

# Confronting Suicide in the Fire Service

## Strategies for Intervention & Prevention



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The National Fallen Firefighters Foundation

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Beginning with a major national summit in 2011, and another in 2013, the National Fallen Firefighters Foundation has led the fire service in a conversation on the serious and pressing issue of firefighter suicide. No expert consulted at either summit could tell those assembled exactly how many firefighters die by suicide, yet most people at both assemblies recognized the problem or knew someone who had taken their own life. What we do know is this: suicide in the fire service is a serious problem. Even at general population rates, a fire department is three times more likely to experience a suicide in any given year than a line-of-duty death. What follows is a review of both NFFF Firefighter Suicide summits and their recommendations for specific efforts to address suicide in the American fire service.

## First Fire Service Suicide and Depression Summit

Baltimore, Md., July 11-12, 2011

The National Fallen Firefighters Foundation, as a part of its Everyone Goes Home® program, began helping fire service organizations develop a solid understanding of what is known about suicide and what we have yet to learn in July 2011, when the NFFF held the first known symposium on the topic of firefighter suicide. Three of the world's leading voices in suicide research and practice each presented an overview of current information important to developing a clear understanding and a rational plan for addressing the issues involved. More than fifty fire service leaders participated in this event, helping put forward a series of recommendations. The complete overview can be accessed at [http://lifesafetyinitiatives.com/13/suicide\\_whitepaper.pdf](http://lifesafetyinitiatives.com/13/suicide_whitepaper.pdf) with a summary and recommendations available at [http://lifesafetyinitiatives.com/13/depressionsuicide\\_summary.pdf](http://lifesafetyinitiatives.com/13/depressionsuicide_summary.pdf).

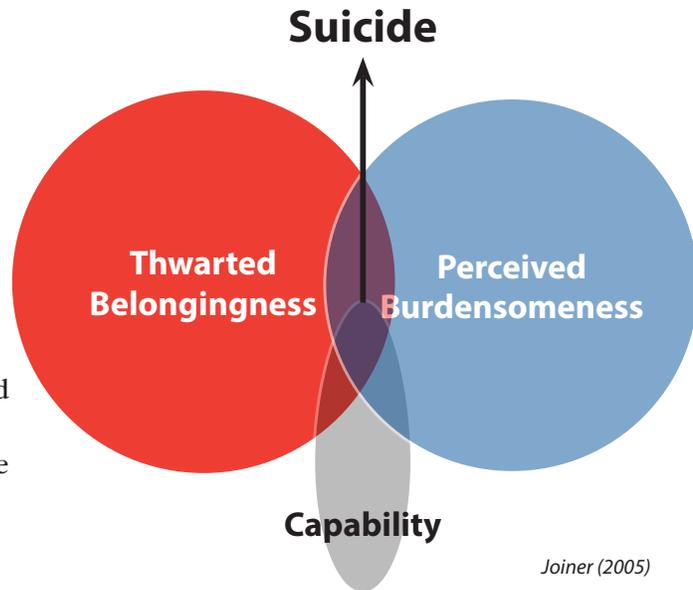
## 2011 Subject Matter Expert Presentations

Several critical issues emerged from these discussions. While the visibility of suicide among firefighters has clearly been growing in recent years, it is unclear whether the actual suicide rate has grown or whether it is disproportional to the rate among similar cohorts in other walks of life. As Dr. Matthew Nock of Harvard University explained, the suicide rate among white males—by far the dominant demographic in the American fire service—climbs systematically throughout the lifespan; an aging white male cohort such as that making its way to retirement age at present would accordingly expect to see steadily rising rates as that cohort matures. But are the rates for firefighters different from those of the overall population when matched for age, gender, and ethnicity?

There is, at present, no clear way to determine this. Death records are not typically indexed by occupation, hence there are no definitive data readily available to use for comparison. This is further exacerbated by the issues surrounding volunteer members whose occupations, even if they were captured on death certificates, may only reflect their primary employment, not volunteer service. What data do exist suggest that the probable rate among firefighters may be somewhat lower than comparable cohorts, suggesting that the close bonds and strong sense of purpose the occupation typically provides may serve somewhat of a protective role, helping perhaps to provide some insulation from the difficult impacts of tragic encounters and fostering resilience under duress. But what may happen when these supports falter, fail, or are lost due to factors such as illness, injury, retirement, or separation?



