



Issues of Depression and Suicide in the Fire Service

Meeting Report

July 11-12, 2011 | Baltimore Maryland



Note: This document is a summary of a White Paper on the topic of depression and suicide in the Fire Service. We encourage you to read the entire report [here](#).



Introduction

The American fire service has been rocked in recent years with reports of apparent “suicide clusters” in several large metro fire departments. Chicago, Phoenix, Philadelphia, and other agencies have experienced multiple high-profile suicides in close proximity, sparking a dramatic upsurge in concern for understanding the incidence of suicide in firefighters; what particular factors may leave a firefighter vulnerable; and what avenues are available or can be developed to help firefighters, their co-workers, their departments, and their families to help prevent and recover from these tragic losses.

Increased attention to suicides among firefighters has led to a strong sense of urgency among many fire service organizations, and a heightened desire to take strong and immediate preventive action. However, up until this point there has been very little in the way of strong evidence to shape those responses or guide responsible action.

**Firefighter Life Safety
Initiative #13**

***Firefighters and their families
must have access to counseling
and psychological support.***

As a first step in coordinating industry-wide efforts to address this issue, the National Fallen Firefighters Foundation (NFFF) convened a summit meeting July 11-12, 2011 in Baltimore, Maryland to discuss **Issues of Depression and Suicide in the Fire Service**. The NFFF, as a part of its Firefighter Life Safety Initiative 13 of the Everyone Goes Home® project, has been at the forefront in developing a consensus-driven agenda to focus efforts and resources to address the behavioral health needs of firefighters and their families.

During this meeting, three of the nation’s leading academic figures in the study and prevention of suicide spent two days providing a detailed overview of relevant research to representatives of the nation’s leading fire service constituency organizations, as well as members of agencies which have been directly impacted by suicides (a complete listing of attendees and affiliations can be found in the [White Paper](#)). Participants sought to review the current “state of the science” with respect to understanding suicidal behavior and the current “state of the art” with respect to prevention and intervention. Dr. Richard Gist of the Kansas City (Missouri) Fire Department and the Department of Emergency Medicine at the University of Missouri-Kansas City and Vickie Taylor, Behavioral Health Consultant to the National Fallen Firefighters Foundation, served as facilitators.

The information put forth at this meeting will serve as the basis for development for an evidenced-informed strategic plan to address suicide in the industry and its effects on firefighters, their families, and the organizations and communities they serve. This meeting summary provides an overview of those discussions and recommended starting points for strategic planning of future action related to depression and suicide among firefighters. This overview is a summarization of a longer, more substantive White Paper on the issue. The White Paper, with complete references is available [here](#).



Objectives of the Symposium

1. To evaluate current information on the prevalence of suicide and apply to observed trends in the fire service.
2. To explore the application of best current empirical* models of suicide behavior to fire service personnel, with specific attention to occupational factors that may affect suicidal actions.

*Empirical models are based on scientific experimentation—they are factual, observed and often pragmatic.

3. To examine current best practices in suicide prevention and intervention, with specific emphasis on empirical evidence of effectiveness, and impact.
4. To consider options available to the fire service to take reasonable and prudent actions to prevent suicide and to assist survivors when suicide occurs.
5. To plan strategies and mechanisms to translate identified best practices and prevention/intervention options into programs that can be disseminated and applied in all segments of the fire service.

Subject Matter Experts

Matthew K. Nock, Ph.D., a 2011 MacArthur Fellow, is Professor of Psychology and Director of the Laboratory for Clinical and Developmental Research at Harvard University. Among the nation's leading authorities on the epidemiology of suicide and self-injury, his research is multi-disciplinary in nature and uses a range of methodological approaches (e.g., epidemiologic surveys, laboratory-based experiments, and clinic-based studies) to better understand how these behaviors develop, how to predict them, and how to prevent their occurrence.

