Suicide:

What you need to know

A Guide for Fire Chiefs

Part of an ongoing Behavioral Health series to support Firefighter Life Safety Initiative 13: Firefighters and their families must have access to counseling and psychological support.

What Fire Chiefs Need To Know About Suicide

Introduction

As a fire chief, you have undoubtedly thought about how you and your department would handle a sudden line-of-duty death. Would you rise to the occasion and demonstrate the leadership skills needed in that situation? Would your department have the courage to examine the LODD from every angle, and be forthright about any shortcomings which may have contributed to the fatality? Or, perhaps your department has already experienced an LODD under your leadership, and you still reflect back on the chain of events which unfolded. While a LODD is undeniably sad, most chief officers find ways to learn from these tragedies, and are able to use those lessons to create stronger organizations.

The death of a firefighter or EMS responder by suicide is often treated very differently. In all likelihood few chiefs think about the potential of suicide among their members until it's too late, and they are mired in the same types of guilt and questioning as other collateral survivors. Too often, deaths by suicide are accompanied by levels of stress and anxiety which result in a reluctance to examine and acknowledge the impact that suicide can have on the survivors and their organization. Organizations can also feel the need to "move on" immediately after the funeral, thus missing the opportunity to get help for those who grieve at different rates and in different ways.

However, it doesn't have to be that way. Suicide awareness and prevention in the fire service is a leadership issue. Thinking about the behavioral health and wellness of department members is as much a chief officer's responsibility as any other health intervention like seat belt usage, smoking cessation, obesity control, or the provision of a Behavioral Health Assistance Program.

Glossary

a) **Suicide** refers to a death due to suicide, meaning that the person who died intentionally killed him/herself.

b) A **suicide attempt** occurs when someone intended to kill him/herself but does not die.

c) **Suicide ideation** is defined as thoughts about killing oneself, and may also involve thoughts about methods, planning, preparations, and mental rehearsal.

d) **Death ideation** (also called **passive suicide ideation**) involves wishes for one's own death and/or thoughts that one would be better off dead, but does not necessarily include suicide as the means.

The National Fallen Firefighters Foundation is asking you to read this guide and confront your own hesitancy to think about and discuss the topic. You are probably already aware that most of your department's members have responded to suicide attempts or suicide deaths. As you learn more you will probably come to the realization that at least one person in your organization, or maybe even in your own family, has thought about suicide. This guide will walk you through an understanding of how and when firefighters are at risk, and provide you with the best data about suicide awareness and prevention. Additional resources are provided to further assist you in taking a strong leadership role in preventing firefighter suicides within your organization.

Remember—suicide is preventable and there are interventions that can make a difference.

What is suicide and how often does it occur?

Suicide is currently the 10th leading cause of death in the United States. Approximately 30,000 people die by suicide each year in the U.S.—more than are killed by homicides. At the same time, suicide is relatively rare in the general population, accounting for approximately 1.5% of total deaths. However, any suicide death is simply one too many. Suicide is a devastating tragedy for those who are left behind, termed "survivors." Survivors include not only immediate family members, but also co-workers and friends.

We do not currently know how many firefighters each year die by suicide. This lack of information is not unique to the fire service: data on suicide and occupations is very limited. We do know that most fire chiefs will never experience losing a firefighter to suicide. ***However, suicide is preventable and fire chiefs can play a key role in prevention.***

Suicide ideation is much more common than suicide attempts, which are more common than suicide deaths. In other words, many more people think about and attempt suicide than will die by suicide. The vast majority of firefighters who think about suicide will not die by suicide. However, making a specific plan for suicide is a significant risk factor for dying by suicide because those who think about suicide and plan for it are much more likely to make an attempt. Some attempts, though, are unplanned or impulsive. It is important to note that the highest risk period for an attempt is during the year after thoughts about suicide begin to develop.