**Dr. Thomas Joiner** of Florida State University, another leading researcher, discussed the factors that lead one to suicidal action. Joiner's Interpersonal Theory of Suicide (2009) stands as the most thoroughly researched and developed model for explaining suicidal behavior. It specifies that suicide occurs when three factors intersect within an individual and his or her relationship to the surrounding environment: a thwarted sense of belonging, a perception that he or she is a burden, and most critically, the capacity to engage in lethal action. The capacity to engage in lethal action is not simply possession of or access to lethal means, though that is always a critical factor. It is even more the capability to overcome our powerful natural instincts toward self-preservation—to suppress fear of pain and death, confront one's own mortality, and take purposive action with the full intent to cause one's own death as a consequence.



Firefighters, as an inescapable consequence of their calling, learn to confront fear and accept their own mortality. Most have addressed pain and have developed a tolerance. They have had to accept that death comes to us all and that none are immune; they have learned that death often comes abruptly and even violently. When factors in their world sever them from the protective factors of belonging and purpose that the fire service so richly provides, the impact of that separation may be all the more acute and the sense of loss all the more profound. Combine these with the learned capacity of firefighters to overcome fear and pain and the risk for those perceiving themselves as no longer belonging and burdensome to others escalates.

Put more directly, it may well be that firefighting in itself does not increase a firefighter's risk for suicide and may in fact provide some protection. But when those protections, for whatever reason, are weakened and other factors in the firefighter's life serve to compound risk, the capacity to actually take that final action may be greater. Accordingly, it is not necessarily that firefighters die by suicide at greater rates than others but rather that factors known to affect anyone's life can become all the more difficult for a firefighter if the bonds and perceptions that make the occupation so attractive and compelling are lessened or lost. This provides a salient framework from which to consider the roles that fire departments and fellow firefighters can play in prevention, intervention, and survivor support.

Despite much attention and research in the past two decades, our capacity to predict and prevent suicide remains sadly limited. Dr. Alan Berman of the American Association of Suicidology provided a very thorough and detailed overview of our current knowledge with respect to prevention and intervention. Broad based, prophylactic prevention programs show little impact on these ultimate outcomes with respect to suicidal behavior and suicide deaths, though they may offer some impact on awareness and willingness to offer aid among those who might encounter persons at risk. Where success has been found, it has generally come from very specifically targeted programs aimed to generate specific actions among a well-defined set of persons dealing with well-defined risk factors in a well-defined risk group.



Accordingly, the focus for fire service efforts is best directed on the one hand toward developing, promoting, and evaluating programs that deal generally with behavioral issues that impact firefighters and their families, and on the other, to focus specific efforts in suicide prevention on specific, targeted programs designed to identify and effectively refer those at specifically increased risk. Of the Everyone Goes Home® program's 16 Firefighter Life Safety Initiatives, #13 deals specifically with the first and broader element, having generated a number of projects to assist fire departments in providing effective behavioral health programs and to prepare mental health providers in methods to effectively serve firefighting populations. These projects have resulted in a number of evidence supported, professionally developed products that can be accessed without cost at <http://flsi13.everyonegoeshome.com>.

Twenty-five specific recommendations came from the initial symposium, grouped into four general topical areas. The first set addressed issues involved in determining the prevalence of suicide among firefighters, a critical step in developing focused, evidence supported strategies to address suicide and related issues in the fire service. The second set addressed matters specifically related to occupational factors influencing risk so that these could be identified and strategies evolved to direct targeted prevention and intervention efforts. The third set dealt with evidence supported strategies for prevention, screening, and intervention efforts based on current research and best practices, calling for these to be incorporated into both immediate and longer term efforts in the fire service. The final group of recommendations identified actions and priorities for NFFF to address in building its strategy for addressing fire service suicide. The complete list of the recommendations from the First Summit is attached at Appendix A.

## **Second Fire Service Suicide and Depression Summit: Generating Strategies and Materials to Support Suicide Prevention and Intervention in the Fire Service**

**The National Fire Academy (Emmitsburg, MD) October 25-27, 2013**

The Second Fire Service Suicide and Depression Summit convened with the support of an R-13 conference grant from the National Institute of Occupational Health and Safety of the U.S. Centers for Disease Control and DHS/FEMA's Grant Program Directorate for Assistance to Firefighters Grant Program – Fire Prevention and Safety Grants. Approximately forty representatives of fire service organizations interested in suicide, behavioral health, and occupational health issues were invited to the National Fire Academy for this two day program.<sup>1</sup> The sessions focused on building a strategic plan for developing, implementing, disseminating, and evaluating targeted programs for prevention of suicide, screening for suicide risk, intervention with individuals showing acute risk, and support for organizations and coworkers dealing with a suicide among their own.

