge of Life, who repeated many times in his interview the importance of having department chiefs involved. The basic principles of the Army (2010) Suicide Risk Reduction Program also mandate that the commander of every Army installation develop and implement a specific program tailored to the needs of a given installation.

Considering the history of suicide within Fire District #1, and the findings of this research effort, it is paramount that a suicide prevention and emotional resiliency program be developed and implemented at Fire District #1. The time is ripe for this type of program to become part of the agency – to prevent any further loss from within the ranks of the department. We may never know if the program will be effective due to the somewhat anonymous nature of its success. However, if even one person is prevented from harming themselves, it is worth the cost and effort a hundred times over.

### Recommendations

Based on the literature review and findings of this research effort, there is both a need and an opportunity for suicide prevention and emotional resiliency efforts for Fire District #1. To that end the following recommendations are offered:

- Fire District #1 should customize and adopt one of the existing suicide prevention and crisis intervention manuals to serve as a guide for the suicide prevention and emotional resiliency program.
- The adopted version of the suicide prevention and crisis intervention manual should address emotional resiliency as well as depression and suicide risk factors, signs, and symptoms.
- A suicide prevention and emotional resiliency program should be implemented as outlined in Appendix D.
- A curriculum to provide initial education about emotional resiliency and suicide prevention should be developed for use in the annual firefighter recruit academy to equip future Fire District #1 personnel with the skills to maintain emotional and mental health and fitness.

- Initial and annual training and education should be provided to all of the current firefighters and staff of Fire District #1 regarding emotional resiliency and suicide prevention.
- Outside presenters should be considered periodically to keep the suicide prevention and emotional resiliency program fresh and current.
- A referral system should be developed and put in place to allow agency personnel an avenue to pursue mental health care and counseling.
- Funding should be set aside for an annual emotional and mental health fitness inventory with a mental healthcare professional of the individual's choosing.
- An agreement should be negotiated with the local mental healthcare provider to reduce the cost of providing an annual mental health fitness inventory for Fire District #1 personnel.
- A presentation should be made to the Board of Directors for Sweetwater County Fire District #1 to provide an opportunity for greater administrative buy-in and support.
- Every effort should be made to reduce stigma associated with the use of mental healthcare services.
- Fire District #1 should develop a culture which makes it acceptable to ask for help with mental and emotional issues.
- Future research efforts should include surveillance of suicide and depression specific to the fire service.

- Future research with regards to suicide prevention should consider establishing emotional resiliency training and suicide prevention efforts which address the needs of the fire service.

## References

- Center for Disease Control and Prevention. (n.d). *Injury Center: Violence Prevention, Suicide Statistics*. Retrieved March 1, 2012, from CDC:  
[http://www.cdc.gov/ViolencePrevention/suicide/statistics/suicide\\_map.html](http://www.cdc.gov/ViolencePrevention/suicide/statistics/suicide_map.html)
- Center for Disease Control and Prevention. (2010). *Preventing Suicide Program Activities Guide*. Atlanta, GA: Center for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention.
- Department of Homeland Security. (2009). *Executive Fire Officer Policies and Procedures, Applied Research Guidelines and Frequently Asked Questions*. Emmitsburg, MD: U.S. Fire Administration.
- Department of the Army. (2010, September 7). *Health Promotion, Risk Reduction, and Suicide Prevention; Department of the Army Pamphlet 600-24*. Retrieved February 20, 2012, from Army G-1 Army Suicide Prevention Program:  
[http://www.apd.army.mil/pdffiles/p600\\_24.pdf](http://www.apd.army.mil/pdffiles/p600_24.pdf)
- Federal Emergency Management Agency [FEMA]. (2011). *Executive Leadership Student Manual* (6th ed.). Emmistburg, MD: Author.
- Gist, R., Taylor, V. H., & Raak, S. (2011). *Suicide Surveillance, Prevention, and Intervention Measures for the US Fire Service*. Baltimore, Maryland: National Fallen Firefighters Foundation. Retrieved January 10, 2012, from  
[http://lifesafetyinitiatives.com/13/suicide\\_whitepaper.pdf](http://lifesafetyinitiatives.com/13/suicide_whitepaper.pdf)

Jed Foundation and Suicide Prevention Resource Center. (2012). *Comprehensive Approach*. Retrieved January 14, 2012, from Suicide Prevention Resource Center: <http://www.sprc.org/collegesanduniversities/comprehensive-approach>

Joiner, T. E. (2009). Suicide Prevention in the Schools as Viewed Through the Interpersonal-Psychological Theory of Suicidal Behavior. *School Psychology Review, 244-248*.

