Suicide Prevention Guide, 2nd Edition

The Joliet Firefighters Peer Support Group, 2022.

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JFPSG Suicide Prevention Guide

Suicide is a form of violence that is directed at the self and is defined as seeking to end one's own life (CDC, 2017; Skaine, 2015). A suicide attempt is an action intended to result in death, whether the person is injured or not (CDC, 2017).

The CDC (2017) tells us that suicide is a problem that is not restricted to any one age group. In 2015, more than 44,000 Americans died by suicide, making it the 10th leading cause of death. Moreover, it must be noted that suicide is the leading cause of death for children aged 10-14, the 2nd leading cause of death aged 15-34, the 4th leading cause in adults 35-44, the 5th from age 45-54, and 8th in aged 55-64. In addition, the suicide rate has increased almost 30% since 1975 and costs $34 billion annually (CDC, 2017; Skaine, 2015). This makes suicide a critical issue in metal health care.

Suicide in the firefighting population is also a significant problem. The National Fire Protection Association (NFPA) reports that between 2015-2019, firefighter suicide outpaced line of duty deaths (LODD) by a wide margin [485 suicides (61%), 309 LODD (39%)]. Unfortunately, this trend continues today.

- 2019: 119 Suicide, 48 LODD
- 2018: 82 Suicide, 64 LODD
- 2017: 91 Suicide, 60 LODD
- 2016: 99 Suicides, 69 LODD
- 2015: 94 Suicide, 68 LODD

Suicide is associated with numerous risk and protective factors. There is no single cause of suicide, combinations of factors play a role. Risk factors are present at many levels including individual – history and genetics; relationship – violent relationships and isolation; community – barriers to care; and societal - media portrayal and stigma of help seeking. There are also protective factors that defend against risk of suicide (CDC, 2017). These include effective coping, supportive relationships, available physical and mental healthcare, and reduced access to lethal means. One important note to mention is that certain life transition periods are also associated with higher suicide risks. These include working to retirement and active duty military to civilian (CDC, 2017).

Strategies for Preventing Suicide

The CDC (2017) lists 7-strategies for preventing suicide. These include strengthening economic supports; strengthening access and delivery of suicide prevention care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at risk; and lessening harms and preventing future risk.

Suicide Prevention Guide

This Suicide Prevention Guide is designed to be used by all parties served by the Joliet Firefighters Peer Support Group (JFPSG).

It is appropriate to be adopted as a Standard Operating Procedure/Guideline (SOP/SOG) for use with active members of the Joliet Fire Department. It may be used by retired members of the Joliet Fire Department, families, friends of firefighters, or anyone else who desires information regarding suicide prevention practices.

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Special thanks to:

The members of the Joliet Firefighters Peer Support Group. You do make a difference.

The men and women of the Joliet Fire Department. Your courage and dedication to the community are unmatched anywhere.

Our JFPSG Suicidologist, Sr. Mary Frances Seeley, PhD. and the Upper Room Crisis Hotline - Dr. Terry Smith, Executive Director. Your support and expertise in the field of suicide provide a unique and needed perspective to the JFPSG.

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City of Joliet Councilwoman Jan Quillman, without whose compassion and intervention this group would not exist.

Fire Chaplain, Br. Ed Arambasich, who is there unfailingly for the member of the Joliet Fire Department and the JFPSG.

The Joliet Firefighters Peer Support Group

"Firefighters Helping Firefighters and their Families"

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The Joliet Firefighters Peer Support Group (JFPSG)

Overview (Adapted from JFPSG Lukancic, 2020)

Suicide is a culmination of severe mental health issues and represents one of the major issues in mental health. It is well known that when minor issues are not dealt with, they may become major issues. These issues may be even more difficult to overcome. One of the reasons that the Joliet Firefighters Peer Support Group (JFPSG) was founded is to provide readily accessible peer support, spiritual support, and mental health contacts to prevent minor issues from growing.

Vision Statement

A fire department where all past and present Joliet Firefighters and their families are holistically cared for by their peer support group regarding all forms of mental, spiritual, and emotional health.

Mission Statement

The Joliet Firefighters Peer Support Group (JFPSG) believes that the path to Joliet Firefighter's mental and emotional health begins with firefighters, retirees, clinicians, clergy, and other stakeholders working together to provide support, education, and connection to resources for our firefighters and their families. The public can depend on firefighters. Firefighters can depend on their peer support group.

Peer Support Use

The idea of peer support in the fire service is not new. Firefighters will say, rightly, that it has existed in some form (though sometimes inconsistently) since the beginning of the American

Fire Service. The concept of peers helping each other has not changed, but the availability of specialized training in individual and group crisis management and crisis first aid (CFA) has made the process more structured and available. These programs have gained widespread support in recent years and are rapidly becoming the accepted standard of care (Mitchell, 2013).

Website and Facebook Page

The JFPSG maintains a website (www.jfdpeersupport.com) and a Facebook page to ensure that the most up-to-date resources and information are available to those the JFPSG serves. There are regular Facebook posts regarding a wide range of issues and regular updates to the website.

JFPSG Mental and Spiritual Health & Wellness

Challenges

The career of a firefighter can be challenging on many levels. During its progression, firefighters are exposed to many traumatic events – some occurring to strangers with the firefighter as a witness, and some occurring to people with whom they are acquainted. Plus, firefighters regularly place themselves in life-threatening situations where injury and death are possibilities. Events such as natural and traumatic death, abuse, violence, and disaster affecting people of all ages are common and expected (DeMoulin et al., 2021). In addition to job-related challenges, firefighters must endure other stressors of everyday life, such as family issues, divorce, illness, and the death of loved ones.

As a result of these varied and cumulative challenges, firefighters may exhibit symptoms of a wide variety of mental issues, from suicide, depression, and anxiety to substance use disorder (SUD) and PTSD, especially if they have not built robust resiliency habits (International Association of Firefighters [IAFF], 2016). The need for adequate firefighter mental health care must begin as a proactive thought and must be planned for accordingly if it is to be effective. A helpful template for this task is the JFPSG Adapted Fire Service Model for Firefighter Mental Health, to be discussed later.

Culture

The firefighter culture is unique in several ways, and entry as an accepted member of the group is a process. Myers (2005) investigated the recruit firefighter assimilation into the culture that drew several thought-provoking conclusions. She found that in a high-reliability organization (HRO), cultural assimilation, such as in fire departments, may be a drawn-out process that may take some time to occur (Myers, 2005). Additionally, Myers astutely discusses the concepts of work ethic, humility, and finally, trust and their importance in the culture; a firefighter will not be accepted until they are trusted (Myers, 2005). One primary limitation of the study identified by Myers is that the fire department described in the research was described as "progressive in its treatment of employees" (p. 377) and that different departments may have different methods of acculturation.

Malmin (2013) argues that firefighters operate in what is referred to as the warrior culture and an attitude of invulnerability exists within it that may be passed on to members. Interestingly, he notes that the culture members may be very resilient but may also be exposed to exposure to more traumatic stress events (Malmin, 2013).

Henderson et al. (2016) point to this culture as perhaps being responsible for exacerbating some mental health problems within the fire service. Studies also discuss issues such as stigma, career concerns, and a host of other issues that make it less likely for firefighters to seek help for the multiple disorders of which they are at risk (Haugen et al., 2017; Henderson et al., 2016). It is a commonly held theory that the firefighter culture is not conducive to the improvement of mental health issues; that admitting mental health challenges is equated with weakness and mistrust, and that stigmatizing behavior is common, preventing firefighters from seeking help (Henderson et al., 2016; Johnson et al., 2020). This may not describe the actual experience typical to firefighters, however. Carey et al. (2011) note the importance of social bonding within the firefighter culture as being a protective mechanism for mental health and that an inverse relationship exists when a firefighter does not have a sense of belonging to the culture.

There are several limitations to some studies that may give pause to potential generalizations. First, the reports of stigma in firefighters are often based on self-reports. These self-reports may stem from the opinion of the firefighter suffering the problem (i.e., self-stigma). This begs the question, are firefighters stigmatizing each other or themselves? Second, the stigma from fellow firefighters noted in the above studies is present at much lower levels in others. In one study, Gulliver et al. (2019) noted that just 3% of firefighters looked unfavorably at another firefighter who seeks mental health treatment, while 23% and 29% of firefighters respectively reported that stigma prevented them from seeking treatment or that seeking treatment would damage their

reputation. It may be that the firefighters are not being stigmatized by the firefighters around them; they are stigmatizing themselves.

In direct contradiction to the studies citing firefighter culture as a negative aspect of traumatic stress management, others have found a protective action that may be provided by belonging to the firefighter culture in the form of positive social support (Armstrong et al., 2014; Linley & Joseph, 2004; Stanley et al., 2019; Thompson et al., 2018). According to Armstrong et al. (2014), this social support may even result in posttraumatic growth (PTG), or "positive psychological change experienced as a result of adversity, trauma, or highly challenging life circumstances" (Jayawickreme et al., 2020, p. 145). The disagreement of studies in this area highlights the need for further investigation.

JFPSG Adapted Model for Firefighter Mental Health (AFSM)

Overview (Adapted from Lukancic, J., 2022)

The adapted model for firefighter mental health is an important component of the Joliet Firefighters Peer Support Group and addresses prevention, perivention, and postvention. This model was designed by the author considering the firefighter culture and firefighting operations to make mental health more understandable and less stigmatizing to the firefighter. It may be used as guidance both on and off the job and with normal stressors and traumatic stress events. The method is based upon two foundational ideas, the firefighter stress tetrahedron (the components required for traumatic stress reactions to occur and grow) and the firefighter cycle of preparation which is composed of four stages mirroring the firefighting process, preplanning, suppression, rehabilitation, and critique. This cycle may be used for all

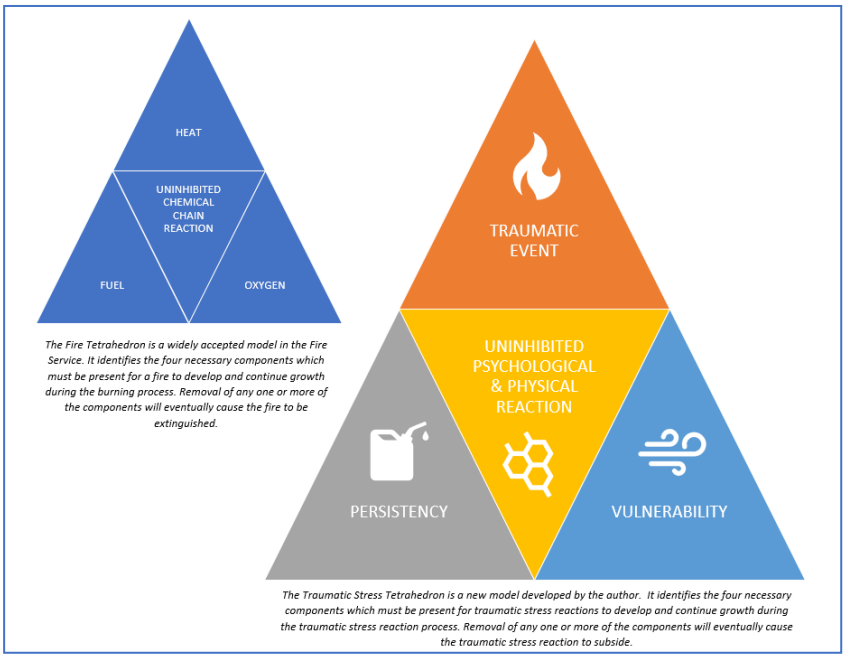
types and severities of stressors both on and off the job and may help the firefighter experience more positive results after traumatic events.

The traumatic stress portion of the model is based upon the concept of the fire tetrahedron and the fire time/temperature curve, both of which are well-known concepts in the career fire service. The fire tetrahedron is a training tool that has been used for decades by firefighters to describe the conditions that must be present for fire to occur and grow. In the world of the firefighter, there are four separate components that must be present for a fire to exist, including heat, oxygen, fuel, and an uninhibited chain reaction; if any of these components are missing, a fire cannot occur (Till & Coon, 2018). For instance, if heat is removed from fire through the application of water, the fire will be extinguished; likewise, if fuel is removed (by being consumed or moved); oxygen is removed (by using agents that displace oxygen, such as carbon dioxide); and/or the chemical chain reaction is inhibited (by an agent such as dry chemical) the fire cannot survive and will be extinguished (Till & Coon, 2018).