Dr. Richard Gist of the Kansas City (Missouri) Fire Department served as principal investigator and facilitator for the conference, assisted by NFFF Behavioral Health Consultant Vickie Taylor. Following an overview of NFFF's behavioral health initiatives from Ms. Taylor, Dr. Gist provided a review of the first symposium and its recommendations, and then detailed the

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<sup>1</sup> Attendee lists for each Summit are attached at Appendix B.



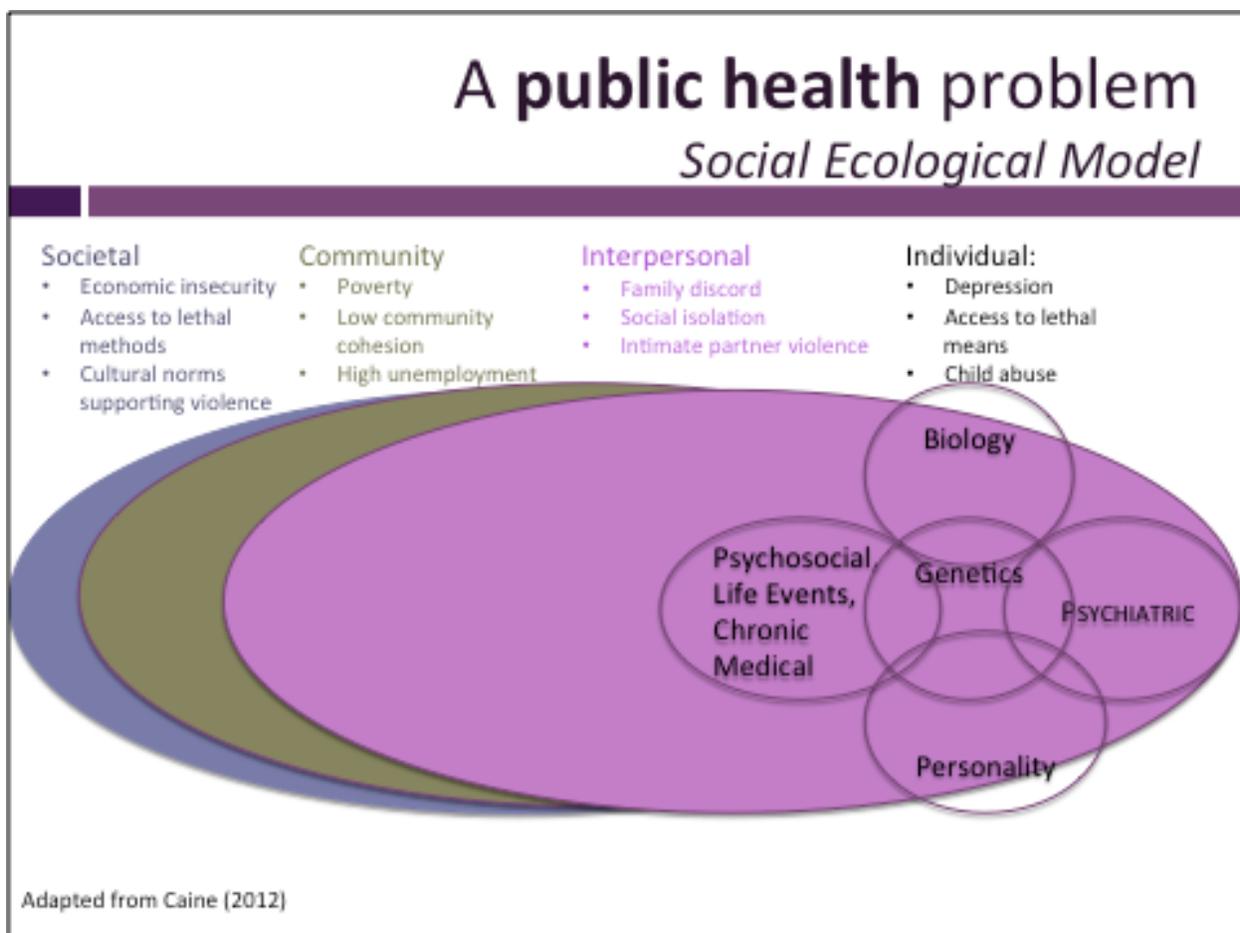
specific objectives for the Second Suicide and Depression Symposium:

- Establish specific intervention points where existing programs can incorporate evidence based approaches to:
  - Education and awareness programming to enhance surveillance and support;
  - Preparation of peers and other potential gatekeepers to identify and effectively refer;
  - Assist FD physicians in screening as a part of annual medical evaluations; and
  - Assist behavioral health assistance programs and clinicians with evidence based interventions for suicide and depression.
- Generate strategies to fund, develop, disseminate, and evaluate projects identified.