Levinson, R. L., O'Hara, A. F., & Clark, R. (2010). The Badge of Life, Psychological Survival for Police Officers Program. *International Journal of Emergency Mental Health, 12(2)*, 95-102.

*Suicide Prevention and Crisis Intervention Guidebook*. (n.d.). Retrieved February 23, 2012, from Fire Nuggets: <http://www.firenuggets.com/suicide.htm>

National Fallen Firefighters Foundation. (2011, July 11-12). *Issues of Depression and Suicide in the Fire Service*. Retrieved January 16, 2012, from LifeSafetyInitiatives.com: [http://lifesafetyinitiatives.com/13/depressionsuicide\\_summary.pdf](http://lifesafetyinitiatives.com/13/depressionsuicide_summary.pdf)

U.S. Department of Health and Human Services. (2001). *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, ND: Author.

United States Air Force. (2001, April). *Essential Current Policy*. (L. C. G. Wayne Talcott, Ed.) Retrieved January 15, 2012, from The United States Air Force Suicide

Prevention Program:

<http://afspp.afms.mil/idc/groups/public/documents/webcontent/knowledgejunction.hcst?functionalarea=AFSuicidePreventionPrgm&doctype=foldersearch&parentFolder=ECP&folderName=Essential%20Current%20Policy&searchWords=afsppolecp&TitleOnly=1&sortBy=dDocTitle>

Zigowicz, W. M. (2008, September). Development of Suicide Prevention Strategies to Reduce Death and Injury in Communities Served by Littleton Fire Rescue.

Emmitsburg, Maryland, United States of America. Retrieved January 20, 2012, from [www.usfa.dhs.gov/pdf/efop/efo42556.pdf](http://www.usfa.dhs.gov/pdf/efop/efo42556.pdf)

## Appendix A

## Badge of Life Suicide Prevention Training Lesson Outline

Material courtesy of Badge of Life: <http://www.badgeoflife.com/programs.php>

## POLICE SUICIDE PREVENTION TRAINING - THE ESC APPROACH

Now, before the trouble begins, placing the responsibility where it belongs--on the officer.

The Emotional Self-Care (ESC) training must begin at the academies and continue, annually.

It cannot be emphasized enough that the primary mechanism for "making this entire program work" is the Peer Support Officer. Peer Support Officers are the "army" of mental health in law enforcement and this is the opportunity to utilize them to their fullest capacity. They must be fully engaged in:

1. Academy Education
2. The selection of Field Training officers
3. In-Service Training
4. Annual training for squads
5. Pre-retirement training.

## 6. Modeling and encouraging annual mental health checks.

ESC is not a substitute for the traditional "suicide prevention training." It is a supplement, given separately and designed to create a healthy police force that will not need suicide intervention. While teaching the "signs of suicide" are helpful, it must be remembered that police officers are less likely than the general population to display them. Why? We have taught them to be masters of their emotions and not show them.

- Emotional Self-Care Training is designed to keep officers from ever needing suicide prevention. This is the element no one has ever dreamed of implementing. Instead of waiting until an officer is deteriorating, we need to train officers in the art of resilience and maintaining their emotional well-being in the face of the highly toxic environment in which they work. One of the tools they use to accomplish this is the "annual mental health check."
- Suicide prevention, on the other hand, is designed to prevent an actual suicide, in the manner for which it has been designed and traditionally performed. It looks for and attempts to spot the officer "in trouble" and provide the resources and assistance to keep the problems from growing worse.

### EMOTIONAL SELF CARE TRAINING - A SAMPLE

#### 1. BLOCK ONE – UNDERSTANDING REAL MENTAL HEALTH IN LAW

##### ENFORCEMENT

- GOAL: Not only to prevent suicide, but keep officers from *becoming* suicidal (or in crisis)

- The myths behind mental illness and suicide
- The need for accuracy and truth in today's training programs
- It's not "all about us" any more.
- The "Crisis of Denial" in the ranks of law enforcement

## 2. BLOCK TWO -- STRESS AND TRAUMA

- The difference between "stress" and "trauma"
- Critical and Cumulative Trauma
- The impact of "dirty little secrets" in law enforcement
- Maladaptive coping techniques

## 3. BLOCK THREE -- THE LIFELONG DEVELOPMENT OF RESILIENCE

- The multiple / adaptable definitions of "Resilience"
- Learning your strengths
- Commitment to finding meaningful purpose in life
- A belief in one's ability to affect the outcome
- A belief one can learn and grow as a result
- Acceptance (particularly of what one does not like)
- Self-reliance (standing apart from "the pack")
- Spirituality (which need not be religious)
- NOT A CLASSROOM EXERCISE--should be done with a therapist.