Thomas Joiner, Ph.D. is the Robert O. Lawton Distinguished Professor in the Department of Psychology at Florida State University. He leads one of the nation's most respected and most productive research programs tackling the etiology of suicide and the effective prevention of suicide behavior. He has published scores of books, papers, and reports in both academic and popular media, and leads a multimillion dollar effort examining prevention of suicide among military personnel.

Alan L. (Lanny) Berman, Ph.D. is Executive Director of the American Association of Suicidology and president of the International Association for Suicide Prevention. He has also served as Director of the National Center for the Study and Prevention of Suicide at the Washington School of Psychiatry (1991-1995) and a Professor of Psychology at American University (1969-1991). He stands among the nation's most respected commentators on contemporary best practices in suicide prevention and intervention.



Expert Presentations

Below is a summary of the expert presentations from Issues of Depression and Suicide in the Fire Service. PowerPoint presentations are available for review [here](#).

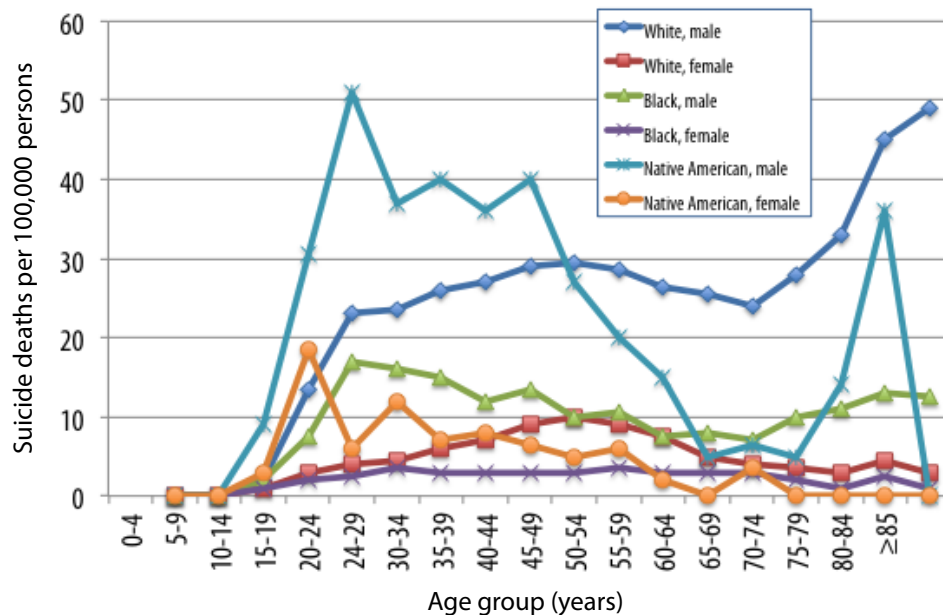
Recent Advances in the Understanding of Suicide and Self-Injury

Matthew Nock, Ph.D.

A leading academic researcher on the topics of suicide and self-injury, Dr. Nock asserts that even at a global population level, the prevalence and spread of suicide is difficult to assess. The terminology and definitions pertaining to the subject matter can vary widely, and data repositories are not always complete or complementary. Still, enough is known to be able to classify suicide as a serious public health issue in the United States and elsewhere.

Among white males, the dominant demographic in the American fire service, suicide rates rise abruptly in the early twenties—a typical age for entering the occupation, especially in career service. Rates trend slowly upward throughout typical working years, spiking once again at the time of typical retirement. More than 70% of US suicides are among white males. Figure 1 shows rates by age for a variety of demographic groups.

Figure 1. Numbers of suicide deaths in the United States by race/ethnicity, sex, and age group 2005.



Nock M et al. Epidemiology Review 2008; 30:133-15.

The use of firearms is the most common method of completed suicide, with approximately 57% of all suicides by gunshot. Firearms account for almost two-thirds of male suicides and slightly more than one-third of suicides by women. Poisonings, primarily intentional overdoses of prescription or over-the-counter pharmaceuticals, account for slightly more than 30% of female suicides. Among males, hanging and suffocation (20%) are more prevalent. Incidence of suicide tends to spike during the spring and early summer months.