### 2013 Subject Matter Expert Presentations

**Dr. Kimberly Van Orden** of the University of Rochester School of Medicine and Dentistry provided a review of current evidence based best practices in suicide prevention and intervention. A longer paper by Dr. Van Orden may be found on the FLSI 13 website<sup>2</sup>.

Suicide is a significant public health problem. Reducing the morbidity and mortality associated with suicide risk will best be accomplished by using a public health—population based—approach. The cornerstone of reducing suicide among a specific population—in this case, the fire service—is an effective surveillance program. This means systematically monitoring and



2 <http://flsi13.everyonegoeshome.com/suicide/VanOrden.pdf>



recording instances of suicide deaths and attempts. A surveillance program is central to a public health approach to suicide prevention and will be a key aspect of a program to reduce suicidal behavior in the fire service.

A public health approach to suicide prevention treats suicide prevention more broadly as health promotion, rather than conceptualizing it more narrowly as a mental health problem. This approach allows researchers, policy makers, educators, and clinicians to target suicide risk factors and suicidal etiological factors at all levels of the social ecological model—the individual, interpersonal, community, and societal levels—and to also use a multi-pronged approach that combines universal, selective, and indicated prevention rather than focusing solely on indicated prevention (i.e., treatment involving working with those with suicide ideation or attempts).

Based on her overview of the current science of suicide prevention, Dr. Van Orden offered the following recommendations for consideration:

1. Utilize a public health approach to suicide prevention, which includes surveillance of suicidal behaviors.
2. Utilize a theoretically grounded approach to suicide prevention; one such theory is the Interpersonal Theory of Suicide, which is relevant to fire service suicide.
3. Utilize a multilayered approach to suicide prevention.

**Dr. Patricia Watson** of the National Center for Post-Traumatic Stress Disorder (NCPTSD) of the U.S. Veterans Administration provided an overview of peer driven programs in military settings with potential applicability to fire service and EMS application. All branches of the military have invested significant time and resources into efforts to mediate and mitigate the impacts of combat, deployment, and military life on their members. As a part of *Everyone Goes Home*<sup>®</sup> program's Firefighter Life Safety Initiative 13, NCPTSD worked with the NFFF to adapt the US Navy/Marine Corps *Combat Operational Stress First Aid* program for dissemination to the fire service known as *Stress First Aid for Firefighters and EMS Personnel*. Stress First Aid (SFA) provides a solid example of how these efforts can be used to advance best practices in fire service organizations

The *SFA model* is an embedded program that lends itself well to inclusion of peer components for suicide surveillance and prevention. Basic elements are intended to be taught to all firefighters and EMTs (*Awareness Level*) while a somewhat more focused training (*Operations Level*), is geared toward company officers. More specific peer roles are developed in a more detailed training program (*Technician Level*) for those who will provide organizational support and liaison elements within the agency.<sup>3</sup>

**Dr. Angela Moreland** from the National Crime Victims Research and Treatment Center (NCVC) at the Medical University of South Carolina provided an overview of innovative new programs to assist both peers and clinicians in developing the information and skills needed to effectively assist fire service organizations and their personnel. In 2013, the NCVC launched a multimedia website, created with support from an Assistance to Firefighters Fire Prevention

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3 A complete overview of Stress First Aid may be found Initiative 13 website: <http://FLSI13.everyonegoeshome.com>



and Safety grant, that provides online training for clinicians to increase their knowledge and skills in order to deliver evidence based treatment to fire service personnel.<sup>4</sup>

Dr. Moreland engaged the group to provide considerable feedback and input regarding ongoing development of the second fire service project directed toward peers and specifically addressing key elements of suicide outreach. This project, also funded through an Assistance to Firefighters Fire Prevention & Safety grant and developed in conjunction with NFFF, represents the initial project in an approach created under Everyone Goes Home® Firefighter Life Safety Initiative 13 and given the working title of PocketPeer™. It is an interactive smartphone app, designed to support skill focused web training in Motivational Interviewing by allowing a fire service peer to have refresher information, screening tools, resource links, referral information, and a wide range of related resources available at his or her fingertips whenever the need may arise.

### **Building an Action Plan**

The American fire service is far from a unitary enterprise. Systems and organizations vary widely in their structure, methods, focus, and priorities. Consistency in standards and operations has been and remains a recognized and often difficult challenge. Compliance with national standards is, in most instances, voluntary and is often partial and/or selective. Authority for action usually resides at the level of the local jurisdiction and successful efforts at progressive change must be adaptable to and embraceable by the wide array of cultures, climates, jurisdictions, and constituencies that make up this incredibly diverse industry. As attractive as the notion may appear, prescriptive agendas for uniform action rarely represent a realistic starting point, even where agreement exists that urgent action is needed.