A similar model has been developed by the author for traumatic stress related to the fire service. To have a traumatic stress reaction, there are four things that must be in place. This includes the traumatic event itself, the vulnerability of the firefighter to the traumatic stress, the persistency of the traumatic stress, and the unimpeded effect of the traumatic stress. Like the fire tetrahedron, the traumatic stress tetrahedron requires all components to be in place in

order for a severe and lasting traumatic stress reaction to occur. If any of these components are eliminated, the traumatic stress reaction will be eliminated. For instance, if the traumatic event does not take place (due to public education or other prevention efforts), the event will not occur. Likewise, if firefighter vulnerability to stress is reduced (with proper protective mechanisms built into the firefighter's mental health prior to the incident), then the traumatic stress to affect the firefighter will be greatly reduced or even eliminated. If the stress is allowed to remain and is persistently present (in cases of reexperiencing or nightmares), the cumulative effect increases. Finally, if the stress reaction to these events is not interrupted (using established and effective coping strategies), outcomes will become negative.

The traumatic stress tetrahedron synthesizes into the remainder of the AFSM in an important way because it describes to the firefighter the ways in which they may be affected by events that generate traumatic stress. This is done in a context with which the firefighter is familiar. By informing the firefighter in this way, it is now possible for both defenses to be built and coping strategies to be developed to enable the firefighter to avoid potential traumatic stress reactions.

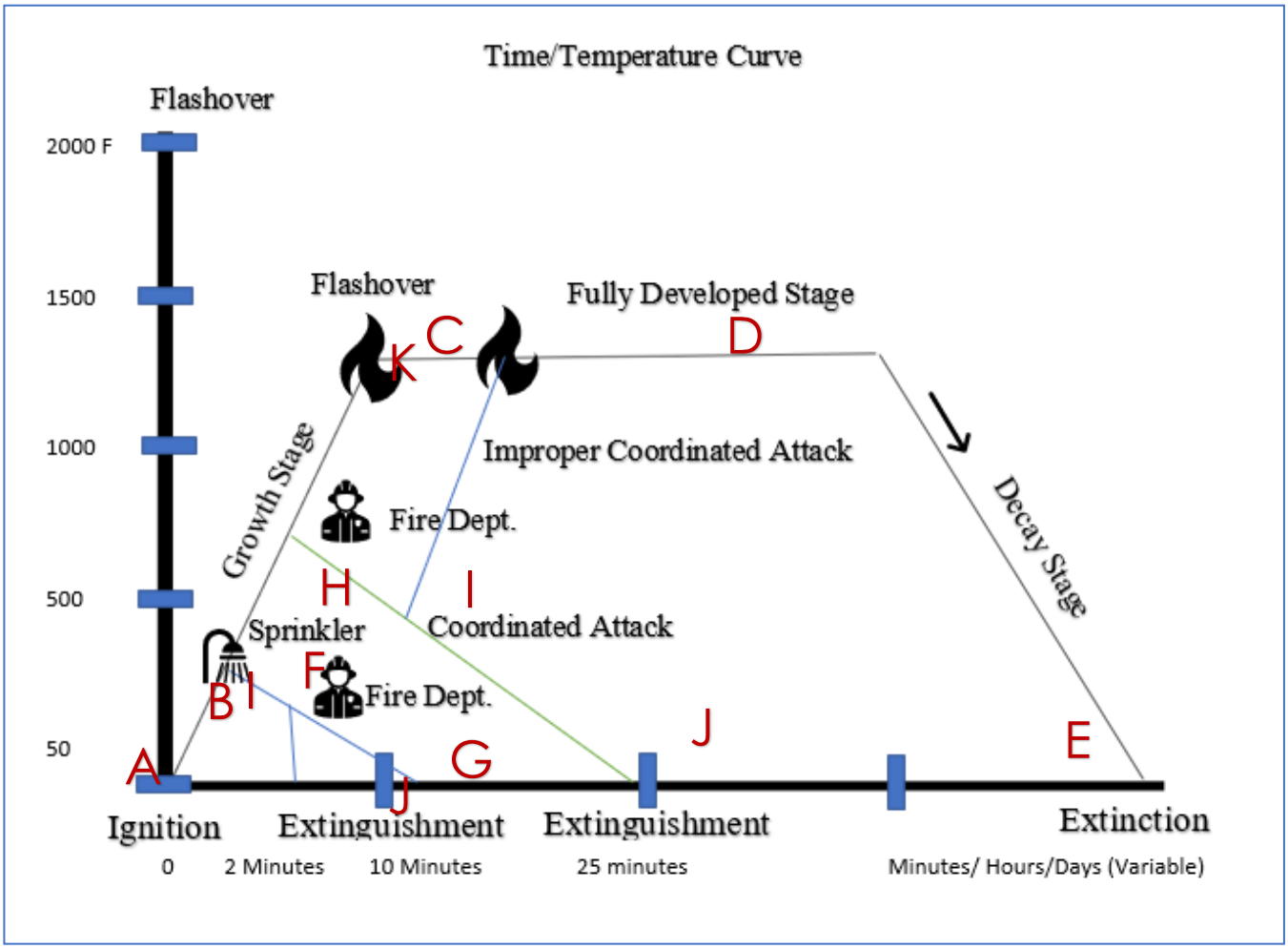


From a scientific standpoint, fire is an extremely complex subject. The nature of fuels, heat release rates, thermal inertia, compartmental configurations, and a host of other concepts give rise to highly intricate mathematical formulae, the understanding of which requires knowledge of several scientific disciplines (Drysdale, 2011). Fortunately, the process which gives birth to fire and the ensuing phases may be described simply enough using the time/temperature curve and the simple stages of fire growth and decay. Again, fortunately, the mental health challenges of firefighters may be placed in a similar model.

The time/temperature curve is a tool used by firefighters to describe when various combustion-related events occur during a structure fire. This graphic depiction of fire growth has evolved over time as fuels have changed, but the science is still sound. Assuming all the components of the fire tetrahedron are in place, there are several identifiable stages that will predictably occur, including ignition, growth, flashover, full development, decay, and extinction. While more involved and complex modern descriptions exist characterizing the stages of fire growth, most current firefighters are familiar with the one presented here.

The ignition stage is the instance where the fire begins (A). It can be the result of an open flame, such as a match, or some other device that allows a flammable material to reach its ignition temperature. As time progresses, the fire enters into the growth stage (B). During this stage, the fire will continue to grow in the presence of heat, oxygen, fuel, and an uninhibited chain reaction. If the growth stage is allowed to continue unimpeded, the space in which the fire is contained will reach flashover (C). While there is a scientific description for this phenomenon, it may be simplified to mean the moment when all combustible material within the compartment has reached its ignition temperatures and begun to burn. At this point, the temperatures can be in excess of 1000◦ F. The unimpeded fire will continue to burn if no action

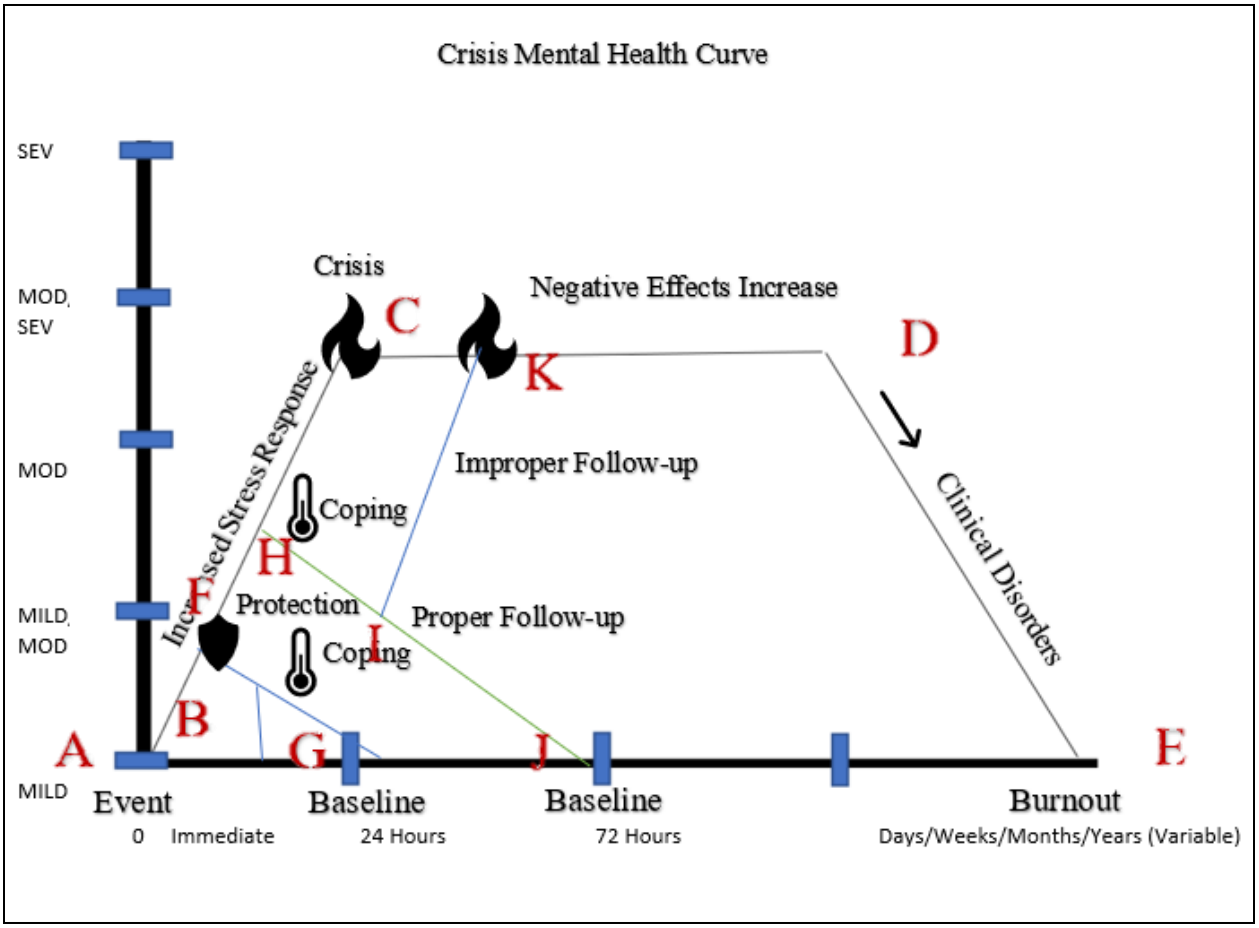
is taken during the fully developed stage, at which time the temperature will remain in excess of 1000◦ F until the heat, oxygen, fuel, or chemical chain reaction is interrupted. Although there are other events that may occur at this time, commonly, the first of the fire tetrahedron to be removed is the fuel. The fire will consume the available fuel until there is not enough to sustain the current level of combustion, at which time, the fire will enter the decay stage (D). The fire will remain in this stage as it gradually cools and reaches the extinction stage, at which the fire goes out (E).



There are several other potential steps that may be added by firefighters and builders to interrupt this progression and initiate an early end to the fire. First, the structure may be equipped with a sprinkler system (F). The sprinkler system is composed of an interconnected network of water piping that employs sprinkler head devices at regular intervals throughout the building. In many systems, a fusible link made of alloy is placed within the sprinkler head to restrain the water from exiting the pipe. This link is designed to melt at a set temperature. When the compartment reaches this temperature, the link will melt, allowing water to exit the pipe into the compartment. The temperature at which a link melts varies, but a common temperature is 160◦ F – meaning that water will be applied to the fire area very early in the event. The sprinkler will control or extinguish the fire depending on the relationship between the location of the fire and the sprinkler head. This process will occur even faster if the fire department arrives and finishes extinguishment (G).

If no sprinkler is present, the onus of extinguishment lies with the fire department (H). If the fire department response is successful, they will perform a coordinated attack on the fire, which includes both ventilation and the application of water to the fire area (I). If this is properly done, the fire will be extinguished (J). If it is not successful and the structure is ventilated without water application, the fire will grow and may reach flashover (K) and the fully developed stage.

There is a comparison to be made between the structure fire progression and mental health crisis progression in the fire service. Like the time/temperature curve, the time/severity curve follows a predictable pattern of effects when the firefighter is exposed to traumatic stress.



