Joliet Firefighters Peer Support Group (JFPSG)

Suicide Prevention Guide

The Joliet Firefighters Peer Support Group, 2020.

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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.

The clinicians at Aspire Center for Positive Change, Courtney O'Brien, Nancy Nelson, Carissa Silunas, and Aubrey Thornton, who during difficult and stressful times made themselves available to our group whenever they were needed.

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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"

Cover art used with permission. Special thanks to IAFF Local 44 (L44 Logo), & the Joliet Fire Department (JFD Logo).

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The Joliet Firefighters Peer Support Group (JFPSG)

Overview

While there are many areas of history and culture that firefighters can and should be proud of, one of our most glaring cultural failures has been the way we view and treat mental health within our community. Studies have shown that many firefighters, past and present, see mental illness as a weakness (IAFF, 2017). This gives rise to denial and the tendency to ignore critical issues that affect us, preventing help-seeking behavior.

It is well known that when minor issues are not dealt with, they may become major issues. These major issues are 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.

As a group, firefighters have a higher rate of cancer, depression, substance abuse, post-traumatic stress disorder (PTSD), and suicide than the public (Joliet Firefighters Peer Support Group [JFPSG] & Lukancic, 2020). We must create a culture shift within the fire service to reverse these trends. Further, retirees and fire service families and loved ones also carry a substantial burden. They must also be cared for in mental health and spiritual capacities.

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 psychological first aid (PFA) 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.

Website and Facebook Page

The JFPSG maintains a website (www.jfdpeersupport.com) and 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. As a result, firefighters may exhibit symptoms of a wide variety of mental challenges 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 Emergency Management model to be discussed in the next section.

Culture

The firefighter culture is another important consideration in selecting effective mental health management strategies. There are certain characteristics of this culture (in both active and retired firefighters) that make management techniques important regarding firefighter stress. These cultural attributes include the self-sufficient nature of firefighters, the "can-do" attitude of firefighters, and the culturally supported heroic image of firefighters. Historically, firefighters have seen themselves as being the one called for help, not requiring it. For this reason, a modality must be found that allows the firefighter to participate more fully in that management (Lukancic, 2020).

Also, throughout the history of the American Fire Service, firefighters have earned a reputation for being able to adapt to overcome obstacles. They are ostensibly problem solvers and do not allow challenges to get in their way. The culture reinforces this at each level of the firefighter's career, including retirement. This too must be included at all phases of management

for the firefighter to gain confidence that they are aiding the process – they must have a challenge to overcome (Lukancic, 2020).

Finally, since the beginning of the fire service culture itself in ancient Egypt and Rome, the profession has received consistent recognition as a group of people who bravely enter dangerous areas when others are exiting. This has created a culture of "mental toughness," the result of which is the belief that nothing is supposed to disturb firefighters. This leads to the belief that if something does disturb them, they are weak. This attitude is extremely damaging to firefighters. When seeking mental health care is seen as a weakness, the firefighters may not seek the help they need, resulting in small, manageable problems becoming larger in scope (Lukancic, 2020).

JFPSG Adapted Emergency Management Model for Firefighter Mental Health (JEM Model)

Overview

The field of Emergency Management is a rapidly expanding field that recognizes the need for robust psychological support for those affected by the occurrence of traumatic events. Emergency Management has however been in existence from time immemorial (Philips, 2012).

Several Emergency Management phase models exist within the field. In most cases, they are five-phase models that recognize the consistent and cyclical nature of traumatic events and the need to prepare for them. The most accepted model is offered by the Federal Emergency Management Agency (FEMA) and is described in terms of mission areas to include prevention, protection, response, recovery, and mitigation (Federal Emergency Management Agency [FEMA], n.d.). Due to the hazard assessment within Joliet, we will use an event that the members of the JFD are

familiar with (a tornado) to illustrate our process. This example will then be tied to the mental health process.

Note: The process to be described may be adapted to fit most groups including firefighters, paramedics, police officers, dispatchers, spouses, loved ones, and extended family.