More men die by suicide than women in the U. S. White men in particular are at greatest risk. The risk of suicide increases for white men in their early twenties, an age when many firefighters are beginning their careers or volunteer service. Older white men (aged 65 or older) are at greatest risk for dying by suicide, around the age when many firefighters separate from the fire service. It may appear that suicide occurs with unusually high frequency among firefighters because white males, the predominant demographic group in the fire service, is a high risk group among the general population. This cohort is also aging, which data from the general population indicates increases risk for suicide. These factors, in addition to the nature of emergency response work and the exposures it brings, means that ***the majority of firefighters and EMS responders become an at-risk population from their first days on the job.***

Most suicide deaths are caused by gunshots. Hanging and suffocation are also common methods among men.

If a firefighter is having thoughts about suicide, he/she should be asked about access to a firearm. If the firefighter has access to a firearm, safety planning should be done immediately. An example of this could be locking the ammunition and having someone else hold the key until the suicidal crisis resolves. If the firefighter will not agree to this, any actions that can be taken to "slow down" the process of accessing a loaded gun should be used up to and including notifying local law enforcement officials. This can interrupt the plan, and give the firefighter more time to potentially choose to live and to be discovered by others. Many fire chiefs have implemented zero tolerance policies of **NO GUNS IN THE FIREHOUSE**.

People with mental health disorders, including depression, anxiety, and substance abuse are more likely to have thoughts about suicide, to attempt suicide, and to die by suicide. Acting on suicidal thoughts is more common among people with:

- Certain types of anxiety problems, including PTSD;
- Alcohol or substance abuse problems; and/or
- Problems controlling their impulses.

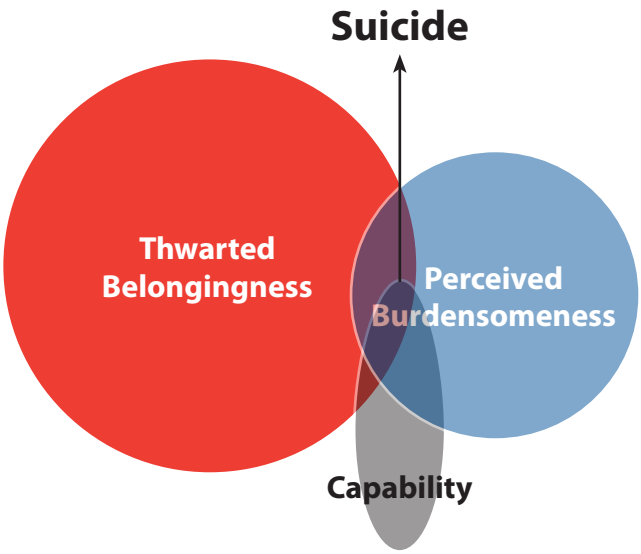
We strongly urge that every firefighter, after a potentially traumatic event, have the opportunity to complete a Trauma Screening Questionnaire (TSQ) to determine if a stress injury is present. The TSQ is attached to this guide.

Firefighters demonstrating signs of depression, anxiety, and substance abuse should be referred for appropriate treatment. Depression screening tools are widely available and should be accessible for every member of the organization. A variety of depression screening tools can be found at the Substance Abuse and Mental Health Services Administration (SAMHSA) website. These screening tools are intended for use by primary care physicians and other healthcare providers. A fire department should also consider incorporating a depression screen as a component of the annual physical. As most suicides are rooted in depression, it is vital to discover when a clinical depression persists in an individual in order to help him or her seek treatment.

Why do people die by suicide?

People die by suicide because they *want to* and because they are *able to*. In other words, people have to have the desire for suicide and the capability to engage in such a scary and painful act. The ***Interpersonal Theory of Suicide*** proposes that suicide results from three mental states: 1) low (or thwarted) belongingness; 2) perceived burdensomeness; and 3) capability to engage in suicidal behavior *(see the figure above)*. The sizes of the shapes represent how common the states are estimated to be in the general population and the area of overlap of the three shapes represents the place of highest risk for suicide.