The event stage is the point where the event occurs (A). It can be the result of any number of traumatic events. As time progresses, the response enters into the increased stress response stage (B). During this stage, the difficulty will continue to grow in the presence of the event, vulnerability, persistency, and an uninhibited psychological reaction. If this stage is allowed to continue unimpeded, the firefighter will reach crisis (C).

The unimpeded reaction will continue if no action is taken during the crisis stage, at which time the severe stress will remain until the event, vulnerability, persistency, or reaction is interrupted. The event will continue to consume the available resources until there is not enough to sustain the current level of mental health, at which time, the firefighter will develop deeper clinical

disorders (D). The condition will remain in this stage as it gradually cools and reaches the burnout stage, where severe mental disorders become problematic.

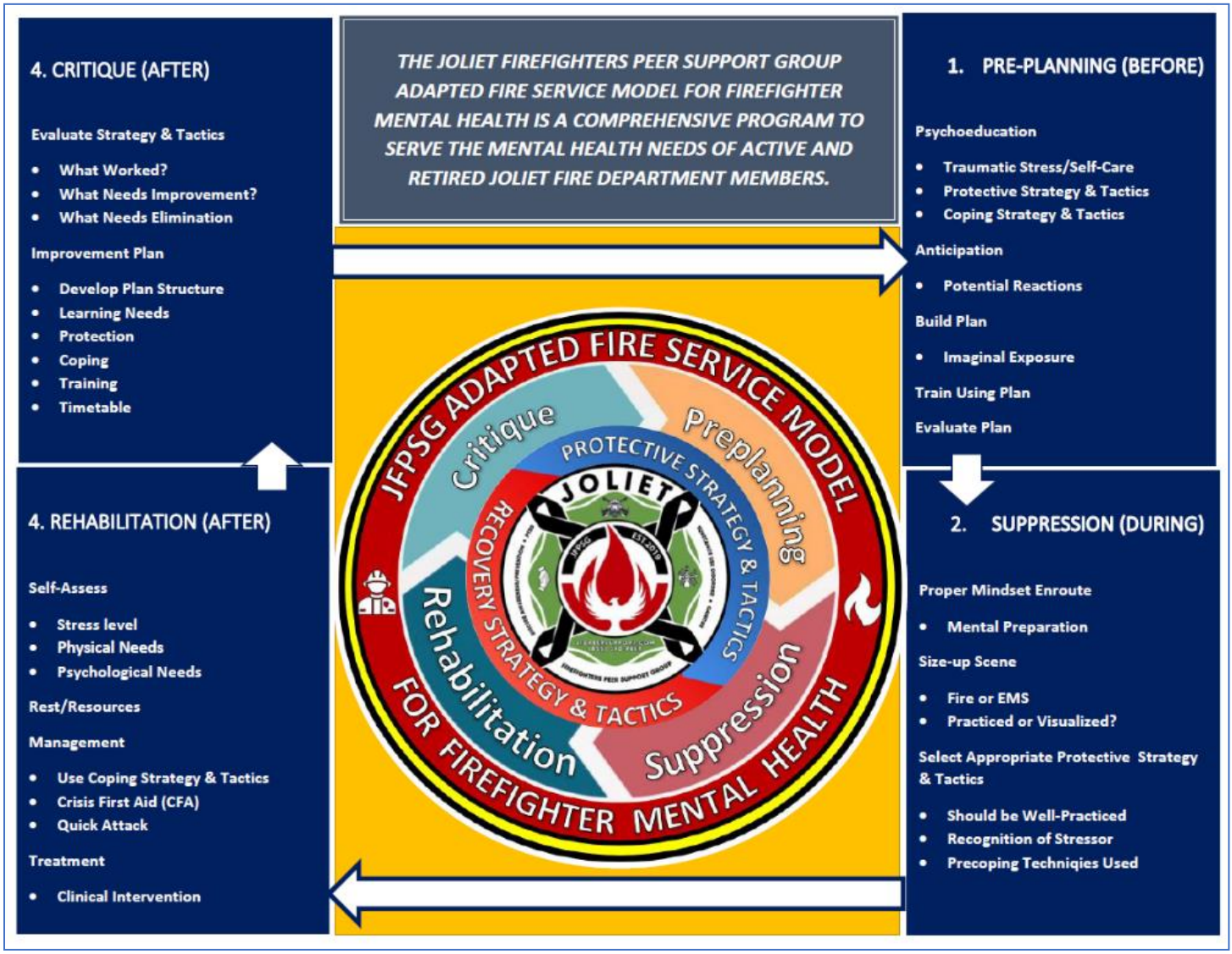
Like the structure fire, there are several other potential steps that may be added to interrupt this progression and initiate an early end to the response. First, the firefighter may be equipped with protective mechanisms through training (F). These mechanisms are composed of numerous protective mechanisms that will impede the stress response. This process will occur even faster if the firefighter has adequate coping and follow-up strategies (G).

If no protective strategies are present, the onus of recovery lies with coping (H). A coordinated attack against the response involves the combination of protection and coping (I). If this is properly done, management will occur (J). If it is not successful and the follow-up is not done, the issue may continue to grow into a crisis (K).

The remainder of the program is based on the primary actions of firefighting, including preplanning, suppression, rehabilitation, and critique. The familiar nature of these events again will enable the firefighter to better understand the process by which they may develop mental health protection strategies. In many fire departments, all of these steps within the cycle are performed, but they may be described in slightly different manners.

Preplanning. Preplanning is a common occurrence in the fire service. The purpose of the preplan is to assess a structure (or event) and plan for an incident before it occurs to identify tactics and strategies that may be useful in preventing difficulty should an event occur. This results in a pre-established plan prior to an event occurring. In fire parlance for structures, this includes inspecting the structure to ascertain its construction features, layout, and type (these may influence the behavior of the fire); evaluating built-in fire protection systems (sprinklers

and standpipes); testing communications methods (radios) in various areas of the structure; evaluating fire hydrants around the structure (for sufficient water flow); assessing access and egress (stairways, elevators, door location) for occupants and firefighters; assessing special hazards, assembling crews to rehearse the response (training); and finally, updating the plan with corrections after evaluation (improvement plan.



These activities may be metaphorically tied to mental health. Evaluating construction type is akin to the firefighter performing an honest evaluation of their condition, both mental and

physical. Has the firefighter prepared mentally, introducing and improving protection and coping strategies? Are they aware of the necessary policies to complete the operation successfully? Is the firefighter physically fit to perform at peak levels? In mental health, these items may influence the way the firefighter responds to traumatic stress-inducing events. For example, if the firefighter does not feel they are at their best on a particular day, either physically or mentally, they may experience strong guilt if they are faced with a stressful situation, especially if that situation involves failure on the firefighter's part, leading to complications in traumatic stress.

There are several components to this phase which are all pertinent to mental health:

- Physical ability standards (CPAT). While it may seem that physical fitness would not be mentioned here, physical ability and preparation may have a profound impact on self-blame. If the firefighter is not prepared and physically fails in an emergency situation resulting in negative consequences, the guilt associated with this may be severe. The Candidate Physical Ability Test (CPAT) was established in the late 1990s to create a minimum physical standard to which firefighters will be held and includes several events related to physical activities that a firefighter may perform on the fireground. These include a stair climb, hose drag, equipment carries, ladder raise and extension, forcible entry, search, rescue, ceiling breach, and pull (IAFF CPAT). The firefighter often performs this as part of the application and selection process for hire. Over the years, the firefighter's condition may worsen, making the annual performance of this test critical.

- Physician delivered annual physical. Similar to the above reasons for fitness standards, the firefighter should be given an annual physical to assess their physical condition. Much like completing the CPAT, the firefighter can be confident that they are physically prepared to do the job.
- The clinician-administered an annual mental health evaluation. NFPA 1582 (2021) recommends that part of the above physical include certain physician-administered mental health assessments. If the firefighter has a positive screen for behavioral issues, the physician will work in concert with a mental health professional to manage the issue. The more comprehensive idea is to require the firefighter to participate in an annual mental health evaluation. It is accepted that 90% of people who complete suicide have a mental health disorder, 88% of which are undiagnosed at the time of the suicide (American Psychiatric Association, 2013). If those firefighters with mental health disorders can be found early, treatment may be done before the firefighter is in crisis.
- Regular training (mental health and firefighting). Periodic mental health check-ins (testing instruments). Firefighter competence is an important factor in the perception of traumatic stress. It is critical that the firefighter possess the proper attributes that display competence in the aspects of their job. This, again will reduce stress when events occur. Part of regular training must include access to self-evaluation tools that enable the firefighter to manage their mental health. Certain instruments may be distributed for firefighters to review with instructions on when and who to call for help. Some of these instruments include the PCL-5, PHQ-9, GAD-7, RAPS, and SSRS. Additionally, the fire department should provide quarterly live mental health training for their members, where new research and

current best practices are discussed with all firefighters. Firefighters must also be trained and reminded about employee assistance programs and services that they provide.

- Access to resources that help provide sound physical health, such as diet management, effective exercise, tobacco cessation programs, alcohol misuse education, and sleep education programs, are also critical.

The firefighter must also be intimately aware of the protections that they have in place if a traumatic stress-inducing event occurs. As is true with fire protection systems, the time to find out that a standpipe or sprinkler system is nonfunctional is not during an active structure fire but before when it can be more easily addressed. To wit, a firefighter must have a good command of the available resources that they can draw upon should a traumatic stress-inducing event occur. This may include psychoeducation regarding known factors that are related to negative outcomes related to traumatic stress, including:

- Self-efficacy
- Sense of coherence (Borowitz & Sokolowski, 2015)
- Locus of control
- Hostility
- Self-forgiveness (Carpenter et al., 2020)

In addition, the firefighter should seek out training that will make them more immune to the effects of stress such as Stress Inoculation Training (SIT) and self-forgiveness training.

When a preplan is performed, one of the most critical tasks is to ensure that firefighters understand communication techniques within the building. They must know if their radios function properly throughout the entire building, and they must understand built-in

Communications Systems that they may utilize during a fire event. Establishing this communication assessment plan will ensure that, during a fire, all personnel on the scene can talk to one another. Comparatively, there must be open and tested lines of communication within the fire department and with mental health partners in place for when a traumatic stress-inducing event occurs. Just like the structure fire, the time to realize that the radios do not work is not while the firefighter is in the basement of the burning building. The firefighter must establish lines of communication prior to the event with peers, chaplains, and clinicians to ensure that adequate communication will be possible in the event of the traumatic stress-inducing event.

The firefighters must plan for the appropriate amount of water to be available to extinguish the fire and address other strategic and tactical plans to manage life safety, property conservation, and the environmental impact of the fire (Smith, 2008). This involves locating nearby fire hydrants, determining water main sizes, and ensuring the hydrants operate properly. In the firefighter service, this amount of water needed fire flow (NFF) can be calculated by using a formula based on building size and fire involvement. The better the plan, the more likely the successful resolution to the problem. In mental health, the firefighter must be confident that their prevention and coping skills will be adequate to enable them to manage or even grow from traumatic stress-inducing events. In the event that the firefighter does not believe there are adequate coping strategies in place to manage the event, they may create a strategy for accumulating more robust strategies, just as with the structure fire example above.

Each structure will invariably have special hazards resulting from its purpose and function, which must be addressed in the preplan. Hazards such as toxic substances, possible chemical

reactions, high potential for life loss, occupancy, and limited water supply may affect the characteristics of the fire and must be addressed (Smith, 2008). Similarly, certain characteristics of an event may cause a more severe reaction due to the firefighter's past experience or current life situation. For instance, if the firefighter has children at home, they may want to pay close attention to their protective and coping mechanisms should they come into contact with an injured child in the field.

Based on the above factors, the plan may include resources that may be needed to mitigate the event. If the structure is large or has a highlife hazard, such as a hospital, the plan must reflect this and detail how many and what type of resources may be needed to handle the event. During the mental health size-up, the firefighter should review the resources that are available and include them in the plan should an unexpected reaction take place.

Finally, fire department administrations and training officers must create time and resources for firefighters to train and rehearse what they've learned. This is true in both physical fire preparation and mental health preparation. Regular training with peers and mental health professionals will enable the firefighter to have access and hypothetically practice their responses through training scenarios.