Prevention

Prevention, as the name implies, is based on the best-case scenario ability to halt a traumatic event from occurring, thus avoiding the peril, and resulting trauma altogether (FEMA, n.d.). Of course, this is the preferred method of managing any event because there will be few, if any negative consequences. In the tornado example, we understand that prevention is not a feasible strategy. Tornadoes may occur anywhere in the United States and cannot be wholly stopped. This is like the fire service because, even though prevention is a strong aspect of firefighting, there will inevitably still be fires and other emergencies which have negative consequences. We understand and accept this fact moving to the next phase.

The theory may be used in the prevention phase of the Emergency Management model in various ways. It must be understood first, however, that the nature of the firefighter's employment dictates that they will be exposed to multiple incidents that produce traumatic stress reactions. The prevention addressed in this model is a continuation of the mitigation phase to be discussed later. When the traumatic event occurs, the firefighter must have an existing and robust resiliency and support system in place. A primary way this may be accomplished is to facilitate the creation of a therapeutic alliance between firefighters, peer supporters, clergy, and clinicians before an event occurs. This may seem to be a misuse of

resources, but it will be valuable after the model is in effect. This alliance may come in several forms including peer support and clinical support structures. First, a peer support system must be in place for the firefighters to seek immediate help if needed. Further, peer supporters must be trained in crisis intervention and psychological first aid. This will enable the peer supporter to respond immediately in the event of a stressful event and begin the process of crisis management.

Next, a basis for a positive therapeutic relationship must be cultivated with clinicians who are dedicated to fire service personnel. Congruence, unconditional positive regard, and empathy can all be developed between the clinicians and the firefighters before treatment is needed. Congruence refers to the feeling of genuine care for the firefighter, positive regard refers to the acceptance of the firefighter as a person, and empathy refers to the ability to put oneself in the boots of the firefighter (Seligman & Reichenberg, 2014). This will enable the clinicians to build the trust necessary to instruct firefighters regarding the development of their resiliency and wellness strategies. These items combined may help prevent or minimize a traumatic stress reaction from occurring post-event.

Protection

The protection phase is focused on the ability to know and understand the common threats and hazards that may affect a particular group (FEMA, n.d.). This knowledge is key to the process of planning and preparing for these events when they occur. Understanding the events that are most likely to cause a negative consequence will enable the emergency manager to better prioritize the planning and response process. In the tornado example, the protection phase includes acquiring experts in the field of severe weather forecasting and warning processes as resources. It also includes ensuring that the people in each area are adequately informed regarding the risk and

trained in their response should an event occur. Added to this is the need for robust planning by the local authorities such as police, fire, emergency medical, other local services, and mutual aid resources.

The protection phase is one challenging aspect of this model. The primary way to accomplish protection is by ensuring that the first phase of prevention is done correctly. If there is congruence, unconditional positive regard, and empathy between firefighters, peer supporters, and clinicians are established early, there will be stronger trust and communication which will enable a more clearly defined threat and risk assessment of the firefighters themselves. In short, this therapeutic alliance will ensure that communication channels between all involved parties are open and threats may be discussed in a supportive atmosphere.

Response

The response phase is one that is often the focus of the FEMA model. This is largely due to the scope and immediate needs of most incidents and addresses the problems that present themselves as an event is occurring and just after it occurs (Philips, 2012). This phase is highly time-dependent. Sometimes managers dismiss the other four mission areas in favor of response. We see this trend within mental health services as well, the reactive versus the proactive. We sometimes see the focus of the initial response and the aftermath of an event with less attention given to the prevention or mitigation of the same event. During this phase, existing life threats and basic needs are the focus. In the tornado example, the response would occur during and after the tornado event occurred. It would include trained spotters, search and rescue of survivors, initial medical care, food, and temporary shelter.

If the prevention and protection phases are done properly, the response phase will be much easier to implement. As we saw earlier, the response phase is typically one of the most complicated and

robust of all phases. With the proper application of the first phases, there should be a strong resiliency level built up within the firefighter ranks. If the stress event is substantial enough, however, it may be necessary to implement a more aggressive treatment approach. Since the major components of the person-centered therapeutic alliance are already in place (e.g. congruence, unconditional positive regard, and empathy), it is simply a matter of connecting the firefighters with peer support and, if needed, clinical care (this will be done in the next phase).