Obviously, suicide fatalities are not a viable group for study; in some cases details can be inferred through a “psychological autopsy,” but there are often lingering questions remaining that pertain to the individual’s personal journey. Typically, the progression to suicide flows from suicidal ideation (thinking of or envisioning suicide) to creating a plan to action, though some completed suicides are enacted without the known presence of a premeditated plan. Among the US population, lifetime prevalence for ideation has generally been found to range from 5-14%; 34% of those with ideation form plans and 72% of those with plans proceed to an attempt. It should be noted, however, that 26% of persons with ideation but no plan proceed to make an unplanned attempt. Also important, the majority of transitions from ideation to action take place within the first year after onset.

There is some consistency in ideation, in that it is more likely to be found among those with depression, anxiety, conduct disorders, and substance abuse; transition from ideation to attempt is more than twice as likely among those with anxiety disorders such as Post-Traumatic Stress Disorder (PTSD) and conduct disorders, and almost three times as likely in the presence of alcohol abuse or dependence. A number of other conditions or active stressors may also exacerbate this progression.

Dr. Nock has done extensive research in other areas of self-injury and suicide. These are more fully discussed in the [White Paper](#).

The lack of data pertaining to suicide among firefighters was discussed extensively during Dr. Nock’s presentation and throughout the conference. Despite the level of concern in the fire service and the perceptions of an escalating problem, ***very little is actually known about suicide rates among fire service personnel***. Death certificates often do not reflect data regarding occupation, making it difficult to track these data or to define relevant trends—especially regarding volunteer members. Since the American fire service contains a very substantial volunteer component, even those states with partial occupational data are not likely to fully or accurately reflect fire service affiliation. Similar difficulties exist regarding attempting to capture occupational data for retired firefighters.

It will not be easy to capture this data. A 2002 study conducted by Dr. Nock of suicide among New York police officers required labor-intensive work to investigate death records. Despite perceptions of escalating suicide rates among retirees, what increases were documented paralleled expected increases within an aging white male cohort and remained below expected rates for similar cohorts of the general population. A similar pattern may exist in the fire service, where the occupation is even more strongly dominated by an aging white male age group. Efforts to investigate this in depth, however, have not yet been undertaken.





Interpersonal Theory of Suicide—Why?

Thomas Joiner, Ph.D.

According to Dr. Joiner, suicide is not a condition or disorder, but rather an outcome that may result from the presence of many risk factors, including underlying conditions, individual dispositions, interpersonal dynamics, social interactions, and other factors. Finding commonalities that can lead to successful intervention requires the development of a conceptual framework that promotes understanding of the pathways from experience to ideation, from ideation to intent, and from intent to action.

During his presentation, Dr. Joiner summarized his ***Interpersonal Theory of Suicide*** in simplest terms by saying people die by suicide “because they want to and because they can.” He describes three essential conditions involved in generating motivation for suicide and the capability to act on that motivation.

- a) ***Thwarted belongingness*** is the belief that one is alone, without connection or having lost the connections one felt to be essential to meaning, purpose, or sense of self; it is the feeling that one is no longer an integral part of family, friends, workplace, or other relevant index groups.
- b) ***Perceived burdensomeness*** arises from the perception that one’s continued existence creates a drain on family, friends, coworkers, or even society. Inherent in that belief is the perception—almost invariably a misperception—that the world would be a better place if one were no longer a part of it.