This theory was developed to explain why people die by suicide. It has been tested by scientists around the world and received a great deal of support. The following brief description of this theory may help fire chiefs understand why firefighters might think about and attempt suicide. For survivors, having an understanding of why people die by suicide can also be helpful. *Understanding these concepts can help us be alert to warning signs for self-destructive behavior.*



Desire for suicide is caused by mental pain and anguish and the loss of hope that the pain will ever go away. Often people who are suicidal are in pain because they are experiencing low belongingness and/or perceived burdensomeness.

1. **Low belongingness occurs when someone's fundamental need to belong is unmet, or thwarted**. Low belongingness involves the belief that one is not connected to and cared about by others, including friends, family, and coworkers. People experiencing low belongingness may feel they have no one to turn to, that they are alone in the world, or that they don't fit in. **For many years it was believed that firefighters may be protected from low belongingness because of the strong sense of connectedness in the fire service. However, if a firefighter begins to feel disconnected, perhaps because of depression, alcohol problems, irresolvable family problems, an injury, or retirement, the feeling of low belongingness may be even more painful because it is such a profound loss.**

Department-sponsored organizations and events, such as regular retiree lunches, can go a long way in combatting this phenomenon.

2. **Perceived burdensomeness is the belief that one is a burden on others, so much so that others "would be better off if I were gone."** This is almost always a misperception but is believed strongly by the person who is suicidal. This belief often involves a mental calculation of sorts in which a suicidal person believes that his death is worth more than his life to the people around him. People may openly share thoughts such as "I'm a burden" or "I'm no good to anyone around here." **Firefighters may be protected from perceived burdensomeness because of the contributions they make to society through firefighting and EMS work, and the strong value they place on service to others. If a firefighter is unable to work or volunteer and contribute (as with retirement, injury, or disability) he or she may see themselves as a burden because his or her most valuable avenue of contribution is suddenly gone.**

3. **Capability to engage in suicidal behavior.** Dying by suicide is not an easy thing to do. Nature has seen to it that humans are afraid of things that are physically painful or threaten our survival. In order to overcome the survival instinct and die by suicide, people have to get used to the pain and fear involved in suicidal behavior. One way this can happen is through planning, preparing for, or rehearsing suicidal behavior, or by actually making an attempt.

Evidence from numerous studies suggests that the capability for suicide can be acquired in other ways. Note the use of the term "acquired"—none of us are born with this capacity. It develops over time and with repeated practice. Exposure to situations that are physically painful and make people think about—and even face—their own deaths is one pathway to acquiring the capability for suicide.

Earlier, we discussed how firefighters might be protected from suicidal desire because the sense of connectedness may protect against low belongingness and the sense of contributing to the well-being of others may protect against perceived burdensomeness. **However, firefighters are likely to have acquired the capability for suicide given the high frequency of occupational injury that can cause them to become used to physical pain, and the dangers inherent in firefighting may make the loss of one's own life a real and tangible risk. Also, the constant exposure firefighters and especially EMS responders have to pain in others may lessen their own thresholds.**

It is essential to point out, however, that capability for suicide will only increase risk for suicide deaths if a firefighter *wants* to die by suicide. Capability does not cause someone to think about or engage in suicidal behavior. Rather, if suicidal desire is present, capability increases the likelihood that someone will engage in—and die from—suicidal behavior.

How can fire chiefs help prevent suicide?

Fire chiefs should be aware of the warning signs for suicide. The American Association for Suicidology devised the mnemonic **IS PATH WARM** to help people remember the warning signs for suicide:

Ideation
Substance abuse

Purposelessness
Anxiety/agitation
Trapped
Hopeless

Withdrawal
Anger
Recklessness
Mood changes

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Ideation refers to suicide or death ideation—thinking about killing oneself or wishing for death.