Recovery

The recovery phase involves the transition from the response phase to the normal, or "new" normal condition (Philips, 2012). It is the point in the cycle where rebuilding begins within the affected area and may last for an extended period. This category is extremely broad and can include physical, spiritual, historical, and behavioral aspects. In the tornado example, the recovery phase includes such things as structural stability and rebuilding, commercial and industrial refitting, and other infrastructure revitalization. It must be noted, however, that the term normal may not refer to conditions that existed before the event. Just as in behavioral health, there is often a "new" normal that the client is presented with and must adapt to.

The recovery phase is also enhanced if the other phases are complete. After a significant event that breaks through the firefighter's coping mechanism, the peer supporters will respond. After the initial contact with the peer supporters, the peer supporters and the firefighter discuss the steps moving forward. The full recovery phase is only required if the response phase completed by the peer supporters is ineffective or more professional intervention is required. When the peer supporter is finished with their crisis intervention, they will discuss the need for further treatment with the firefighter. At this point, the firefighter may be referred to a clinician for further, more definitive therapy. As with the other phases, this phase will be much easier to implement, again due to the

groundwork already laid in the previous phases. With the therapeutic alliance already established, the process should progress more rapidly.

Mitigation

Finally, the mitigation phase will dovetail back into the prevention phase. Once this phase is reached, the lessons learned from the event will be applied to the next phases to reduce the impact of the next event. In this case, the type of event will be better planned for and better and stronger coping and resiliency strategies should be developed and put into use (FEMA, n.d.). The mitigation phase is arguably the most important in the Emergency Management model because it encourages the continuous improvement of the entire platform. Over time, the resiliency built from this model will be substantial.

The main concern with this model is to recognize the cyclical and lasting nature of the process. This model must be followed consistently, preferably in permanence for the process to work. The most effective way to operate is, to begin with, the prevention phase and graduate to the protection phase within a set timeframe. This will enable the baseline contacts to be made and a positive therapeutic alliance to be created before an event.

The event frequency for firefighters depends upon location, call volume, and chance. These attributes make this a difficult model to put a definitive timeline on. The first two phases may be done within a timeframe provided there are no critical incidents at that time. After that, the response and recovery phases are predicated upon event occurrence. The key to success in the management of the program to ensure the repetitive nature of the program remains intact and that the program is constantly moving forward with developing relationships and knowledge.