Suppression. Suppression refers to many functions on the fire ground. It includes rescue, exposure protection, confinement, extinguishment, overhaul, salvage, and ventilation (Smith, 2008). It is the act of responding to and extinguishing a fire. After the plans have all been made and tested in the previous step, the firefighter will be more prepared and confident in the skills and abilities that they have developed during training. This will enable them to better manage traumatic stress-inducing event when it occurs. During this phase, the firefighter

employs the protective strategies that they developed in the preplanning phase (i.e., mental health and supplementing fire protection systems). This will help the firefighter deflect some of the impact of the traumatic stress-inducing event so the next phase, rehabilitation, will be easier.

The main goal of this category is for the firefighter to perform protective actions mentally without having to process them cognitively. In essence, the protective mechanisms should be so built into the firefighter (like a sprinkler system in a building) through training that they are not aware that they are doing anything at all, only acting as they were trained to act. This is difficult and time-consuming but possible with sufficient realistic and progressive training.

Techniques such as stress inoculation and visualization training make it possible for the firefighter to slowly progress from an area of comfort into more stressful situations in preparation for the work they will do in the field. This is not possible only in firefighting but in EMS as well.

Rehabilitation (Rehab). Rehabilitation, also called rehab, is a stage where the firefighter is able to rest, rehydrate, and recover from the physical and mental stressors endured during the event. Standard incident rehab programs involve managing reactions to heat and cold stress, medical evaluation, hydration, and sometimes behavioral intervention (FEMA, 2008).

This period of time is comparable to mental health in that it is the time that is available for the firefighter to use the coping strategies that they have developed in order to manage whatever traumatic stress has made it through their protective barrier. If the previous steps are properly done, the firefighter may need very little time for rehab because they have been less affected by the traumatic stress-inducing event. In contrast, rehabilitation is also a time for

discovering that the effect of the traumatic incident has overwhelmed the firefighters coping mechanisms and that further help, such as crisis first aid (CFA) or clinical care, may be required. The steps of firefighter mental health rehabilitation are self-assessment, rest, management, and clinical care.

This possibility should have been contemplated during the preplanning phase, and a baseline relationship with peers and mental health professionals and training in PFA will have been done department-wide. This will enable the firefighter to either discuss stress reactions with members of their crews or more easily approach the peer supporters to discuss potential challenges they have been having with their traumatic stress-inducing event. The peer supporters, in turn, do their job of performing CFA should the firefighter desire. The presence of fire chaplains and other religious and spiritual, and pastoral care are critical as well. The final catchall, clinical care, is available if the firefighter is unable to manage the crisis with the help of a coworker, peer, or pastoral care. The professional clinician stage is the final stage of rehab, where care is passed off to the clinician.

The PFA program created by the author, entitled Crisis First Aid for Paramedics (CFA-P), addresses the common issues that affect people in the fire service and the community and may be useful for managing both mental illness and traumatic stress in both firefighters and the public. When all paramedics in the fire department learn this system, they may use it with other firefighters and the public in times of difficulty and in their personal lives. While there are many components to general PFA programs, the JFPSG CFA-P program has been simplified due to previous education and experience that Paramedics experience through licensure training, continuing education, and practical experience. There are only four main instructional components and two practical components to the JFPSG CFA-P Program. The

instructional components include a brief description of traumatic stress and other common mental health disorders, the responder support partnership, and the 7 Rs. The practical component includes a brief written test and a proctored scenario to verify that the material has been learned and properly applied (Lukancic, 2021).

After-Action Critique. After fires, especially severe fires with large losses or loss of life, many fire departments perform an after-action critique. The critique gathers together those involved with the event and has two primary benefits, review and improvement planning. A review of the event includes a discussion about what worked and what requires improvement by studying tactics and strategy, outcomes, and shortcomings to ensure that the firefighters get both positive feedback and constructive advice. It is a nonpunitive way of learning from one's mistakes and may be valuable in a wide variety of areas, including standard operating procedures, building code changes, and fire protection systems evaluation. (FEMA, 2008).

The same must be done for firefighter mental health. After the firefighter experiences the traumatic stress-inducing event, they must return to their original plan to evaluate it to determine which aspects work and would aspects need improvement or elimination. This will enable the firefighter to create a plan to improve their responses. The updated plan must be specific and address deficiencies that were experienced after the event. This last aspect of rehab dovetails back into the preplanning phase, where new protective and coping strategies are discovered, evaluated, put into place, and tested.

It is critical to note that this model is used after each stress-inducing event and is never-ending. It is cyclical in nature and designed to enable the firefighter to make consistent improvements in their mental health response to trauma over the course of their entire career. If this model is

followed, the firefighter will become more protected and more resilient to the challenges that inevitably come with firefighter stress, especially cumulative stress, which occurs over time. This is critical due to the lessening of social support during a firefighter's career. This process enables the firefighter to have continual contact with peers, clinicians, and others who may help them manage traumatic stress reactions. As research has revealed, firefighters often lose support as their careers progress, making them more susceptible to traumatic stress effects. A continual process of improvement may prevent this loss from occurring, resulting in better outcomes for firefighters. Appendix B includes self-report questionnaires that the firefighter may complete during the preplanning and critique phases to help them determine how protected they are and where they need to improve.

Training. Regular training in mental health must be done monthly (company) and quarterly (department). On a monthly basis and at the company level, this entails assigned reading, discussion, and instrument introduction. The monthly training allows the firefighter to regularly assess themselves from a mental health standpoint and discuss the idea openly in the fire station. This will increase comfort in discussing the topic and may make it more acceptable for conversation. When the instrument for a particular disorder is presented, instructions for contact with the clinicians will be provided.

The quarterly training is done in person or via live online video. This allows firefighters to have direct contact with members of the group. Firefighters have exposure to peers on a regular basis but are limited in their exposure to clinicians, the suicidologist, and other stakeholders. The formation of the therapeutic alliance espoused by Rogers may begin prior to events in the firefighter's life occurring, making contact and discussion less stressful and less stigmatizing.

Additionally, firefighters may have certain questions regarding clinical care that may be answered during this time. A sample training year may include the following:

Month	Monthly Training Topic	Quarterly Training Topic
January	Sleep Disorders (GASQ)	
February	Prevention & Coping Skills/AFSM	
March		Traumatic Stress
April	Depression (PHQ-9)	
May	Prevention & Coping Skills/CFA	
June		Substance Use Disorder (RAPS)
July	PTSD (PCL5)	
August	Prevention & Coping Skills/AFSM	
September		Suicide (SSRS)
October	Anxiety (GAD-7)	
November	Prevention & Coping Skills/CFA	
December		Family Stress

Operations Manual

The JFPSG has compiled a comprehensive Operations Manual for use by both peer supporters and anyone else who is interested in the function of the group. The manual is posted on the JFPSG website (www.jfdpeersupport.com).

Organization and Chain of Command

An organizational structure and chain of command are necessary for the proper functioning of the group. This includes the use of an adapted modular structure like that used in the fire service.

The JFPSG is organized using a modified version of the traditional peer support model. This model includes a Lead Agency, Steering Committee, Group Coordinator, Clinical Director, Group Liaison, Member Clinicians, Active and Retired Firefighters, Clergy and Religious Members, and members from varying stakeholder groups (Mitchell, 2013). Added to our model is the position of JFPSG Public Information Officer (PIO).

Lead Agencies (Dissolved)

Membership: The lead agencies for the JFPSG were IAFF Local 44 and 2369.

Role: The role of the Lead Agencies was to initially sponsor the group as the umbrella organization. In the case of the JFPSG, the Lead Agencies, in effect, dissolved in this capacity after the group was formed.

JFPSG Steering Committee

Membership: Consists of all members of the JFPSG. The Committee acts democratically to establish the overall direction of the group by consensus.

Role: The role of the Steering Committee is to decide on the strategic direction of the JFPSG. Also, the Steering Committee will be the final word on all policy decisions regarding the group.

JFPSG Group Liaison

Membership: Consists of one Joliet Fire Department member of the JFPSG.

Role: The role of the Group Liaison is to act in the interest of the JFPSG at the JFD level. They are the "person on the inside" of the organization.

JFPSG Clinical Director

Membership: Consists of one Illinois Department of Financial and Professional Regulation (IDFPR) licensed Clinician Member of the JFPSG. This may include a Psychologist, Social Worker, or Counselor.

Role: The role of the Clinical Director is to provide clinical guidance and oversight to the intervention activities of the JFPSG to ensure best practices regarding mental health are adhered to and to make certain members of the group act appropriately within their training and experience.

Member Clinicians

Membership: Consists of licensed clinicians of the JFPSG as recognized by the Illinois Department of Financial and Professional Regulation (IDFPR). These may include Psychologists, Social Workers, and Counselors.

Role: The role of the clinician is to provide advice, receive referrals from members of the JFPSG, and professionally treat Joliet Firefighters and their families if the situation warrants. They also review interventions of peers as needed and provide for training of the Group and members of the JFD and their families.

Religious & Clergy

Membership: Consists of one or more member(s) of the JFPSG.

Role: The role of the Clergy and Religious within the JFPSG is to provide spiritual support to those contacts that require such support.

JFPSG Coordinator

Membership: Consists of one member of the JFPSG.

Role: The role of the day-to-day general management of the team includes the following:

- Evaluate the need to deploy members;
- Assist in developing team membership;
- Represent the group at meetings;

- Author/revise JFPSG Standard Operating Guidelines (SOG) with Steering Committee Approval.

JFPSG Peer Supporters

Membership: Consists of active and retired firefighters, community members, suicidologists, elected officials, and other stakeholders who are trained in peer support techniques.

Role: The role of the peer supporter is to provide active listening and individual crisis intervention for members of the JFD and their families and to refer them to higher levels of care if needed.

Stakeholders

Membership: Consists of any other group or individual who believes in the vision and mission of the JFPSG. This may include local business owners, mental health groups, and other firefighters.

Role: The role of the stakeholder is to support the vision and mission and vision of the JFPSG by providing services to firefighters that will enhance their well-being.

JFPSG Suicidologist

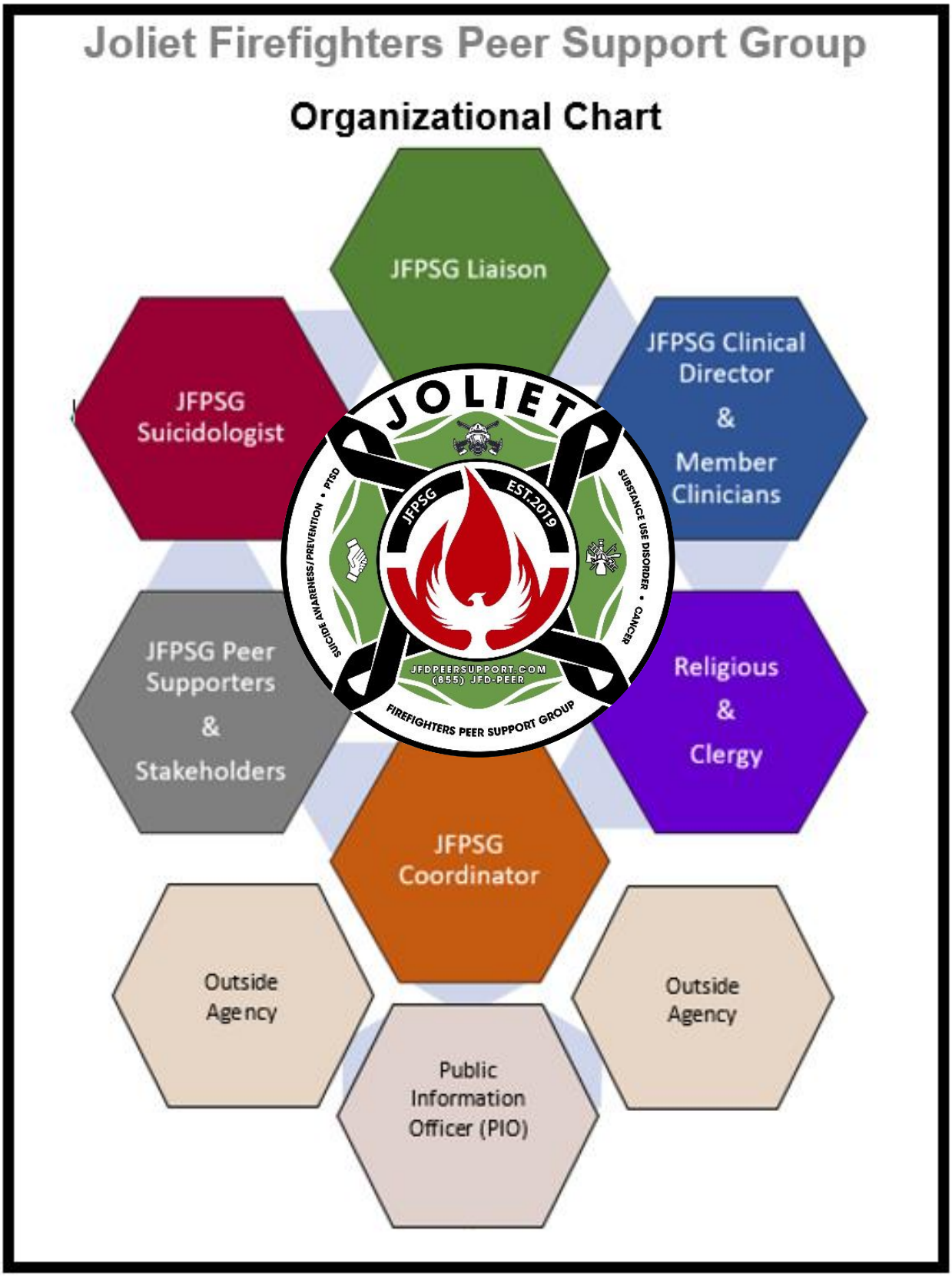
Membership: Consists of one or more member(s) of the JFPSG who is a suicidologist.