In public health practice as well, local adaptability is the crux of any effective agenda and local adoption its avenue to impact. A practical tool or two put to effective use will trump the impact of an elaborate machine that never finds its way to the workshop floor. Accordingly, the design of the symposium sought specifically to focus on identifying for development and dissemination specific tools that could meet the following criteria:

- **Effective:** Demonstrated evidence of empirical efficacy in identifying parties at risk, directing persons at identified risk into appropriate treatment venues, facilitating delivery of evidence based interventions, and/or providing support for families and coworkers following firefighter suicides;
- **Applicable:** Able to be translated for effective use in fire service and EMS populations;
- **Executable:** Able to be broadly disseminated by cost effective means without sacrificing outcomes or efficacy;
- **Affordable:** Supportable through available sources of funding and development; and
- **Acceptable:** Compatible with current fire service behavioral health strategies and initiatives.

The remainder of the second Summit was spent in facilitated consensus building to put forward an outline of specific projects and actions to support suicide awareness, surveillance, prevention, intervention, and recovery in fire service settings.

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<sup>4</sup> For more information on free clinician training, see the Helping Heroes website: [www.helping-heroes.org](http://www.helping-heroes.org)



### Setting an Action Agenda

Using the stated objectives as a starting point and employing both the information provided through the expert reviews and the collaborative input of the expert presenters, several specific projects were outlined for development and dissemination under the aegis of Everyone Goes Home® Firefighter Life Safety Initiative 13:

1. NFFF should support specific research to enhance our understanding of suicide in the fire service and should lead the way in knowledge translation projects to bring empirically supported best practices to fire service organizations and personnel.

Limitations of current research into suicide in the fire service continue to hamper efforts to address the problem in sound, empirically supported manners. Where research of potential relevance exists, applicability to fire service organizations and settings is not always clear and adaptation to those settings and circumstances is required. NFFF has been the leading voice in translational research respecting occupational behavioral health in fire service and EMS; it should apply its good offices and efforts to both improving our basic body of knowledge and adapting empirically supported best practices for use in the fire service.

- a. Consistent with recommendations from the first suicide and depression symposium, NFFF should help identify support for specific research efforts dealing with the etiology and epidemiology of firefighter suicide.
  - b. Following its successful approaches with respect to other behavioral health issues, knowledge translation projects should be implemented to identify potentially useful, empirically supported best practices and adapt these for fire service settings and situation.
2. Design, implement, and evaluate a broad, multilayered social marketing campaign (including social media) promoting mutual support and action.

There are multilayered approaches to awareness and action messaging that have been demonstrated to yield statistically significant impact, particularly in certain military organizations where uniform mandates and “top down” dissemination are more feasible than the diversity of the American fire service may allow. Even in these settings, however, implementation presents challenges. Embedded programs that work to enhance social support have shown particular promise for reaching targeted audiences such as firefighters. Programs focused on identification of behaviors indicating risk followed by specific actions to support engagement of professional care have emerged as a best practice approach in several organizational structures and mission settings. Accordingly, efforts to identify compatible elements of established and tested military programs, and to adapt these specific elements for fire service dissemination and implementation, were identified as a major priority for action.





- a. Develop adaptation of Air Force LINK strategy for incorporation into Operations Level component of NFFF Stress First Aid model.
- b. Develop adaptation of Army ACE strategy into Awareness Level component of NFFF Stress First Aid model.
- c. Include the MUSC/NCVRTC developed motivational interviewing and smartphone app in Technician Level component of NFFF Stress First Aid model.

A specific recommendation was made to create a modified version of the Army ACE strategy as part of a wider social marketing effort. The recommended revision was to employ the acronym ACT (ask about intent or ideation; care for the person at risk; take the party to professional help) to emphasize the need for direct and decisive action. Marketing approaches should avoid overstatements or over-specification of issues or actions with emphasis to be placed on the following points:

- a. Anyone is capable of experiencing suicidal ideation.
  - b. Those closest to a person becoming suicidal are best situated to notice changes.
  - c. If you suspect a person may be struggling, reach out to offer help.
  - d. If suicide is a concern, ACT.
  - e. Potential tagline: It takes an act to stop an act.
3. Advocate adding basic mental health screening to NFPA 1582 annual medical evaluation.
- Current standards do not call for screening of mental health status as part of annual medical evaluations. Simple and efficacious screening tools exist for PTSD, depression, and suicide which can be either self-administered and rote scored (as with the 10-item Trauma Screening Questionnaire) or administered with two simple questions by examining practitioner (as with abbreviated version of WHO-5 for depression screening and Wintersteen protocol for suicide screening). Simple, direct screening inquiries by primary practitioners have also been emphasized in recent published studies related to alcohol and substance abuse.
- a. Recommended language should be developed and submitted in the next revision cycle for NFPA 1582 which will be due in 2018. The period for public comment is now open.
  - b. Evidence supported screening instruments and/or protocols should be identified and made available for utilization in annual medical evaluations.
  - c. Model referral protocols should be developed and disseminated, consistent with standards for Behavioral Health Assistance Programs put forward in the 2013 revision of NFPA 1500.
4. Develop, disseminate, and evaluate adaptation of the Wintersteen protocol for primary care screening to be employed by fire department physicians as a specific element of suicide screening and prevention.