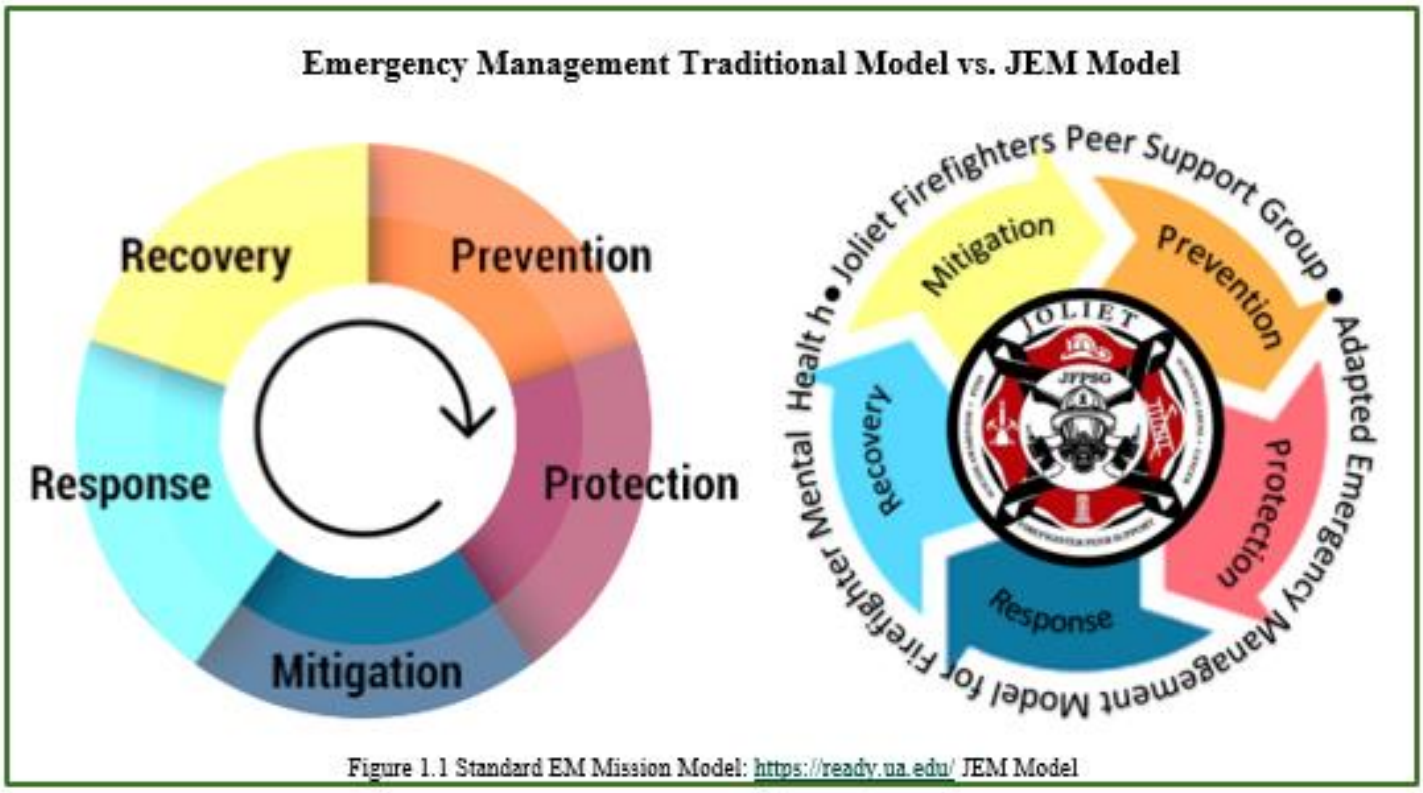


Figure 1.1 Standard EM Mission Model: https://ready.ua.edu/ JEM Model

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 organizations. 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 to include 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