Substance abuse is a significant risk factor for suicidal behavior.

Purposelessness is the feeling of being without purpose or meaning.

Anxiety/agitation, or feeling like you are "crawling out of your skin," is also seen in people at acute risk for suicide.

Feeling **trapped** and/or **hopeless** is reported by people at risk for suicide.

Withdrawal from family, friends, and co-workers is seen frequently prior to suicide attempts.

Significant **anger** and rage can be precursors to suicide attempts.

Reckless behavior and significant mood changes are also signs of risk for suicide.

Fire chiefs interested in obtaining additional training in recognizing warning signs of suicide may wish to complete the *Question, Persuade, Refer (QPR) On-Line Gatekeeper Training* (one hour) for a small fee. An adaptation of the full course for EMS/ Firefighters is also available online. This 8-hour self-paced class provides continuing education credit. There is a volume discount, plus special pricing for volunteers. This course teaches members of the fire and emergency services to recognize and respond positively to someone exhibiting suicide warning signs and behaviors. Like CPR, QPR uses a "chain of survival" approach in which the gatekeeper learns to recognize early suicide warning signs, **Q**uestion their meaning to determine suicide intent or desire, **P**ersuade the person to accept or seek help, and **R**efer the person to appropriate resources. It is intended to assist first responders when dealing with the public, and to help each other in times of crisis. Additional information about QPR is available on the QPR Institute's website.

A person in acute risk for suicidal behavior most often will show any/all of these warning signs:

1. Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself;
2. Looking for ways to kill him/herself by seeking access to firearms, pills, or other means; and/or
3. Talking or writing about death, dying, or suicide.

If you observe these signs, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral. All firehouses should post the 1-800-273-TALK (8255) number for the National Suicide Prevention Hotline and firefighters should know when to use or encourage others to use this number. We are attaching a flyer to this guide—print out enough for all your work sites and make sure they are posted in visible locations.

Remember, asking another person if they are having thoughts of suicide will not cause someone to have these thoughts or to act on them. If a fire chief is concerned about the safety of a firefighter 1) he/she should ask if the firefighter is having thoughts of suicide and 2) determine whether he/she has access to a gun. 3) The fire chief should help the firefighter get evaluated by a mental health professional as soon as possible. The fire department's BHAP (Behavioral Health Assistance Provider) may be able to provide crisis counseling. If needed, referrals can be provided through the National Suicide Prevention hotline: 1-800-273-TALK.

In many departments, the fire chief is several layers of supervision removed from the "troops." In these situations, chiefs should encourage company officers and all levels of supervisory personnel to be aware of the information contained in this guide.

If a firefighter is expressing suicidal thoughts and states with resolve that he is going to kill himself, do not leave the person alone, and get the person evaluated by a doctor or a mental health professional right away. Do not hesitate to use the Emergency Department if needed. **It is a myth that people who talk about suicide do not go on to die by suicide.**

Restricting access to lethal means for suicide is an effective intervention. If a firefighter shares suicidal thoughts, a fire chief can ask "what ways have you thought about killing yourself?" The chief can then urge the firefighter to remove the means from the home, or to store the means safely with a friend or a relative. **It is essential that access to firearms is restricted while a firefighter is experiencing suicidal thoughts. It should be the policy of every fire service organization that NO WEAPONS be permitted anywhere on fire department property.**

There are effective treatments for suicidal thoughts and behavior that can save lives. Fire chiefs should help firefighters find access to: a) a cognitive behavioral therapist (**CBT**), and b) a physician/psychiatrist to evaluate for the suitability of medication that may help. The fire department's BHAP or the National Suicide Prevention Lifeline can provide referrals. The widespread use of the Trauma Screening Questionnaire (**TSQ**) will also help to identify individuals with stress injuries (see Resource List). The universal practice of routinely performing an After Action Review (**AAR**) following every call is becoming widely adopted in the fire service, and may also assist company officers in identifying individuals in their crews who may be at risk of suicide.