Role: The role of the suicidologist within the JFPSG is to act as an expert in the field of suicide prevention, providing advice and direction regarding group management of suicide-related issues.

Public Information Officer (PIO)

Membership: Consists of one or more members of the JFPSG with required training found in SOG 02-20-13.

Role: The role of the PIO is to speak for the group regarding activities related to the group. The PIO is to be notified before any member speaks about group operations.



Joliet Firefighters Peer Support Group [JFPSG] & Lukancic. 2020)

2

The Problem of Suicide

Suicide Facts

Suicide is a form of violence that is directed at the self and is defined as seeking to end one's own life (CDC, 2017; Skaine, 2015). A suicide attempt is an action intended to result in death, whether the person is injured or not (CDC, 2017).

The CDC (2017) tells us that suicide is a problem that is not restricted to any one age group. In 2015, more than 44,000 Americans died by suicide, making it the 10th leading cause of death. Moreover, it must be noted that suicide is the leading cause of death for children aged 10-14, the 2nd leading cause of death aged 15-34, the 4th leading cause in adults 35-44, the 5th from age 45-54, and 8th in aged 55-64. Also, the suicide rate has increased by almost 30% since 1975 and costs $34 billion annually (CDC, 2017; Skaine, 2015). This makes suicide a critical issue in mental health care.

Firefighter Suicide

Suicide in the firefighter population is also a significant problem. The National Fire Protection Association (NFPA) reports that between 2015-2019, firefighter suicide outpaced line of duty deaths (LODD) by a wide margin [485 suicides (61%), 309 LODD (39%)]. Unfortunately, this trend continues today.

- 2019: 119 Suicide, 48 LODD
- 2018: 82 Suicide, 64 LODD
- 2017: 91 Suicide, 60 LODD
- 2016: 99 Suicides, 69 LODD
- 2015: 94 Suicide, 68 LODD (Fahy et al., 2015, 2016, 2017; Fahy & Molis, 2019)

The International Association of Firefighters (IAFF) (2020) has discussed some sobering thoughts regarding firefighter suicide.

- Firefighters are four times more likely to die by suicide than a line of duty death (LODD).
- 16% have engaged in self-harm like cutting or burning (usually in hidden areas such as thighs or upper arms).
- Suicide is the last step in building problems coupled with witnessing traumatic events and maladaptive coping mechanisms. Remember that firefighters have a high tolerance for misery, but it is not unlimited.

While these statistics must be read with a critical eye, there is no denying that firefighters do complete suicide.

Firefighters do complete suicide at a rate higher than they experience line of duty-death (LODD) (Fahy et al., 2016; 2017; Fahy et al., 2018; Fahy & Molis, 2019); however, firefighter suicide estimates require some scrutiny. Some sources estimate the firefighter suicide rate at 18 per 100,000 firefighters (FBHA, n.d.; Ruderman Family Foundation et al., 2018). This number represents the estimated number of completed firefighter suicides. Of note, however, the Firefighter Behavioral Health Alliance (FBHA) estimates that 40% of suicides go unreported based on the numbers of seminar attendees who know they exist (FBHA, n.d.; Henderson et al., 2016), which may artificially inflate these numbers (the FBHA also tracks confirmed numbers, which are far lower). According to confirmed numbers put forth by the FBHA and the NFPA, it is more likely that completed firefighter suicides from 2015 to 2019 have averaged approximately 118 per year as a five-year average (Fahy et al., 2016; 2017; Fahy et al., 2018; Firefighter Behavioral Health Alliance [FBHA], n.d.; NFPA et al., 2020).

The NFPA reports that there are just over one million firefighters in the US (NFPA et al., 2020). simple mathematics tells us that 118 (annual firefighter suicides)/1,000,000 (firefighter population) equates to 0.0118%, or 11.18/100,000 firefighters who complete suicide per year. Similarly, the public experiences just over 45,000 suicides per year (six-year average 2014-2019) (Centers for Disease Control and Prevention [CDC], 2021). Using the same formula, 45,000

(suicides)/330,000,000 (US population, estimated) (United States Census Bureau, 2021) equates to 0.0136% or 13.64 /100,000 people. This number agrees closely with Centers for Disease Control and Prevention (CDC) reports of 13.9/100,000 in 2019 and 14.2/100,000 in 2018 (Centers for Disease Control and Prevention [CDC] et al., 2021). Using these data, it can be surmised that the rate of suicide in the public may actually be higher than confirmed suicides among firefighters.

One of the primary problems with suicide reporting in the fire service is the lack of structure and the lack of required reporting in a systematic manner, as is done in law enforcement (Law Enforcement Suicide Data Collection Act, 2020). While semi-structured reporting programs do exist and are referenced above, there is no national legislation that requires fire service or EMS suicides to be reported. In law enforcement, federal law dictates that all law enforcement suicides be reported to the Federal Bureau of Investigation (FBI) and are included in an annual report (Law Enforcement Suicide Data Collection Act, 2020). This mandate assures that all law enforcement suicides are documented and reported appropriately. This directive does not exist for firefighters or EMS practitioners, making the accuracy of the data far more uncertain than it is with police officers.

Additionally, while it appears to be generally accepted that firefighters have a higher rate of suicide ideation and attempt than the public, much of the research can be traced back to a single study – a study with significant limitations. Stanley et al. (2015) performed self-report survey research with firefighters where the estimated suicide ideation rate was 46.8%, the planning rate was 19.2%, and the attempt rate was 15.5%. This was compared to the general public rates of 5.6 to 14.3%, 3.9%, and 1.9% to 8.7% (Nock et al., 2008; Stanley et al., 2015). Further, another self-report study published by the National Volunteer Fire Council in 2012

indicated that the percentage of surveyed firefighters who considered suicide during their career was 23.8% (National Volunteer Fire Council, 2012). These numbers have been used in public forums and academic studies since their release as an example of firefighters' proneness to suicide. One such study was published by Bond and Anestis (2021), which used the results of the Stanley (2015) study as a basis for their investigation of firefighter suicide ideation. Their study was grounded upon a larger self-report study of firearm ownership and found a lifetime firefighter suicide ideation of 62.5%, a staggeringly high number.

These self-report surveys, while certainly more convenient than interviews with mental health professionals, may not be the most accurate way in which to assess suicidality across the entire fire service community, however. As Stanley et al. (2015) note, the "findings may not be generalizable beyond the current sample" (p.169), and the National Volunteer Fire Council stated that selection bias was a possibility in their study (National Volunteer Fire Council, 2012). Also, the Bond and Anestis (2021) study included only 48 firefighters, 52.1% of which were male. Bendersky (2018) tells us that 96% of firefighters in the United States are male, which, combined with the small sample size, may call into question the representativeness of the sample used.

There is little doubt that accurate numbers are present in the above-named studies; the question remains whether this is a representative sample of the firefighter population – a limitation acknowledged in two of the studies. Interestingly, a different study by Stanley et al. (2018) discusses the role of distress tolerance and firefighter suicidality, noting that firefighters are often chosen for employment due, in part, to high distress tolerance, which is associated with lower suicide risk.

While the true depth of the problem of suicide is unknown for certain, firefighters are completing suicide. For this reason, the topic must be taken seriously and addressed. It is thought that specific firefighters may conceal thoughts of suicide from coworkers due to embarrassment (Hom et al., 2016); therefore, it is important that those outside the fire service, such as families and friends of the firefighter, are educated regarding the warning signs of suicide to recognize when a critical condition exists (Everly, 2020; Henderson et al., 2016). These people should also be educated on less common warning signs such as substance abuse, self-isolation, agitated behavior, and the corresponding ages of suicidal ideation onset (Henderson et al., 2016; Nock et al., 2008). The more informed the firefighter and their loved ones are, the greater the odds that a risk factor will be identified and the firefighter may receive the help they require. It is not enough for the firefighters themselves to know and understand the warning signs. The firefighter's entire social circle must know and understand.

The relationship of completed suicide to acute stress and other behavioral health conditions must be addressed as well. Studies have shown that acute stress diagnosis is related to completed suicide (Nock et al., 2008), often within the same year of diagnosis and that subjects with PTSD and depression, two issues present in the fire service, have a greater risk for suicide (Gradus et al., 2010).

As with warning signs, several protective factors may be introduced into a firefighter's life to reduce the probability of suicide. These include the presence of family and friends, religious support, a strong sense of purpose, and the view of other firefighters as a family (Henderson et al., 2016; Nock et al., 2008). These protective factors may help prevent a tragedy; it is a well-known tenant that it is much easier to prevent a disaster than to recover from one after it occurs. Mann et al. (2005) report that safety plans are available that may be followed to

reduce the completion of suicide for those at risk. These safety plans may include identification of safe places to go, means of suicide limitations (firearms and medication control), and restrictions on substance use (Centers for Disease Control and Prevention [CDC], 2017; International Association of Firefighters [IAFF], 2020; Mann et al., 2005). Despite thoughts to the contrary, there are effective professional clinical treatments for suicidal ideation. Mann et al. (2005) link higher therapeutic drug intervention, cognitive behavior therapy (CBT), and means restriction (in the form of drugs and firearms) to lower suicide rates (Nock et al., 2008).

While it seems to be accepted knowledge that firefighter suicide ideations, plans, attempts, and completion our higher than the general public, the body of research is not large enough to make that assumption. It is clear that more research using gold-standard interview techniques is needed to establish the true incidence of these suicidal factors in firefighters. This is not to say that suicide is not a genuine problem within the fire service, just that not enough research is available to identify the extent of the problem. More and better data must be available to better define the issue.

Suicide in Newer Firefighters and Retirees, FYRE Program

Research suggests that the most at-risk for suicide in the fire service are low rank, fewer years in service, history of suicide exposure, and military history (due to additional exposure) (IAFF, 2020). Education must begin at the beginning of the firefighter's career to change this trend. The recruit is not the only important subgroup, however. Special attention during a recruit's first year is critical, but pre-retirement counseling and support post-retirement are just as important for firefighters nearing this transition period. Toward this end, the JFPSG has developed the

FYRE Program (First Year Recruit/Retirement Experience) to support recruits and retirees during these life changes (Lukancic, 2020).

When a firefighter begins their career, they are prone to certain stressors that may begin to accumulate. Issues may develop regarding reputation, acculturation, and substance use, just to name a few. The program is designed so the recruit may have monthly contact with a peer supporter over the course of 12 months to confidentially discuss any issues they may be having. Those in the fire service are well aware of the "rumor mill," and stories passed from crew to crew may have a negative effect on the firefighter and their reputation. If a firefighter has the benefit of an experienced peer supporter, one who understands the culture, they may be more able to manage these issues. This program is required by the fire department for all new hires who have begun their career since 2020.