## 4. BLOCK FOUR – ANNUAL MENTAL HEALTH CHECKS

- Voluntary, confidential, the department not to know
- To be done even (ESPECIALLY) if nothing is "wrong"
- Officer may use EAP or outside therapist through own co-pay.

- No requirement for reporting
- The value to the individual officer (health/ wellness/ other comparisons)
- Trauma preparation, stress relief, personal development
- Development of individual resiliency (being prepared for trouble BEFORE it happens!).
- Why the checks should be at least annually.

#### 5. BLOCK FIVE – PEER SUPPORT ROLE

- Peer Support Officers in promoting ESC at the academy and annual ESC squad level training.
- Promotion of Drug and Alcohol programs (Private, AA, NarcAnon, law enforcement if available)
- Promotion of family therapy, other 12-step programs (CODA, etc)
- Modeling and promoting annual mental health checks at all ranks.
- It's the critical role of the Peer Support Officer to show that emotional well-being goes full circle--that it is not only about problems when they happen and suicide, but also about maintaining good mental health and continually developing resiliency and tools with which to deal with stresses and trauma BEFORE they happen.

#### 6. BLOCK SIX – FINDING THE THERAPIST FOR YOU

- Minimum licensing and qualifications
- Should I insist on a “cop-doc?”
- The interview and the first visit
- The “Journey”

## 7. BLOCK SEVEN – (FOR MANAGEMENT)

- The administrative/economic advantages of a good emotional health program.
- “Suicide Prevention” programs are still necessary – they are the “other half of the formula.”
- It’s not “just” about suicide.
- Defusing the fear of officers having total confidentiality.
- The absolute need for management support and direct involvement

## Appendix B

## Synopsis of Interview: Ron Clark, Badge of Life

## Background:

An email was sent for further information regarding the Badge of Life Program and Suicide Prevention programs. In response to the email, Ron Clark called the author to discuss the principles of the Badge of Life program and the issue of suicide in law enforcement and other public safety disciplines. A summary of the conversation is entered below.

Mr. Clark began the discussion with an introduction and brief review of his background. Ron Clark is a retired Connecticut State Highway Patrolman; he has been associated with the Badge of Life Program for six years as of the conversation.

Mr. Clark noted that everyone focuses on the act of suicide – not the problem that caused the act in the first place. Suicide is the tip of the iceberg, the visible part of the problem; however, the greatest hazard lies beneath the surface. This is not to say that suicide prevention programs don't have their place – they are important as a last-ditch effort to avoid the tragedy of suicide. The real issue is that of emotional self-care (ESC).

Mr. Clark explained that ESC involves teaching those skills which help one cope with the emotional trauma inherent in fire and emergency services before they occur. By giving individuals the skills to cope with emotional trauma and teaching them the difference between trauma and stress, they go into the workforce armed with the proper tools to help keep them mentally fit throughout and after their career. Mr. Clark noted

that if those skills are not present in the darkest hour “when you are in the abyss – the black room with no way out, it is too late to reach out for help.”

Just as the individual is responsible for their own physical fitness and health, they are also responsible for their own mental and emotional well-being. In 75% of law enforcement suicides there were no signs or symptoms of suicide at all – no outward indications of suicidal thoughts or tendencies. Mr. Clark commented that no one can know what another person is thinking or feeling. In those cases all of the gatekeeper training and suicide awareness training in the world would not have prevented the act of suicide from occurring.

Mr. Clark suggested that the hardest part of any emotional and mental well-being program is support from agency management. He indicated that most chiefs are unwilling to take a stand and publicly announce that mental and emotional health and well-being are as important as good marksmanship. In light of the fact that more law enforcement officers die nationwide each year by their own hand than are killed in the line of duty, Mr. Clark believes that administrative support of emotional self-care is a must. Mr. Clark made the point that both law enforcement and the fire service are very proactive in their attempts to prevent line of duty deaths; however, both are very negligent when it comes to addressing the problem of suicide within their ranks.