Peers and peer teams can be invaluable assets in both connecting a suicidal person with life-saving resources, and helping coworkers heal in the aftermath of a successful suicide. Peer teams should be trained in suicide prevention and be regarded as the first line of defense. The National Fallen Firefighters Foundation has developed a course, ***Stress First Aid for Fire and EMS Personnel***, which will give your peers the training they need to support stress-injured coworkers. In addition, the ***QPR On-Line Gatekeeper Training for Suicide Prevention*** will provide a foundation for firefighters and EMS responders when interacting with colleagues contemplating suicide.

If a firefighter dies by suicide, the death should be openly discussed to reduce stigma and promote help-seeking among survivors. However, the discussion should not describe or emphasize the means or methods of the death, or other aspects of the death that could facilitate acquired capability for suicide in others. Debriefings have been proven not to be particularly helpful to survivors. Newer approaches emphasizing individualized supportive care are proving to be more effective. Sometimes suicide deaths "cluster" together in time and space. It is not known if suicidal thinking is "contagious" but it is known that clusters occur. Survivors and their family members should be offered support and given information about suicide, such as the information contained here, as well as a referral for clinical support should they choose to seek a higher level of assistance.

Conclusion

As a fire chief, your job is to to provide services which support the health and well-being of your personnel. This includes educating personnel on issues such as depression and suicide, and providing access to behavioral health providers when indicated. Addressing this issue at the department level can be very tricky, as the goal is to remove enough of the stigma as to make help-seeking a normal behavior, while still keeping the suicide taboo as an effective preventive measure. The NFFF hopes that this guide will motivate you to learn more about suicide. In addition to this resource, the NFFF has prepared a similar document for your behavioral health providers. Please make sure that any clinician who works with your staff has a copy.

Additional resources

The American Association for Suicidology serves as a national clearing house for information on suicide. The AAS has many resources and publications available to you. If a suicide does occur in your department, the AAS had booklets and resource catalogs for survivors, as well as a state-by-state list of support groups.

The Suicide Prevention Resource Center (SPRC) has material to help everyone in your department. Two fact sheets *The Role of EMS Providers in Preventing Suicide* and *The Role of Co-workers in Preventing Suicide* will be particularly helpful. These can be copied and freely distributed and may be useful as the basis for training discussions.

There are other organizations that can also help:

The American Foundation for Suicide Prevention (AFSP)
Survivors of Suicide
The Link National Resource Center

Reports, Books & Articles:

There are many reports, books and articles that can help you prepare for this topic. Here are a few which should be helpful.

Joiner, T.E. *Why People Die by Suicide*. Harvard University Press. 2005.

World Health Organization (WHO) *Preventing Suicide: A Resource for Police, Firefighters, and Other First Line Responders*. 2009.

US Forest Service, *Learning from a Traumatic Event—Suicide*. 2013.

Attached Resources:

Trauma Screening Questionnaire
Suicide Prevention Lifeline Flyer

NFFF Resources:

We will post all NFFF information pertaining to suicide prevention and intervention on the Firefighter Life Safety Initiative 13 website.

The free online ***After Action Review (AAR)*** training course may be accessed here.

To learn more about ***Stress First Aid for Fire and EMS Personnel***, please visit the Firefighter Life Safety Initiative 13 website.

This guide was prepared by Kimberly A. Van Orden, Ph.D., University of Rochester (NY) Medical Center. She is the co-author of *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients* (American Psychological Association, 2009).