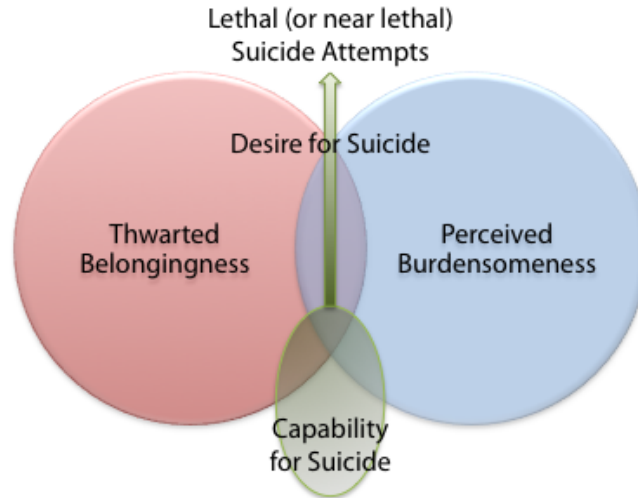
When these perceptions exist within a person, the result readily becomes a desire to die and suicidal ideation is, essentially, a natural consequence. But the desire to die, even in the presence of persistent ideation and a suicide plan, is usually not sufficient to precipitate suicide behavior. Moving from thought to action demands the capacity to carry out an act that is contrary to the most basic instinct of living things—the drive for self-preservation.

- c) ***Capability for suicide*** is found where some combination of experience and disposition becomes sufficient to overcome one’s natural aversion to pain and annihilation. This may result from a learned capacity to ensure or ignore pain through repeated exposure and/or habituation; progressive disinhibition through prior attempts, exposure to combat or violence; the modeling effects of suicide in others; or any of a number of routes and vectors. This capability must, however, be present for ideation to evolve into action. In other words, *the power of the suicide taboo weakens.*

Among the general population, the capability for suicide is typically the limiting factor in transition from ideation (thinking about suicide) and planning to lethal action. Firefighters, however, are regularly exposed and become accustomed to pain and to the inevitability of death. Firefighting exceeds most other occupations in frequency of occupational injury; moreover, death is a frequent feature in situations firefighters encounter in the normal course of their duty, and loss of one’s own life is an ever-present, and even culturally accepted occupational risk. These factors can compel firefighters to come to terms with their own mortality in ways that vary greatly from the general population, and as a consequence, the capability for suicide among firefighters may be further evolved, whether or not desire or ideation may be present.



Figure 2.



Joiner, T. (2005) *Why People Die By Suicide*. Cambridge, MA: Harvard University Press.

It is only within a narrow intersection set (Figure 2) between these three conditions that an individual has the capacity for lethal suicidal action. An abundance of information supports this theory for understanding and predicting suicidal action, and it has proved useful in helping to target efforts to prevent suicide in particular populations. The possible adoption of this theory in the understanding the particular risks presented by a firefighting career merits further research.

Belongingness and personal contribution—opposites of the conditions that must theoretically be present to create a desire for suicide—are generally accepted as strong elements of fire service culture. Firefighters are extraordinarily committed to their jobs and their roles within the community, and central to those roles is a placing of a high value on service to others and a firm belief that one’s contribution in that role gives life meaning. The entire concept of “brotherhood” permeates occupational life in the fire service, and emphasizes how critical belongingness is to the profession. Accordingly, since perceived contribution and brotherhood are paramount values and rewards for those in fire service and the very nature of the occupation promotes tolerance of pain and habituation of fear, the intersection—when it in fact occurs—may be even more profound for a firefighter.

There are obvious potential implications arising from application of this theory to suicide among firefighters. Heightened risk can be suggested wherever factors interrupt or diminish belongingness (e.g., retirement, separation) or diminish perceived contribution (e.g., injury or disability, impact of escalation of depression or substance abuse). Intervention efforts centered on those affected by such risk factors seem obvious starting points for intervention.

Dr. Joiner also stressed that the lack of acknowledgement of suicide within the fire service was problematic. There are obviously cultural barriers to seeking help, in particular the stigma that is attached to the issue. While stigma can generally be characterized as fear + ignorance, unfortunately in de-stigmatizing suicide, there can also be a paradoxical effect of making people unafraid. Thus, in terms of overall education efforts the goal is to remove the ignorance surrounding the issue, but maintain some level of fear—and distance—from it.