A two question simple screen in primary care visits led to a nearly 400% increase in identification and referral of suicidal patients; this is one of few preventive measures with a strong, empirically demonstrated impact. These results were attained and sustained with minimal training effort. Since firefighters are expected to receive annual medical evaluations as mandated by NFPA 1582, incorporation of a similar short screening protocol has the potential to provide significant impact with limited investment of time or resources.



- a. Wintersteen protocol should be reviewed to determine applicability and adaptability for use in firefighter annual medical evaluations.
  - b. If deemed applicable, adaptation should be made with input from fire service behavioral health specialists and selected fire department physicians.
  - c. Pilot testing should be conducted and evaluated in at least three active departments (replicating Wintersteen approach—see <http://pediatrics.aappublications.org/content/125/5/938.full.pdf>).
  - d. If deemed successful, protocol should be disseminated to fire departments and their medical providers for inclusion in annual medical evaluations.
5. Develop, implement, evaluate, and disseminate one or more additional modules for Helping Heroes website covering issues of suicide and depression for clinicians serving fire service populations.

*Helping Heroes* has gained excellent traction in its first months of availability as a resource for clinicians seeking access to straightforward and inexpensive training in evidence based interventions for their fire service clients. It was deemed reasonable and prudent to develop the site further as a resource for that population. Adding one or more elements specific to suicide and depression is a relatively less expensive way to supply appropriate support to clinicians, the ultimate referee in the client flow process from peer recognition to definitive professional care of the suicidal firefighter. It also helps to reinforce connection between clinicians and a specific site for evolving information regarding care of firefighters and their families.

- a. Appropriate material should be identified to support clinicians in providing efficacious, evidence based intervention for suicide and depression.
  - b. Material should be translated into a design for additional modules on the Helping Heroes site.
  - c. Funding should be identified, sought, and secured to develop, implement, and test these additional modules.
  - d. Full scale implementation should include further evaluation elements and social marketing to the targeted clinician population.
6. Material should be developed, implemented, evaluated, and disseminated to support fire departments in addressing the impact of completed suicides within their ranks.

Fire departments experiencing a suicide are often profoundly uncertain of how to react. Guidance in this area has been speculative at best and is often unclear; in too many cases, contradictory opinions are offered and the result is a muted, confused, or marginal response that leaves coworkers distressed or uneasy. Empirically supported guidance has been limited.

- a. A consensus model should be utilized to research current data regarding post-suicide organizational response.
- b. Evidence supported best practices should be identified and evaluated for translation to the fire service setting.
- c. Realizing that no single approach is likely to apply to the wide range of situations and circumstances departments may encounter, resources to assist fire departments should



be developed and made accessible in a simple online format, preferably as part of the FLSI 13 web portal.

- d. Suicide should be included as a topical area in revisions to Taking Care of Our Own® curriculum and support materials to help prepare fire chiefs and fire departments for addressing suicide among their active or retired members.
7. Sample templates should be developed for funeral policies related to suicide deaths among active members and retirees.

Fire departments have specific, detailed, and often elaborate plans for line-of-duty deaths. Even at general population rates, a department is at least three times more likely to experience a suicide in its ranks in any given year. How funeral ceremonies should be handled can become a matter of concern and contention. A plan determined in advance that treats suicide in accordance with other non-duty deaths can help ensure that these difficult decisions are not forced upon the agency and its leadership at a time where emotions and uncertainty can make the decision process all the more difficult.

- a. Model templates should be gathered from a sampling of departments where this issue has been encountered and addressed.
  - b. These templates, along with NFFF guidance, should be available on the web and through Advocates and Funeral Teams.
8. Specific efforts should be directed toward development, dissemination, and evaluation of evidence supported approaches to address suicide among fire service retirees.

Joiner's Interpersonal Theory of Suicide suggests that retirement or other separations from service might enhance risk by separating the firefighter from an occupation that has provided both a high sense of purpose and productivity, and strong bonds of social belongingness and connection. What data do exist also suggest that retirement may be associated with enhanced risk beyond that which accrues epidemiologically with advancing age. Impact of retirement and other transitions should be explored and avenues probed to provide support as indicated.