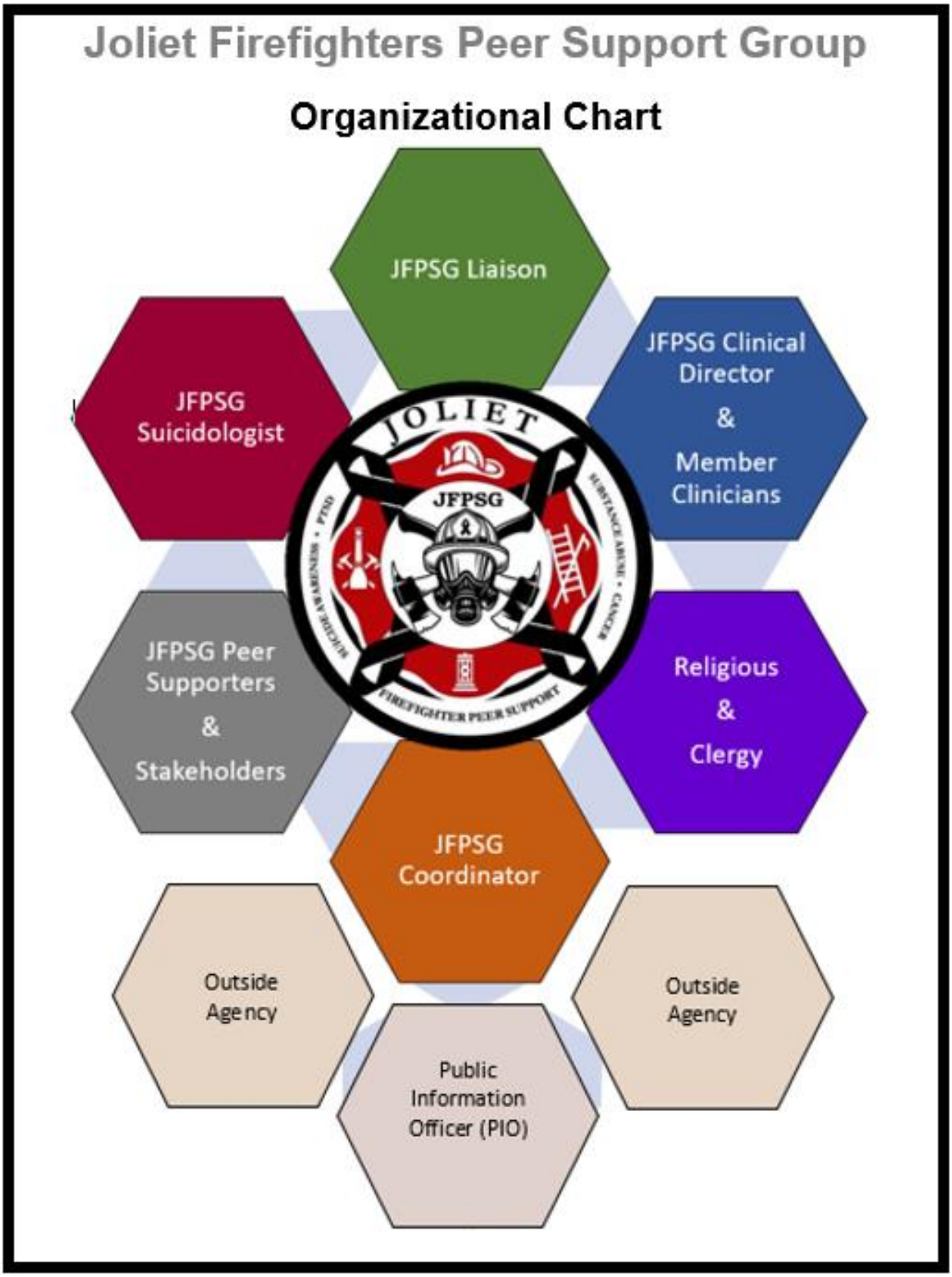
Membership: Consists of one or more member(s) of the JFPSG who is a Certified Suicidologist.

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 notify before any member speaking about group operations (Joliet Firefighters Peer Support Group [JFPSG] & Lukancic, 2020).



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

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The Problem of Suicide

Suicide Facts

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Firefighter Suicide

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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).
- Over a career, more than 40% of firefighters have suicidal ideation. That means that they have thought about completing suicide at least once.
- Of the 40% with ideation, 20% develop a plan, which means they seriously consider means to complete suicide.
- 15% of the fire service has attempted or has "practiced" attempting suicide in some form (empty firearms, etc.).
- 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.

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.

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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)

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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)

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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 for 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 is to strengthen household financial security to reduce the stress associated with financial hardships (CDC, 2017).

JFPSG Recommendations

At the writing of this document in 2020, the Covid-19 pandemic has caused a great economic strain on many people and families. For firefighters and retirees, there has been a minimal direct financial impact due to the stability of the workforce (no layoffs) and the stability of the pension fund. However, the effect of this pandemic and other events may have a severe effect on family economic stability. Many have lost their jobs and businesses with related losses in income and many families rely on multiple incomes to manage expenses.

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 the 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 quarterly 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.

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 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 the 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 the fire stations. At home, this includes the safe storage 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 such as heights 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 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, even group exercise classes. We encourage firefighters, retirees, and families to maintain broad social contact with family, co-workers, 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 strategies are unhealthy or dangerous. Parents must understand that their children are constantly watching and learning from them. They will often imitate their parental 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 how to identify and develop effective strategies for firefighters, retirees, and families. Training regarding coping will be done as the firefighters complete quarterly 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.