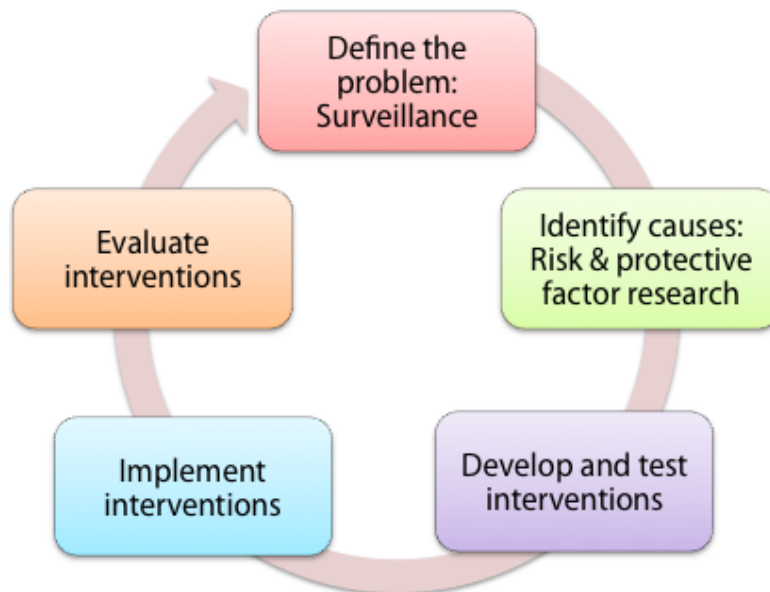
Suicide Prevention/Interventions

Dr. Lanny Berman, Ph.D.

Dr. Berman discussed the enormous social and financial impact that a single suicide or suicide attempt can have on a community, including contagion, economic impact, liability or negligence, and the long-lasting effects on survivors, discoverers, and witnesses. He also stressed that in general, prevention is less costly than intervention.

So how does the fire service go about determining what will be effective prevention/intervention mechanisms? Using the public health model for prevention (Figure 3), the appropriate next step involves the establishment of effective surveillance mechanisms. As was discussed repeatedly during this meeting, **collecting data to accurately identify the problem will facilitate the accurate identification the problem**, and thus establish a basis for determination of appropriate prevention/intervention efforts that can be targeted to vulnerable individuals or populations.

Figure 3. The Public Health Approach to Prevention

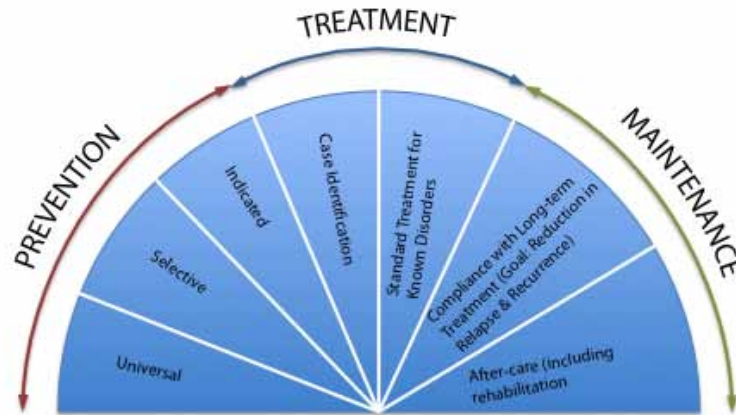


Suicide Prevention: The Public Health Approach. Suicide Prevention Resource Center.
<http://www.sprc.org/library/phasp.pdf>

Logically, the starting point for any type of prevention initiative will lie in the examination of approaches seen as current best practices, assessment of their proven success, and consideration of their potential for adaptation to address fire service specific risk factors impacting suicide. Intervention efforts are typically classified under several levels of the Institute of Medicine *Spectrum of Mental Health Interventions* (Figure 4).



Figure 4. Spectrum of Mental health Interventions



Muñoz, Ricardo F. et al. Institute of Medicine report on prevention of mental disorders: Summary and commentary. *American Psychologist*, Vol 51(11), Nov 1996, 1116-1122.