- a. Fire departments should be surveyed regarding their efforts to address impacts of separations, specifically including injury/disability and retirement.
- b. Programs addressing retirement preparation and retiree support should be identified and explored for impact and utility.
- c. A white paper or similar informational vehicle should be developed for the fire service regarding dealing with career transitions.
- d. Model programs and resources should be made available through the web and through other avenues (e.g., Advocates).



# Attachment A: Recommendations from the First Suicide and Depression Summit 2011

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## Group 1: Determining Prevalence of Suicide in the Fire Service

1. The limited state of current accurate empirical information and understanding regarding suicide in the fire service should be clearly acknowledged in all discussions and presentations on the subject, regardless of source, audience, or objective.
2. NFFF and other fire service constituency organizations should advocate for funding and support of empirically sound epidemiologic study of fire service suicide to provide a solid basis for understanding and action.
3. Researchers working on military projects should be specifically recruited, encouraged, and supported to translate appropriate elements of that research to investigate suicide in the civilian fire service.
4. NFFF and other fire service constituency organizations should advocate funding and support for similar empirically sound epidemiologic study in fire service populations of conditions known to interact with and/or increase suicide risk (e.g., depression, PTSD, conduct disorders, and substance abuse), where speculation regarding prevalence is widespread but data are presently limited.
5. Advocates for action should be cautioned to stick closely to documented empirical findings, in order to avoid inadvertent paradoxical impacts.

## Group 2: Occupational Factors Affecting Suicide Risk for Firefighters

6. Funding and support for empirical testing of applicability, goodness of fit, and utility of the Thomas Joiner's Interpersonal Theory of Suicide with respect to firefighter populations should be widely disseminated and strongly advocated.
7. Elements of belongingness and personal contribution in fire service culture should be explored with respect to the roles that disruption of these factors may play in heightened suicide risk.
8. Approaches to screening and intervention should be developed and tested for use in fire service populations.

## Group 3: State of the Art/State of the Science in Suicide Prevention

9. Intervention programs should be grounded in specific and relevant theory, and should be informed by reliable empirical surveillance data regarding incidence and impact.
10. Prevention programs containing a relatively narrow focus (i.e., suicide specific) appear less likely to yield substantial and sustained impact than do programs directed more generally toward behavioral health, social support, and treatment of disorders and conditions associated with suicide.
11. Programs to provide accessible, low cost instruction for fire service health care and behavioral health providers (e.g., fire department physicians, EMS medical directors, occupational health nurses and physicians, employee assistance providers) in screening for suicide ideation and intent should be developed and widely disseminated.



12. Providers delivering behavioral health care to firefighters and their families should have access to accessible, low cost instruction in evidence based interventions with demonstrated efficacy for treating self-injurious behavior (e.g., CBT, DBT).
13. Peer outreach and support programs, where present, should have access to appropriate training and assistance in addressing suicide as an element of a comprehensive outreach and health promotion strategy.
14. Department level efforts, where undertaken, should represent broad based strategies to impact a range of protective and risk factors, and should be imbedded within a variety of organizational levels and processes.

#### **Group 4: Actions and Priorities**

15. NFFF should incorporate efforts to address suicide into projects of the Behavioral Health Initiative (FLSI 13) of its Everyone Goes Home® project.
16. Efforts of individuals and organizations addressing suicide in the fire service should endeavor to remain consistent with a structured strategic plan of action (parallel to and complementary of the National Strategy for Suicide Prevention).
17. Suicide prevention projects and materials should be outlined and made available in a designated area of the Everyone Goes Home® website. A suicide tagline should appear on all depression and suicide material consistent with the American Society of Suicidology:

***IF YOU ARE IN CRISIS AND NEED IMMEDIATE HELP,  
PLEASE CALL 1-800-273-TALK (8255).***

18. High priority with respect to research support should be given to epidemiologic and surveillance projects in conjunction with established academic research programs, and other granting agencies such as FEMA's Assistance to Firefighters Fire Prevention and Safety Grant program.
19. High priority with respect to research and development support should be given to adaptation of theory driven intervention projects currently underway in military settings for application in the fire service.
20. High priority in program development activities should be given to adaptation of evidence based projects training health care providers serving firefighters and their families in screening and referral.
21. High priority should be given to building a suicide and depression component to complement web based CBT training currently in development for behavioral health providers serving firefighters and their families.
22. Priority should be given to developing suicide prevention aspects into FLSI 13 peer support projects.
23. Materials to support fire departments in integrating comprehensive suicide preventions programs into their health, wellness, and safety initiatives should be developed in conjunction with IAFF, IAFC, NVFC, and USFA.
24. Specific protocols for assisting fire departments after high profile/high impact suicides and/or serial suicides should be developed and implemented by NFFF.