Similarly, a firefighter nearing retirement may experience challenges as well. Since social support is so important in the firefighter culture, there may be consequences when this support is removed. Studies have shown that the retirement of firefighters may contribute to suicidal ideation due to the removal of this support. For this reason, the FYRE Program also offers extra support for retirees. It is a voluntary program in which a firefighter may participate and allows for contact from a peer supporter once monthly over the course of the first year of retirement. This ensures that extra support is there for anyone who needs it.

Suicide: Risk Factors

There are many recognized risk factors for suicide. Risk factors may be separated into one of three general categories. These categories include factors related to health, environment, and history. Some of the more common risks are listed below.

Risk factor: Health

- Mental health conditions
    - Depression
    - Substance use problems
    - Bipolar disorder
    - Schizophrenia
    - Personality traits of aggression, mood changes, and poor relationships
    - Conduct disorder
    - Anxiety disorders
- Serious physical health conditions, including pain
- Traumatic brain injury
- Lack of healthcare, especially mental health and substance abuse treatment

(*Risk Factors and Warning Signs*, 2019)

Risk factor: Environmental

- Access to lethal means, including firearms and drugs
- Prolonged stress, such as harassment, bullying, relationship problems, or unemployment
- Stressful life events, like rejection, divorce, financial crisis, other life transitions, or loss
- Exposure to another person's suicide or graphic or sensationalized accounts of suicide
- Local clusters of suicide
- Lack of social support and sense of isolation
- The stigma associated with asking for help
- Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma

(*Risk Factors and Warning Signs*, 2019)

Risk factor: Historical

- Previous suicide attempts
- Family history of suicide
- Childhood abuse, neglect, or trauma
- Hopelessness

(*Risk Factors and Warning Signs*, 2019)

Suicide: Warning Signs

There are observable signs of suicide. Like risk factors, they may be placed in specific categories. These include signs related to talking, behavior, and mood. Some of the most common signs are listed below.

Something to look out for when concerned that a person may be suicidal is a change in behavior or the presence of entirely new behaviors. This is of sharpest concern if the new or changed behavior is related to a painful event, loss, or change. Most people who take their lives exhibit one or more warning signs, either through what they say or what they do (*Risk Factors and Warning Signs*, 2019).

Warning sign: Talk

If a person talks about:
- Killing themselves
- Feeling hopeless
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Unbearable pain

(*Risk Factors and Warning Signs*, 2019; IAFF, 2016)

Warning sign: Behavior

Behaviors that may signal risk, especially if related to a painful event, loss, or change:
- Increased use of alcohol or drugs
- Looking for a way to end their lives, such as searching online for methods
- Withdrawing from activities
- Isolating from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression
- Fatigue
- Acting anxious or agitated, behaving recklessly

(*Risk Factors and Warning Signs*, 2019; IAFF, 2016)

Warning sign: Mood

People who are considering suicide often display one or more of the following moods:

- Depression
- Anxiety
- Loss of interest
- Irritability

- Humiliation/Shame
- Agitation/Anger
- Relief/Sudden Improvement
- Extreme mood swings

(*Risk Factors and Warning Signs*, 2019; IAFF, 2016)

3

Suicide Prevention Plan, CDC

The Centers for Disease Control and Prevention (CDC) has created a programmatic approach to suicide prevention. This guide will summarize these points and provide specific recommendations by the JFPSG. The CDC uses a 7-step strategy for suicide prevention plans. It is represented below (Centers for Disease Control and Prevention [CDC], 2017)

Preventing Suicide

Strategy	Approach
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access and delivery of suicide care	• Coverage of mental health conditions in health insurance policies • Reduce provider shortages in underserved areas • Safer suicide care through systems change
Create protective environments	• Reduce access to lethal means among persons at risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm programs • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning programs • Parenting skill and family relationship programs
Identify and support people at risk	• Gatekeeper training • Crisis intervention • Treatment for people at risk of suicide • Treatment to prevent re-attempts
Lessen harms and prevent future risk	• Postvention • Safe reporting and messaging about suicide

Strengthen Economic Supports

Rationale

Simply put, the existence of economic stressors may, directly or indirectly, increase suicide rates – especially for people aged 25-64 years (CDC, 2017). It stands to reason the increased stress from events such as a job, or home loss that results in financial hardship could be a factor in suicidal ideation. While more study is needed, research suggests that stabilization of the economic aspects of a person may reduce suicide (CDC, 2017).

Approaches

The primary way economic causes for suicide may be approached to strengthen household financial security to reduce the stress associated with financial hardships (CDC, 2017).

JFPSG Recommendations

The JFPSG reminds firefighters that the Employee Assistance Program (EAP) is available for both firefighters and retirees regarding financial matters. This extends to families as well. The phone number for Lifeworks is (888) 267-8126, and the website is https://cityofjoliet.lifeworks.com/. The username is Joliet, and the password is city. The site may also be reached from the LINKS page at jfdpeersupport.com.

Strengthen Access and Delivery of Suicide Care

Rationale

Those with current mental health issues are at greater risk for suicide (Mental Health First Aid USA, 2015). For this reason, access to mental health care is a necessary measure to prevent suicide (CDC, 2017).

Approaches

Widely available, effective, and efficient mental health care is critical to the prevention of suicide. Issues such as local availability, the proper number of mental health professionals for the community, and insurance issues are all important considerations (CDC, 2017).

JFPSG Recommendations

There are several avenues to help that are available. The JFPSG has partnered with Aspire Center for Positive Change, located in Channahon, IL. Firefighters, retirees, and their families always have access to professional clinical care through the JFPSG. Also, the JFPSG has teamed with the Joliet Fire Department to provide on-shift training for all on-duty firefighters.

Peer support and professional care may be accessed 24/7 via a toll-free number that may be called or texted (855) JFD-PEER. Also, firefighters and retirees have access to the IAFF Center for Excellence, which provides in-patient care for various mental health issues that are covered by health insurance; the Upper Room Crisis Hotline, which provides trained operators to answer calls from anonymous callers; and Lifeworks employee assistance. The phone number for Lifeworks is (888) 267-8126, and the website is https://cityofjoliet.lifeworks.com/. The username is Joliet, and the password is city. The site and other resources may also be reached from the LINKS page at jfdpeersupport.com. Finally, the City of Joliet has partnered with

Thriveworks® Counseling to allow for no-cost mental health care to firefighters, retirees, and their dependents. Appointments are available usually same-day or next-day.

Create Protective Environments

Rationale

The culture of organizations is a primary hindrance to help-seeking behaviors. Programs, policies, and practices must be implemented in the workplace that may be carried to the employees' homes that support the employee and encourage them to seek help if needed (CDC, 2017).

Approaches

Several methods are used in creating protective environments. These include:

- Reducing access to lethal means
- Safe storage of lethal means (firearms, drugs, other means)
- Organizational policies
- Alcohol abuse treatment (CDC, 2017)

"Research also indicates that: 1) the interval between deciding to act and attempting suicide can be as short as 5 or 10 minutes, and 2) people tend not to substitute a different method when a highly lethal method is unavailable or difficult to access. Therefore, increasing the time interval between deciding to act and the suicide attempt, for example, by making it more difficult to access lethal means, can be lifesaving" (CDC, 2017, p.25). Safe storage of lethal means allows that critical time period between deciding to complete suicide and making an attempt to be elongated. This time may be critical for the suicidal person.

Organizational policies that address mental illness must be instituted and followed from the top down. These policies help create a supportive and accepting attitude within the organization. Alcohol also plays a large role in suicide. "Research studies in the United States have found that greater alcohol availability is positively associated with alcohol-involved suicides… These policies are important because acute alcohol use is associated with more than one-third of suicides and approximately 40% of suicide attempts" (CDC, 2017, p.25).

JFPSG Recommendations

The JFPSG encourages the Joliet Fire Department, JFD members, retirees, and their families to create a protective environment around them at home and work. At work, this includes steps such as current Standard Operating Procedures (SOP) and laws banning the presence of dangerous weapons in fire stations. At home, this includes the safe storage or removal of firearms, ammunition, and medications.

The organizational culture of the fire service is in a period of slow transition. The acceptance of mental health care is becoming more widespread, and firefighters are being encouraged to discuss their issues with peers and clinicians – this includes the overuse of alcohol.

The fire service is rife with dangerous conditions and other potential access to lethal means. For this reason, we must ensure that our members are trained to see the signs of potential suicidal behavior within themselves and others. This support must come from the top down and include skill-building and access to mental health care.

Promote Connectedness

Rationale

Since the 1800s, the connection between human connection and suicide has been known. Social interaction in all its forms is important to the reduction of suicide – this includes neighborhood organizations, churches, and work peers (CDC, 2017).

Approaches

Greater participation in community activities may help prevent suicide - connection with those in the community has been proven to alleviate depression and reduce stress, and proper social leadership may help establish more open-minded ideas regarding mental illness and local support (CDC, 2017).

JFPSG Recommendations

The JFPSG understands the importance of connectedness. This is important both at work and at home. One of the strongest points of the JFPSG is to promote this connectedness – a trait that is built into the culture of the fire service. It has been shown that peer support is an effective means of maintaining this important element.

It is also important to maintain this connection with families and communities. This may be done in many ways, including community groups, religious organizations, and group exercise classes. We encourage firefighters, retirees, and families to maintain broad social contact with family, coworkers, friends, and other loved ones.

Teach Coping and Problem-Solving Skills

Rationale

Some suicide experts believe that suicidal behavior may be, at least partially, a learned behavior. When negative thoughts and behaviors are exhibited in an environment, it may teach those in that environment (especially children) that those behaviors are valid ways to manage stress (CDC, 2017).

A far more constructive solution is to model behaviors that encourage problem-solving and critical thinking (CDC, 2017). When this is done, the skills that are needed to successfully deal with stress and related issues may be successfully passed from generation to generation.

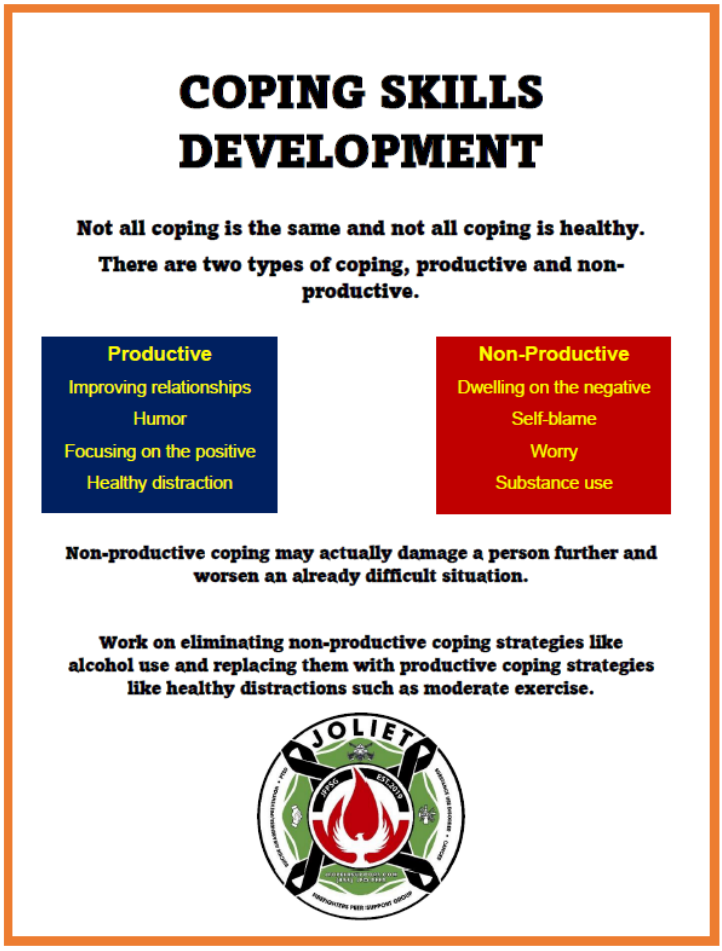
Approaches

Since behavior modeling is a common method for parents to pass knowledge to their children, it stands to reason that children will use the stress relief skills of their parents to manage their stress. The issue arises when the parent's strategies are unhealthy or dangerous. Parents must understand that their children are constantly watching and learning from them. They will often imitate their behavior.