- *Universal* approaches are directed toward entire populations in relatively unselected fashions with the objective of impacting incidence.
- *Selective* interventions are more targeted, typically to those identified at risk and/or those likely to hold or encounter specific risk factors.
- *Indicated* interventions are directed to those showing identifiable symptoms but not yet displaying the targeted injury or disorder (often as the result of specific screening efforts).
- Other elements in the treatment and maintenance components are relevant to those with expressed ideation or those who have attempted suicide while after care aspects may be argued to be applicable for survivors.

In the past, the public health field has devoted significant resources into developing an evidence-based approach to a coordinated suicide prevention strategy. However, evidence for the lasting impact of such universal programs (such as resiliency training) appears to be limited. **Caution must also be demonstrated here, because some broader-scale efforts, especially ones connected to “awareness” strategies, have been demonstrated to hold the potential for increasing the probability of suicidal action, particularly in vulnerable individuals.**

Dr. Berman continued that significant levels of investment have also been made in research, program development, implementation, and evaluation at the selective and indicated levels of the prevention continuum. Indicated preventive measures typically include specific screening and referral measures. Most suicide prevention efforts focus on identifying those at risk, and the screening for suicide risk factors by primary care providers among their patient populations has demonstrated efficacy, and adapting existing training programs for use by occupational health physicians should be explored.

There are currently several acronym models for screening based on factors and characteristics known to be associated with suicidality have been proposed and are in common usage (e.g., “SAD PERSONS” and “IS PATH WARM”).

**(IS PATH WARM model)**

- I**deation/threatened or communicated
- S**ubstance abuse/excessive or communicated

- P**urposeless/no reason for living
- A**nxiety, agitation, or insomnia
- T**rapped
- H**opelessness

- W**ithdrawal from friends, family, society
- A**nger (uncontrolled)/ rage/seeking revenge
- R**ecklessness/risky acts-unthinking
- M**ood changes (dramatic)

Selective and indicated prevention programs, particularly those directed toward individuals with histories of depression and/or substance abuse, are promising in light of the fact that 86% of those who made at least one suicide attempt had previously been diagnosed with one or more psychiatric disorders. These disorders may be affected by appropriate treatment interventions—the burden of major depression can clearly be alleviated by treatment—and may reduce the risk of suicide. Alcoholism is a particularly troubling condition, in that alcoholic intoxication increases lethality, increases impulsive behavior, and exacerbates depression.

There is also significant optimism involving the use of alternative strategies that accentuate or enhance “protective” factors in individuals with some demonstrated risk factors. Dr. Berman stated that in such individuals, focusing on preventive factors—such as emotional well-being, connectedness, and/or therapeutic alliance with a skilled clinician—may be the most effective way to prevent suicide. Building protection, and building it early, may also be important. Follow up procedures, such as keeping retirees engaged in the department community, have also shown a positive preventive effect. However, for those at the highest risk, these factors may not influence the pathway from ideation to planning to implementation.

Only one approach to selective or indicated prevention has been proven effective, and that involves the restriction of access to lethal means. Restricting access to firearms for all possible actors, or at least those with clear risk factors or stated intent, will obviously interrupt the transition from thinking to action. Other programs, such as suicide barriers along places known for fatal jumps provide documented examples of successful strategies. However, **firearms are the leading instrument of suicide in the United States, especially among white males, and by far the leading instrument in known fire service suicides.** Within the United States, the discussion of restriction of access to firearms raises Constitutional issues and is unlikely to receive widespread recommendation.

Appropriate interventions for those identified and referred are not well established. Standards currently exist for treatment of depression and other mental disorders associated with suicidal behavior. Variants of *Cognitive Behavioral Therapy* (CBT) show the most support, but may not be currently be readily available to firefighters. However, Medical University of South Carolina (MUSC), as a component of the NFFF's Initiative 13 efforts, is adapting an online platform



to train clinicians to provide CBT to firefighters following their exposure to a potentially traumatic event. Particularly recalcitrant cases, especially those with borderline features, have been successfully treated with *Dialectical Behavior Therapy* (DBT, a specific CBT variant) in a range of studies. The MUSC website for clinician support is expected to be posted in 2012.