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Trauma Screening Questionnaire (TSQ)

If you have recently been exposed to a potentially traumatic event (a PTE), here is a tool that may help you to identify whether or not you should seek additional help in recovering from its effects. Have you recently experienced any of the following:	YES at least twice in the past week	NO
1. Upsetting thoughts or memories about the event that have come into your mind against your will		
2. Upsetting dreams about the event		
3. Acting or feeling as though the event were happening again		
4. Feeling upset by reminders of the event		
5. Bodily reactions (such as fast heartbeat, stomach churning)		
6. Difficulty falling or staying asleep		
7. Irritability or outbursts of anger		
8. Difficulty concentrating		
9. Heightened awareness of potential dangers to yourself and others		
10. Feeling jumpy or being startled by something unexpected		

It is recommended that the TSQ be offered 3-4 weeks post-trauma, to allow time for normal recovery processes to take place. If at that point an individual has 6 or more YES answers, a referral to a behavioral health practitioner is indicated.

C. R. Brewin, et al, 2002. (Used by permission)

Recommended Protocol for Exposure to Occupational Stress

The stress to firefighters that is created by exposure to traumatic events is very real. These kinds of experiences happen with unfortunate regularity because they are an essential part of what the fire service does. No matter the size or type of the organization, it is important that firefighters be prepared to deal with the impacts of these exposures, and that fire departments provide access to resources that can make a difference.

The actions recommended in the model shown in the flowchart (on Page 1) reflect best practices based on current research, and should fit easily into the operations and support systems that most fire departments have in place. The key elements of this model include:

Determination of a Potentially Traumatic Event (PTE): A trauma for one responder may be a routine event for another. Reaction to a trauma is subjective, driven by an individual's experience, sensibilities and personal situation. After exposure to a PTE, members should be asked if they require assistance. If so what type? If not, expression of support may be all that is required.

Time out/hot wash: This concept is borrowed from the military as an element of After Action Review (AAR). It is a mechanism that allows those affected by an event to review what happened, what was successful, what could have gone better and how they might improve the next time they respond to a similar situation. This post-incident assessment will often help firefighters put the event into perspective. After a brief "time out," they may elect to return to service.