For this reason, it is also reasonable to assume that some parents and children may not have learned the proper coping techniques to make them the most successful at managing stress. Many educational resilience development programs exist. The programs may be geared toward children (usually in school) or parents. Topics discussed in both programs include problem-solving skills and communication methods (CDC, 2017)

JFPSG Recommendations

One of the core beliefs of the JFPSG is the need for robust positive coping strategies and problem-solving skills. These strategies are invaluable in managing stress caused by all sorts of events, from minor to severe. We encourage people of all ages to identify stress relief mechanisms for use during difficult times. Our clinicians are available to help people identify and develop effective strategies for firefighters, retirees, and families. Training regarding coping will be done as the firefighters complete monthly mental health training. Also, the employee assistance program (EAP) is available to provide toolkits concerning family issues. It bears repeating the children imitate the stress management behaviors that the parent models. Parents must be aware of this fact and develop positive strategies for managing stress. Section 8 includes productive and non-productive coping strategies (Freydenberg, 2017).



Identify and Support People at Risk

Rationale

While the suicide rate of firefighters is debated, it is critical not only to provide adequate resources but to attempt to identify at-risk individuals (CDC, 2017).

Approaches

The CDC (2017) identifies two major methods of identifying and supporting people at risk. These methods include both the training of Gatekeepers and access to crisis intervention. Gatekeepers refer to people trained in recognizing suicidal behavior. Once the behavior is identified, crisis intervention may be done.

JFPSG Recommendations

The JFSPG is dedicated to the education of firefighters, retirees, and families regarding signs of suicide. Also, we recognize the importance of early notification of peer supporters and clinical care for those experiencing suicidal ideation. The JFPSG maintains a toll-free hotline (855) JFD-PEER that members may call or text 24/7.

The JFPSG peer supporters may be considered Gatekeepers. Our peer supporters are trained in suicide prevention and crisis intervention strategies and are available to discuss these issues with anyone who needs help. Also, our clinicians are on-call to handle emergent issues.

Finally, the JFPSG has included online links to suicide prevention and crisis hotlines linked to our website. We- have connections to the National Suicide Prevention Lifeline 988, the Upper Room Crisis Hotline (888) 808-8724, and other resources for suicidal people who wish to talk to someone.

Lessen Harms and Prevent Future Risk

Rationale

When suicide does occur, it must be understood that many who are left behind will be traumatized. These individuals must also be cared for, and suicide contagion must be avoided.

Bohinna (2013) describes suicide contagion as to the tendency of a population exposed to suicide to imitate that behavior. This may result in clusters of suicides that occur in one place.

A critical consideration that will make a difference in this respect is the way suicide is announced. Care must be taken to avoid exaggerated or rumor-laden descriptions of the event (CDC, 2017).

Approaches

Some potential interventions that may be used after suicide include postvention approaches and appropriate messaging techniques (CDC, 2017). "Postvention approaches are implemented after a suicide has taken place and may include debriefing sessions, counseling, and/or bereavement support groups for surviving friends, family members, or other close contacts. These programs have not typically been evaluated for their impact on suicide, attempts, or ideation, but they may reduce survivors' guilt, feelings of depression, and complicated grief" (CDC, 2017, p.41) Also, when a suicide occurs, the message to the public and department must be appropriate. Contained within the message should contain messages of hope, prevention, risk, and available resources (CDC, 2017). See Appendix A for more information.

JFPSG Recommendations

The JFPSG has a policy in place for firefighter suicide. Due to the closeness of the peer support group to the members of the JFD, we intend to have our peer supporters perform surveillance on members to identify persons who may be in crisis while our clinicians and the Northern Illinois Critical Incident Stress Team (NI-CISM) help manage the resulting information sessions, defusings, potential debriefings, and alerting others of the event. We intend to assign a point of contact to loved ones for a peer supporter should aid be needed. Additionally, we have created a brief announcement script that may be used by the JFD Administration to inform the members of the department should an event occur. See Appendix A.

4

The Houston Fire Department (HFD) Model

According to Finney et al. (2015), as a result of losing numerous firefighters and retirees to suicide between 1984 and 2007, the City of Houston, TX Fire Department (HFD) engaged in the creation of a suicide prevention program for their firefighters and their families. This was initially intended to be a multi-phased approach that began with firefighters and families and was planned to be later instituted with retirees. The program was deemed necessary because it was found that although the HFD has an Employee Assistance Program (EAP), it was not used regularly by firefighters (Finney et al., 2015).

"The Firefighter Support Network (FSN) was formed as a recognized unit with the HFD. This unit consists of an assistant chief, staff psychologist (director), member's advocate, family assistance coordinator, chaplain, assistant chaplain, Critical Incident Stress Management (CISM) coordinator, and two union representatives. The purpose of this unit is to be able to support any HFD member and their families in their time of need. Services include (but are not limited to) mental health, hospital visits, human resources, peer support, funeral assistance/coordination, spiritual support, education, and research. This unit falls under support command in the HFD hierarchy and has a budget. The FSN team meets every other month to address support issues in the department" (Finney et al., 2015, p.2-3).

Phase 1: Awareness

All stations with the HFD were required to participate in a two-hour suicide prevention training. The training was provided by the members of the group and took three months to complete (Finney, 2015).

Phase 2: Prevention

Once again, members of the team provided training for HFD members, focusing on educational information related to suicide (Finney, 2015). According to Finney (2015), members who were unable to attend Phase 1 were caught up, and additional information was provided, such as the history of suicide within the department and risk factors for suicide. A discussion was held regarding a survey to be administered and what was to come in Phase 3.

Phase 3: Crisis Identification

Phase 3 was completed in six months and was done at the Officer's discretion. The Officers were educated correctly to identify a crisis as well as how to deal with suicidal and homicidal employees (Finney, 2015).

Results

After the institution of this program, suicides in the HFD ceased for the next five years. While it is difficult to ascertain whether the program was the reason for the drop in suicides, it remains a good sign. Also, because of the program, suicide prevention was taught to all recruits within the HFD, and all department heads were trained in suicide prevention techniques (Finney, 2015). From the beginning of the program, the administration conveyed the seriousness of the topic to the members of the department.

5

IAFF Planning for Suicide Prevention

The program is designed for previously trained peer supporters and has the goal of reducing suicide in at-risk individuals (previous attempt, ideation, or otherwise at risk) through a six-step process (International Association of Firefighters [IAFF], 2020). This process includes methods for firefighters to recognize the signs within themselves and tools to manage suicidal thoughts and actions with the hope of preventing suicide (International Association of Firefighters [IAFF], 2020). This process is documented on a form that the firefighter keeps in their possession that aids them through the process and includes follow-up with the peer. The program tasks the peer ostensibly with determining whether the suicidal firefighter poses an imminent risk of suicide. If they do pose this risk, immediate emergency actions are warranted. If they do not, the six steps of the program are completed (International Association of Firefighters [IAFF], 2020).

The six steps of this interventional plan include:

1. Identify warning signs. Includes thoughts, emotions, behaviors, and physical manifestations.
2. Solo activities. Includes distracting activities that the firefighter can perform alone (reading, tv).
3. Identify social settings. Specific, healthy, distracting settings (restaurant, library).
4. Family and friend involvement. People who know about your risk. Who to call.
5. Professional contact. Clinician, suicide helpline.
6. Provide a safe environment. Reduce lethal means (drugs, firearms).

6

The Joliet Firefighters Peer Support (JFPSG) Model

The JFPSG Suicide Prevention Model is a combination of the CDC Model, HFD Model, and individual research from the JFPSG. The model is based on the previously described Adapted Emergency Management Model for Firefighter Mental Health. It is a four-objective model that addresses critical components of the mental and spiritual health of active firefighters, retirees, and families.

Objective 1: Initial Mental Health Training
AFSM Area: Prevention

Active Firefighters:

The initial training regarding mental health for active firefighters took place in March 2020. The training was done across all three shifts and all stations. Topics that were covered included common mental health issues, clinical care, spiritual care, coping, resilience, peer support, and clinical care introduction. Suicide among firefighters was addressed in-depth; the JFPSG Suicidologist, Sr. Mary Frances Seeley, PhD., was present at all training.

All new firefighter recruits receive initial training.

Retirees:

The training was posted on the JFPSG website, and emails were sent to retirees to view the training online.

Families:

The training was posted on the JFPSG website, and emails were sent to firefighters to forward to their loved ones and families. Also, the training was posted on the JFPSG Facebook page, so anyone with interest may view it.

Objective 2: Crisis First Aid for Paramedics (CFA-P)
AFSM Area: Prevention, Rehab

Active Firefighters:

The evidence-based status of many forms of psychological first aid and crisis intervention are well known. It is critical to this program that PFA in some form be taught to the entire Joliet Fire Department (Lukancic, 2021). This benefits not only the firefighters but the public as well. The JFPSG is certified to teach Mental Health First Aid and has created a group of Crisis First Aid courses for responders. Responding soon after a traumatic event may help firefighters recover more quickly (Mitchell, 2017).

Retirees:

CFA information will be posted on the website.

Families:

CFA information will be posted on the website.

Objective 3: Regular Mental Health Training
AFSM Area: Prevention, Suppression, Rehab, Critique

Active Firefighters:

An important aspect of suicide prevention is periodic re-training. The Joliet Fire Department has granted the JFPSG monthly mental health training. A portion of training time will be

dedicated to suicide prevention among firefighters. Among the covered topics will be risk factors and warning signs, help and resources, and self-assessment using the Columbia Suicide Scale instrument for responders (see page 62).

Retirees:

Training will be posted on the JFPSG website and/or Facebook page. Retirees will be sent an email when it is posted.

Families:

Training will be posted on the JFPSG website and/or Facebook page. Firefighters will be sent an email when it is posted so family members may view it.

Objective 4: Regular Outreach
AFSM Area: Prevention, Suppression, Critique

One of the defining characteristics of the JFPSG is the ability to perform regular outreach to firefighters, retirees, and families.

All: A monthly newsletter is released to firefighters and retirees and posted on the Facebook page with tips for mental health.

Firefighters: Quarterly visits are planned for each of the stations.

Retirees: Annual visits will be scheduled for the Retiree Association Meetings.

Families: An annual information seminar will be scheduled for families either in-person or online.

Summary

The JFPSG Suicide Prevention Model incorporates psychoeducation, peer support, regular training, and physical outreach to provide the most comprehensive suicide prevention possible for the active members, retiree members, families, and loved ones of the Joliet Fire Department.

Objectives Met

Each phase of the JFPSG AFSM is addressed in the JFPSG Suicide Prevention Program.

Objective 1, 2, 4

Objective 1, 2, 3, 4

Objective 2

Objective 3, 4

7

Conclusion

Suicide is a serious problem in the US and the fire service. There must be a robust and concrete plan in place to prevent and manage this problem. The Joliet Firefighters Peer Support Group is dedicated to preventing suicide among our firefighters, retirees, and families. We are available 24/7 for any firefighter, retiree, or family member who is considering suicide.

8

Handouts & Flyers

An important aspect of the suicide prevention process is the persistent reminder that help is available for those feeling suicidal. The handouts and flyers attached are sent to all retirees and firefighters/families and are to be posted in a conspicuous area in the fire stations. The flyers may be reprinted or clipped from this guide and posted as needed.

The first is the general post for the JFPSG. These have been distributed to all stations and are posted in the kitchen areas. Copies may be made and posted anywhere the Company Officer deems necessary.

Second, a suicide prevention flyer is available for printing and posting anywhere necessary. This flyer describes signs of suicidal behavior and what to do if you believe someone is considering suicide.

Finally, a flyer for the Upper Room Crisis Hotline is available for printing and posting. The Upper Room Crisis Hotline provides anonymous 24/7 phone support for anyone who needs to talk about any topic, including suicide.

Joliet Firefighters Peer Support Group

Need to talk? We can help!

(855)JFD-PEER

Addiction

Depression

Family

Job

Medical Issues

Spirituality

Suicide

COMPLETELY CONFIDENTIAL!

Firefighter Peers with clinical and spiritual support. Call or email today!