Identify and Support People at Risk

Rationale

Firefighters are a vulnerable population. Firefighters have a higher suicide rate than the public due, primarily to the unique and frequent exposure to traumatic stress and the resulting disorders (Lukancic, 2020). As such, it is critical not only to provide adequate resources but to attempt to identify at-risk individuals as well (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. We also hold bi-weekly meetings on Tuesday at 7 PM and Wednesday at 10 AM and notify active firefighters and retirees to attend. We also invite family to attend if needed.

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 (800) 273-8255, 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).

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) to help manage the resulting information sessions, defusings, potential debriefings, and altering 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 B.

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 institutes 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 its 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 the 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 problem and 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 to 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

The 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 the firefighter 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 (read, 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 help line.
6. Provide a safe environment. Reduce lethal means (drugs, firearms).

6

The Joliet Firefighters Peer Support (JFPSG) Model

The JFPSG 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
Mission Areas: Prevention, Protection, Mitigation

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.

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: Psychological First Aid (PFA)
Mission Areas: Response, Recovery

Active Firefighters:

The benefits of PFA are well known. It is critical to this program that PFA in some form be taught to the entire Joliet Fire Department. This not only benefits the firefighters but the public as well. The JFPSG is certified to teach Mental Health First Aid.

Retirees:

Online classes in Mental Health First Aid will be offered to retirees.

Families:

Online classes in Mental Health First Aid will be offered to families.

Objective 3: Quarterly Mental Health Training
Mission Areas: Prevention, Protection, Mitigation

Active Firefighters:

An important aspect of suicide prevention is periodic re-training. The Joliet Fire Department has granted the JFPSG quarterly mental health training. A portion of each training will be dedicated to suicide prevention among firefighters.

Retirees:

Quarterly re-training will be posted on the JFPSG website and Facebook page. Retirees will be sent an email when it is posted.

Families:

Quarterly re-training will be posted on the JFPSG website and Facebook page. Firefighters will be sent an email when it is posted.

Objective 4: Regular Outreach
Mission Areas: Prevention, Protection, Recovery, Mitigation

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

All: The JFPSG offers bi-weekly online support group meetings for firefighters, retirees, and families. Invitations are sent out weekly to firefighters and families through the JFD Deputy Chief and retirees through the JFPSG Coordinator. A monthly newsletter is released to firefighters, retirees, and posted on the Facebook page with tips for mental health.

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

Retirees: Bi-annual visits will be scheduled for the Retiree Association Meetings.