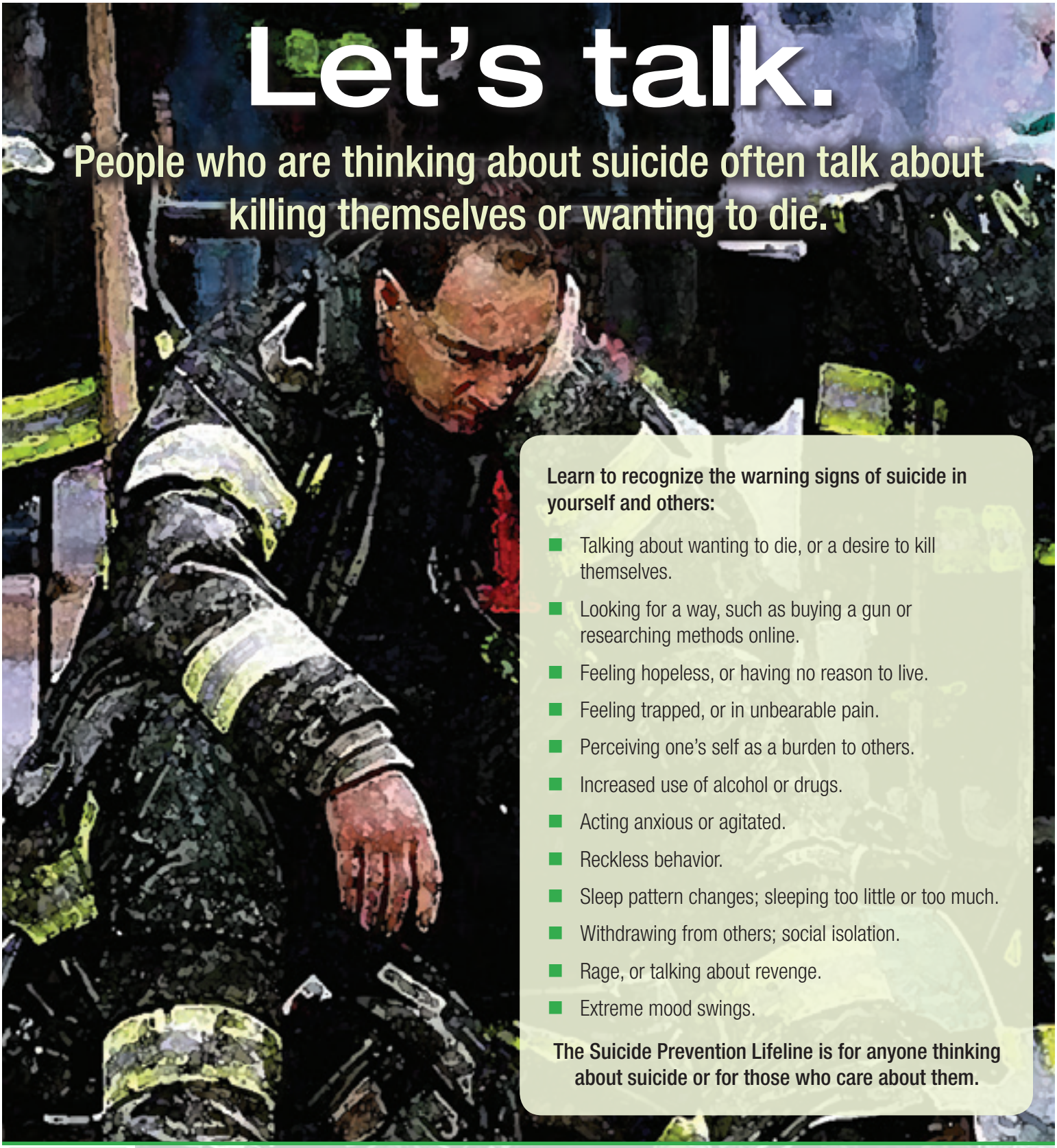
TSQ screening: The *Trauma Screening Questionnaire (TSQ)* is a straightforward and easily scored instrument to identify who is progressing well, and who may need additional help down the road. Used 3-4 weeks after the PTE, it consists of ten simple questions about recent symptoms. More than six positive responses suggest that a more complete screening by a competent behavioral health professional may be warranted.

Complete assessment: This can typically be accomplished by a referral to a department or jurisdiction's Behavioral Health Assistance Program (BHAP) or other competent behavioral health professional. BHAP counselors can often help with managing specific symptoms and dealing with other non-event related stressors of daily living (such as marital problems, financial issues, etc.) that might be interfering with a member's recovery from exposure to a traumatic event.

Treatment by specialty clinician: If more intensive care is needed, it should be provided by a specialist (psychiatrist, doctoral-level psychologist, licensed clinical social worker or licensed professional counselor) with advanced training and supervised clinical experience in specific evidence-based treatment for PTSD, anxiety disorders and depression.

Firefighter Life Safety Initiative #13:
Firefighters and their families must have access to counseling and psychological support.

To learn more about the National Fallen Firefighters Foundation's FLSI #13 Behavioral Health Protocol and for information regarding training in its use, visit http://www.everyonegoeshome.com.



Let's talk.

People who are thinking about suicide often talk about killing themselves or wanting to die.

Learn to recognize the warning signs of suicide in yourself and others:

- Talking about wanting to die, or a desire to kill themselves.
- Looking for a way, such as buying a gun or researching methods online.
- Feeling hopeless, or having no reason to live.
- Feeling trapped, or in unbearable pain.
- Perceiving one's self as a burden to others.
- Increased use of alcohol or drugs.
- Acting anxious or agitated.
- Reckless behavior.
- Sleep pattern changes; sleeping too little or too much.
- Withdrawing from others; social isolation.
- Rage, or talking about revenge.
- Extreme mood swings.

The Suicide Prevention Lifeline is for anyone thinking about suicide or for those who care about them.

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

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