The Badge of Life program espouses the idea that everyone in law enforcement should be taught emotional resiliency beginning with the newest recruit at the academy and that this be reinforced throughout the career of every officer from recruitment through retirement. This can be accomplished by encouraging an annual mental health check-up – inventory if you will, by voluntarily visiting with a mental health professional

of their own choosing. No one has a problem with good dental hygiene, or preventative health services such as mammograms and colonoscopies; why is it such a stretch to think that preventative steps to ensure good mental and emotional health are just as important?

Mr. Clark opined that many such annual visits could be coordinated through EAP's, or they might also be part of a peer counseling program. Obviously the peer counseling would involve only the costs associated with initial training; the EAP would have an associated cost per employee for establishment of the program with local mental health providers.

The last topic touched on by Mr. Clark was the fact that everyone needs to know that it is ok to seek help from mental health services. This simple change of perspective places value on an agency's most important resource – its personnel. The costs associated with preventative mental health and emotional resiliency far outweigh the costs monetarily and of morale in the wake of a suicide.

## Appendix C

### Request for Suicide Prevention Program Information

I am conducting research to establish a suicide prevention program within our agency. We are a small combination fire district in southwest Wyoming. I would like information regarding suicide prevention programs already in existence in the fire service.

Specifically any of the following:

- A copy of the suicide prevention program for your agency.
- The suicide prevention program handbook or policy for your agency's program.
- What template was used to develop the program, if any (i.e. Air Force Suicide Prevention Program, SPRC Comprehensive Approach, etc.).
- What type of fire department – volunteer, combination, career.
- Staffing – maximum roster for volunteer agencies, career & volunteer for combination, total roster for career agencies.
- If the plan is part of an Employee Assistance Program (EAP).
- Annual usage/access to EAP counseling services by % of workforce if known.
- Annual budget for the suicide prevention program if available.
- Have there been any suicides among personnel within your agency?
- Any other information pertinent to suicide prevention efforts within your agency.

## Appendix D

Suicide Prevention and Emotional Resiliency Program for Sweetwater County Fire  
District #1

This program is based on the SPRC/Jed Foundation Comprehensive Approach (Jed Foundation and Suicide Prevention Resource Center, 2012), integrating the applicable portions of the NSSP Goals and Strategies for Suicide Prevention (U.S. Department of Health and Human Services, 2001). Also included are the principles of emotional resiliency set forth by the Badge of Life (Levinson et al., 2010).

- 1) Develop life skills of the personnel of Fire District #1
  - a) Develop curricula for emotional resiliency and suicide prevention education
    - i) New hire presentation for all firefighters hired after implementation
    - ii) Initial training and education curriculum for current firefighters and staff
    - iii) Annual refresher training for all Fire District #1 personnel regarding emotional resiliency and suicide prevention
  - b) Modify and adopt the Suicide Prevention and Crisis Intervention Handbook by San Jose Fire Department
    - i) Include information about self-assessments for depression and suicide
    - ii) Include emotional resiliency information
    - iii) Include emergency contact information for suicide hot-lines at the front and back of the manual
    - iv) Include information regarding the risk factors, signs, and symptoms of suicide and depression

- c) Take measures to reduce the stigma associated with use the mental healthcare services
  - d) Establish that it is okay to ask for help
- 2) Promote social networks
- a) Provide a venue for increased social interaction
  - b) Encourage group activities among agency personnel and families to promote/develop camaraderie
  - c) Improve recognition of personal progress and actions to promote the sense of belonging
- 3) Identify individuals at risk
- a) Encourage annual self-assessments for suicide and depression
  - b) Provide optional free, voluntary annual mental healthcare provider visit
  - c) Provide avenue for referral to mental health services
  - d) Educate about the risk factors, signs, and symptoms of depression and suicide
- 4) Increase help-seeking behavior
- a) Reduce the stigma associated with using mental healthcare services
  - b) Educate about emotional resiliency
- 5) Provide mental health services
- a) Provide referral avenue for access to mental healthcare services
  - b) Provide means of access to counseling and mental health services'
  - c) Provide information about existing benefits for counseling offered through Fire District #1 insurance policies for all personnel

- 6) Follow crisis management procedures
  - a) Educate about suicide
  - b) Train personnel in crisis management/gatekeeper procedures
  - c) Establish crisis referral procedures
- 7) Restrict access to lethal means
  - a) Use the appropriate referral mechanism
  - b) Do not leave the person alone
  - c) Contact the appropriate authority/person for the situation
  - d) Remove firearms from possession
  - e) Engage family/community support
- 8) Evaluate the program on a biennial basis
  - a) Verify effectiveness
  - b) Verify funding requirements
  - c) Modify as necessary