Visit our website: www.jfdpeersupport.com email: info@jfdpeersupport.com
CALL or TEXT: (855) JFD-PEER

JFPSG

SUICIDE PREVENTION

RISK FACTORS

HEALTH · Depression · Substance Use · Bipolar Disorder· Schizophrenia · Personality Traits · Conduct Disorder · Anxiety · Physical Conditions · TBI · Lack of Treatment

HISTORY · Attempts · Family History · Abuse · Neglect · Hopelessness

ENVIRONMENT · Lethal Means Present (Guns/Drugs) · Stress · Bullying · Relationships · Rejection · Loss · Exposure to Suicide · Suicide Clusters · Isolation · Stigma · Culture

WARNING SIGNS

SPEECH · Mention Killing Themselves · Hopeless · No Reason to Live · A Burden · Trapped · In Pain

BEHAVIOR · Alcohol/Drugs · Online Searches · Withdrawal · Sleep (too much/little) · Saying Goodbye · Giving Away Possessions · Aggression · Fatigue · Anxious

MOOD · Depression · Anxiety · Loss of Interest · Irritability · Shame · Anger · Sudden Improvement · Mood Swings

WHAT TO DO:

IF SUICIDAL CALL 911 NOW!

Do not ignore suicide risk factors and warning signs. Call for help.

TALK

About suicide with peers and with families at home.

Talking about suicide will NOT cause someone to become suicidal.

RESOURCES

Call 911
Call 988
Call the Upper Room Crisis Hotline
(888) 8OTURCH
Lifeworks EAP
(888) 267-8126
Thriveworks® Counseling
(855) 511-0149
JFPSG Peer Support
(855) JFD-PEER

The Upper Room Crisis Hotline

888-808-8724

24/7 SERVICE
CALL ANYTIME FOR ANONYMOUS SUPPORT

The Upper Room Crisis Hotline is a compassionate faith-based hotline in the Catholic Tradition. They are a non-judgmental listening and referral hotline to clergy, religious and laity in spiritual need 24/7. They bring comfort to those facing emotional and spiritual need.

Though they are in the Catholic Tradition, you do not need to be Catholic to call. All are welcome.

(888) 808-8724

The Upper Room has partnered with the Joliet Firefighters Peer Support Group (JFPSG)

Additional support provided by trained phone counselors

Completely anonymous

Call anytime

Call even if not in crisis

JOLIET
JFPSG
EST. 2019
SUICIDE AWARENESS/PREVENTION • PTSD
SUBSTANCE USE DISORDER • CANCER
JFDPEERSUPPORT.COM
(855) JFD-PEER
FIREFIGHTERS PEER SUPPORT GROUP

COPING SKILLS DEVELOPMENT

Not all coping is the same and not all coping is healthy.

There are two types of coping, productive and non-productive.

Productive	Non-Productive
Improving relationships	Dwelling on the negative
Humor	Self-blame
Focusing on the positive	Worry
Healthy distraction	Substance use

Non-productive coping may actually damage a person further and worsen an already difficult situation.

Work on eliminating non-productive coping strategies like alcohol use and replacing them with productive coping strategies like healthy distractions such as moderate exercise.

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

988 SUICIDE & CRISIS LIFELINE

Any YES indicates that someone should seek behavioral healthcare.

However, if the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room. STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

Appendix A: Administration Announcement Script

If a suicide occurs, it is important to ensure that the fire department members are notified appropriately with accurate information. It is also essential to ensure that support is offered for those who need it. Below is a script that may be used. The following is adapted from several sources (University of South Florida: College of Community & Behavioral Sciences et al., n.d.; San Mateo County Office of Education, 2017).

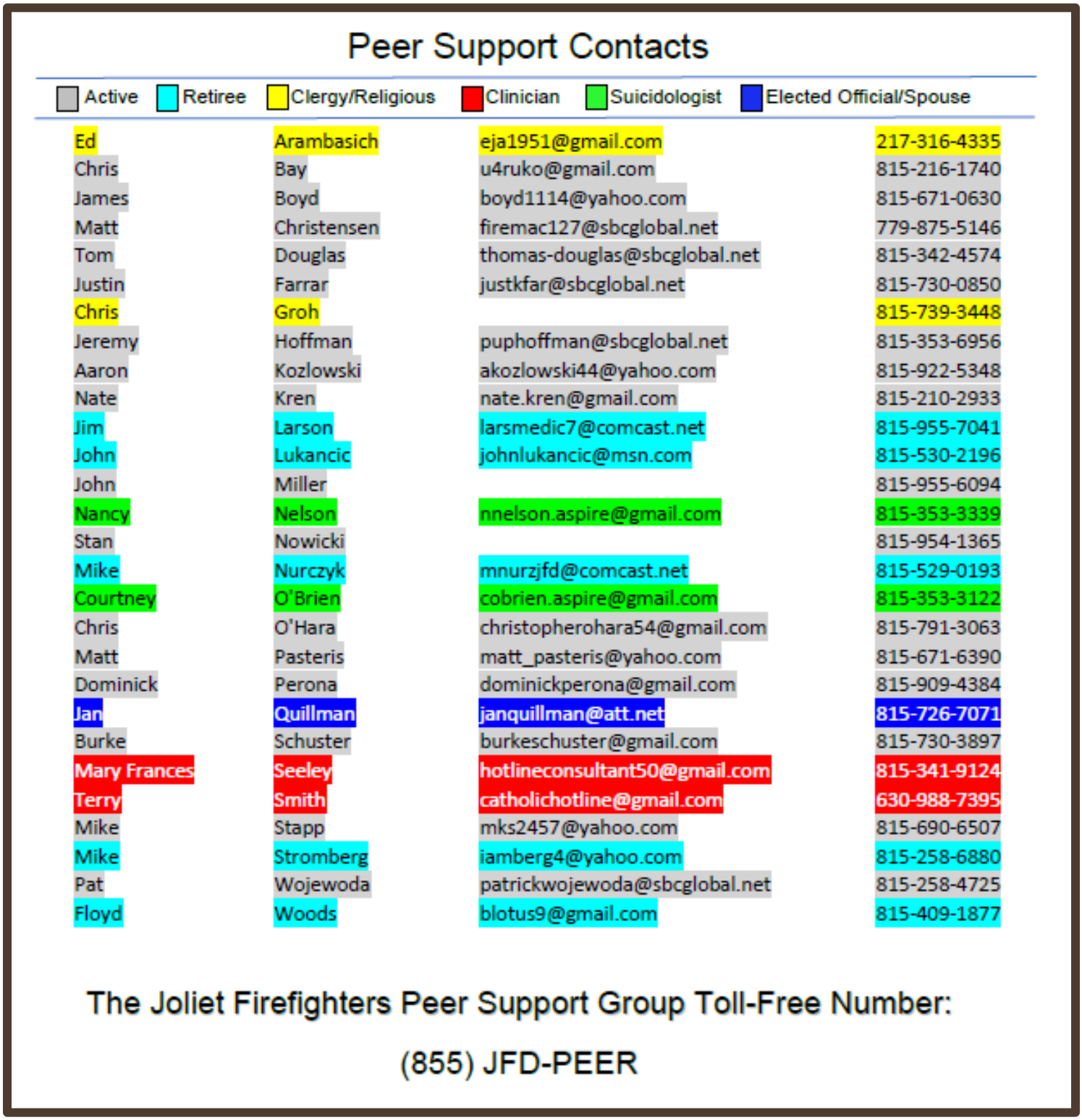
Sample Announcement when Suicide Death has Occurred (When consent to disclose has occurred): Fire Administration

"We have recently heard the extremely sad news that [firefighter name] died by suicide. I know we are all saddened by [his/her] death and send our condolences to [his/her] family and friends. Even if you were not close to [firefighter name], it is possible and normal to experience a variety of traumatic stress reactions. These reactions may be managed by applying coping strategies and resilience methods. To aid in this, peer supporters and clinicians are available 24/7 to aid any firefighter, retiree, or family member who needs more help. Please call or text (855) JFD-PEER if you need to talk. We ask that you please do not spread rumors that you may hear. More information will be provided when it is available regarding the funeral and further support. Thank you."

Sample Announcement when Suicide Death has Occurred (When consent to disclose has not occurred): Fire Administration

"We have recently heard the extremely sad news that [firefighter name] has died. This is the only information we may officially disclose about the circumstances surrounding the event. We are all saddened by [his/her] death and send our condolences to [his/her] family and friends. Even if you were not close to [firefighter name], it is possible and normal to experience a variety of traumatic stress reactions. These reactions may be managed by applying coping strategies and resilience methods. To aid in this, peer supporters and clinicians are available 24/7 to aid any firefighter, retiree, or family member who needs more help. Please call or text (855) JFD-PEER if you need to talk. We ask that you please do not spread rumors that you may hear. More information will be provided when it is available regarding the funeral and further support. Thank you."

Appendix B: Peer Support Contacts



Peer Support Contacts

Active | Retiree | Clergy/Religious | Clinician | Suicidologist | Elected Official/Spouse

Ed	Arambasich	eja1951@gmail.com	217-316-4335
Chris	Bay	u4ruko@gmail.com	815-216-1740
James	Boyd	boyd1114@yahoo.com	815-671-0630
Matt	Christensen	firemac127@sbcglobal.net	779-875-5146
Tom	Douglas	thomas-douglas@sbcglobal.net	815-342-4574
Justin	Farrar	justkfar@sbcglobal.net	815-730-0850
Chris	Groh		815-739-3448
Jeremy	Hoffman	puphoffman@sbcglobal.net	815-353-6956
Aaron	Kozlowski	akozlowski44@yahoo.com	815-922-5348
Nate	Kren	nate.kren@gmail.com	815-210-2933
Jim	Larson	larsmedic7@comcast.net	815-955-7041
John	Lukancic	johnlukancic@msn.com	815-530-2196
John	Miller		815-955-6094
Nancy	Nelson	nnelson.aspire@gmail.com	815-353-3339
Stan	Nowicki		815-954-1365
Mike	Nurczyk	mnurzjfd@comcast.net	815-529-0193
Courtney	O'Brien	cobrien.aspire@gmail.com	815-353-3122
Chris	O'Hara	christopherohara54@gmail.com	815-791-3063
Matt	Pasteris	matt_pasteris@yahoo.com	815-671-6390
Dominick	Perona	dominickperona@gmail.com	815-909-4384
Jan	Quillman	janquillman@att.net	815-726-7071
Burke	Schuster	burkeschuster@gmail.com	815-730-3897
Mary Frances	Seeley	hotlineconsultant50@gmail.com	815-341-9124
Terry	Smith	catholichotline@gmail.com	630-988-7395
Mike	Stapp	mks2457@yahoo.com	815-690-6507
Mike	Stromberg	iamberg4@yahoo.com	815-258-6880
Pat	Wojewoda	patrickwojewoda@sbcglobal.net	815-258-4725
Floyd	Woods	blotus9@gmail.com	815-409-1877

The Joliet Firefighters Peer Support Group Toll-Free Number:

(855) JFD-PEER

Appendix C: Preplanning and Critique Questionnaires

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JFPSG Pre-Plan Stress Management Self-Survey

To help preplan before experiencing a traumatic stress inducing event, please complete the self-survey below. This will enable you to size-up gaps in protection and coping strategies in your current plan and adjust the plan accordingly. This will not be collected and is only for your information.

If you have any questions or need ideas, please call the JFPSG at (855) JFD-PEER.

1. **Do you need to talk to someone now? If so, STOP HERE and call (855) JFD-PEER.**

2. Do you feel both physically and mentally prepared to perform your duties? YES/NO
3. If NO, what needs improvement? _____
4. What are techniques that you use to protect yourself from effects of traumatic stress (e.g., blocking things out, emotional numbing)?

   _____

5. Are the techniques listed in question 4 enough? YES/NO
6. List available resources that you are confident you would use if experiencing an issue

   _____

7. With whom are you comfortable talking about problems?

   _____

8. What healthy coping strategies do you use? (e.g., healthy distraction, positive thinking)

   _____

9. Do you feel as if the coping strategies listed in question 8 are enough? YES/NO
10. List any other things you may be susceptible to that may require special attention (incidents involving kids, recent traumatic events) _____
11. Please list any deficiencies in your training that need addressing._____

JFPSG Post-Event Stress Management Self-Critique

After experiencing a traumatic stress inducing event, please complete the self-critique below. This will enable you to see gaps in protection and coping strategies and alter your plan accordingly.

If you have any questions, please call the JFPSG at (855) JFD-PEER.

Self-Critique Questions:

1. **Do you need to talk to someone now? If so, <u>STOP HERE and call (855) JFD-PEER.</u>**

2. Did you feel mentally prepared for the event you experienced? Why or why not?

3. What aspects of your stress management plan do you feel worked well?

4. What aspects of your stress management plan do you feel need work?

5. If your stress management plan needs improvement, how are you planning to proceed?

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