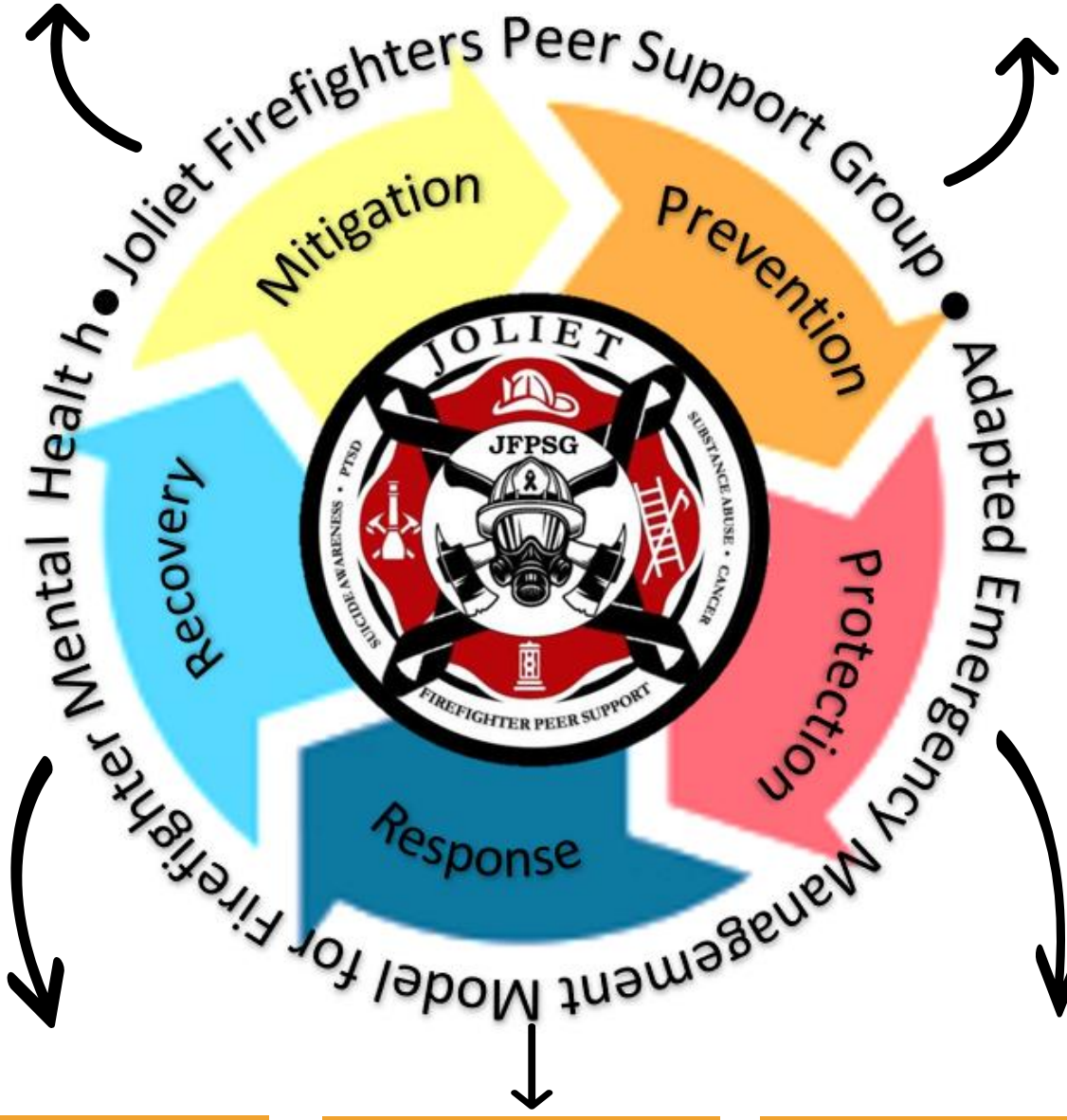
Families: Annual visits will be scheduled for families at a Fire Station.

Summary

The JFPSG Suicide Prevention Model incorporates psychoeducation, peer support, regular training, and physical outreach to provide for the most comprehensive suicide prevention possible for the active members, retiree members, families, and loved ones of the Joliet Fire Department. The five Emergency Management mission areas are addressed in this plan.

OBJECTIVE 1, 3, & 4

OBJECTIVE 1. 3. & 4



OBJECTIVE 2

OBJECTIVE 2

OBJECTIVE 1, 3, & 4

7 Conclusion

Suicide is a serious problem in the U.S. 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 of the documents is the announcement flyer for the bi-weekly support meetings held online. They are held every Tuesday at 7 PM and Wednesday at 10 AM. All firefighters, retirees, family, and friends of firefighters are invited to attend to discuss any issue they wish. Registration information is on the flyer.

The second 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.

Third, a suicide prevention flyer is available for printing and posting anywhere necessary. This flyer describes a sign 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.

Joliet Firefighters Peer Support Group

Online Support Group Meetings

Who May Attend?

- Firefighters
- Retirees
- Family Members
- Friends

Come to Talk About

- Job
- Retirement
- Family
- Stress
- Old Times
- Current Stressors

Every Tuesday at 7PM & Wednesday at 10AM

To Register: Visit www.jfdpeersupport.com/EVENTS

Need to talk? CALL or TEXT (855) JFD-PEER

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

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

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).8

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 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 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 may hear. More information will be provided when it is available regarding the funeral and further. 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

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Joliet Firefighters Peer Support Group

(JFPSG)

(855) JFD-PEER

Info@jfdpeersupport.com

www.jfdpeersupport.com