25. Reports of this summit, its proceedings, and its recommendations should be disseminated through the fire service and venues.

***If you are reading this report seeking to help yourself, a family member, or a peer who may be at risk of suicide, please seek assistance immediately. You can consult resources in your community, fire department EAP or other behavioral health professionals. If a crisis is imminent, help is available in the emergency room of your local hospital. Do not leave a person alone if you think they are at risk—seek help and encourage anyone to call the Suicide Hotline to be connected to help in your area:***

***IF YOU ARE IN CRISIS AND NEED IMMEDIATE HELP,  
PLEASE CALL 1-800-273-TALK (8255).***



## Attachment B: Summit Attendees

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### 2011 Baltimore, MD

Ron Acierno, PhD	Medical University of South Carolina
Adams Danny	International Association of Fire Fighters
Michael Beasley	Montgomery County (MD) Fire/Rescue Services
Alan Berman, PhD	American Association of Suicidology
Sandy Bogucki, M.D., PhD	Yale University, National Association of Emergency Medical Physicians
Jim Brinkley	International Association of Fire Fighters
Malacy Corrigan	Counseling Service Unit FDNY
Stacey Daniel	Montgomery County (MD) Fire Rescue Services
Dan DeGryse	Chicago Fire Department, IAFF
Jeff Dill	Palatine (IL) Rural FPD
Hugh Doherty	International Association of Fire Fighters
Rich Duffy	International Association of Fire Fighters
Kevin Gallagher	International Association of Fire Fighters
Richard Gist, PhD	Kansas City (MO) Fire Department
Scott Graham	Montgomery County (MD) Fire Rescue Services
Steve Hess	Prince George's County (MD) Fire/Rescue
Ken Holland	National Fire Protection Association
Tricia Hurlbutt	National Fallen Firefighters Foundation
Thomas Joiner, PhD	Florida State University
JoEllen Kelly, PhD	NFFF
Pat Kenny	Illinois Fire Chiefs Association
Frank Leto	FDNY/IAFF
Tom Miller	National Volunteer Fire Council
James Naifeh	NIOSH
Matthew Nock, PhD	Harvard University
Wendy Norris	Federation of Fire Chaplains
Leonard Orlando	International Association of Fire Fighters
Brain Parks	Phoenix Fire Department
Shannon Pennington	Firefighters Veterans Network
John Prato	Phoenix Fire Dept
Ronald Siarnicki	National Fallen Firefighters Foundation
Tonya Slawinski, PhD	Supportive Solutions Inc
Susan Tamme	International Association of Women in the Fire & Emergency Services
Rob Tapscott	Phoenix Fire Department, IAFF
Vickie Taylor	Prince William County (VA) Fire/Rescue, NFFF
Paul Trumpore	TN Federation of Fire Chaplains



## 2013 Emmitsburg, MD

Bob Baird	United States Forest Service
Sharon Baroncelli	International Association of Women in the Fire & Emergency Services
Bill Baxter	CAL-FIRE
Ronald D. Blackwell	Wichita (KS) Fire Department
Debbie Blalock	Charleston-Dorchester (SC) Mental Health Center
Karen Brack	City of Charleston (SC)
Johnny Brewington	International Association of Black Professional Fire Fighters
Butch Browning	Louisiana Office of State Fire Marshal
Bill Carey	PennWell Public Safety
Dennis Compton	National Fallen Firefighters Foundation
Henry Costo	Philadelphia Fire Department
David Dalberg	The Salvation Army
Maia Dalton-Theodore	Fairfax County Fire and Rescue
Lisa DeMarco-Tilley	Prince William Department of Fire & Rescue
Stacey Daniel	Montgomery County Fire Rescue
Jeff Dill	Firefighter Behavioral Health Alliance
Kate Elkins	Maryland Highway Safety Office
Eriks Gabliks	North American Fire Training Directors
Glenn Gaines	United States Fire Administration
Richard Gist, Ph.D.	Kansas City (MO) Fire Department
Laree Harbour	Montgomery County (MD) School District
Tom Harbour	United States Forest Service
Bobby Halton	Fire Engineering/FDIC
Ronald Heath	Memphis Fire Department
Bill Hinton	National Fallen Firefighters Foundation
Ken Holland	National Fire Protection Association
Angie Hughes	Baltimore County (MD) Fire Department
	International Association of Women in Fire & Emergency Services
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