The area of after care for survivors is particularly relevant for the fire service. The tightly knit brotherhood characteristic of firefighters is clearly disrupted by a suicide in its midst. Since alienation and withdrawal typically precede a suicide, the impact is often confused by ambivalence and guilt over prior treatment and/or lack of intervention by co-workers. Given the association of suicide with issues such as substance abuse, conduct disorder, and other conditions that negatively affect interpersonal relationships, there may be a history of strained interactions. Moreover, since the brotherhood within any given fire service organization is such that most everyone knows, has had interaction with, and/or is somehow connected to any other member, awareness of such events and circumstances is inescapable. The resulting accusations, blame, and speculations about responsibility can take many forms and will invariably prove counterproductive to individual and organizational resolution.

“Contagion” or “clustering” effects can be one consequence of these social factors. The visibility of a suicide and its aftermath can provide a modeling effect of sorts to other vulnerable individuals, making the suicide option seem more concrete and more “doable.” This both lessens inhibition and increases “suicide capability.” The effects of serial suicides on a given department are obviously enormously disruptive to its social fabric and may generate impetus and urgency with respect to large scale intervention efforts. While the drive to take action may be seen as a positive force, clear courses for positive action have not been readily available and some routes that may seem positive may in fact be paradoxically not so. Such efforts must be undertaken with the greatest care.

Peer-focused intervention approaches are widely established within fire departments. However, there is no clearly established most effective structure for these programs and their success in such situations has not been well established. Psycho-education elements, a typical core element of peer efforts, have similarly shown only limited success and only in relatively narrow applications and populations. Their greater benefit may be found in social support, which has been shown to be beneficial with respect to suicide contagion.

Comprehensive programs with the most promise seem to have broader objectives than suicide prevention alone, and are typically imbedded simultaneously in a range of organizational processes. The Air Force “ACE” suicide prevention program (<http://www.af.mil/suicideprevention.asp>) is one such multilayered model. It acknowledges that reducing suicide requires a community effort, and contains 11 components that range from surveillance systems and psycho-education to leadership and community support. Empirical support for sustained impact has recently been reported, but the need for continuous management of all aspects is stated as being a specific challenge.



Group Discussion & Recommendations

After the three subject matter experts made their presentations, participants discussed how the the information presented could be melded into a series of initiatives to help the American fire service construct a set of evidence informed, best practice approaches to addressing suicide and depression among firefighters. Group discussion was devoted to identifying options and priorities, and centered on generating starting points for appropriate action based on information provided during the expert presentation. The recommendations on the following pages reflect the general consensus of the group.

Again, for broader discussions of the presentations by Drs. Nock, Joiner and Berman we urge you to read the entire [White Paper](#).





Recommendations:

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.

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.

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 provides) 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.

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 Fire Act Grant (Fire Prevention and Safety Grants).
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 prevention 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 fire service media and venues.

**IF YOU ARE IN CRISIS
AND
NEED IMMEDIATE HELP,
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EVERYONE GOES HOME[®]

FIREFIGHTER LIFE SAFETY INITIATIVES

1. Define and advocate the need for a cultural change within the fire service relating to safety; incorporating leadership, management, supervision, accountability and personal responsibility.
2. Enhance the personal and organizational accountability for health and safety throughout the fire service.
3. Focus greater attention on the integration of risk management with incident management at all levels, including strategic, tactical, and planning responsibilities.
4. All firefighters must be empowered to stop unsafe practices.
5. Develop and implement national standards for training, qualifications, and certification (including regular recertification) that are equally applicable to all firefighters based on the duties they are expected to perform.
6. Develop and implement national medical and physical fitness standards that are equally applicable to all firefighters, based on the duties they are expected to perform.
7. Create a national research agenda and data collection system that relates to the initiatives.
8. Utilize available technology wherever it can produce higher levels of health and safety.
9. Thoroughly investigate all firefighter fatalities, injuries, and near misses.
10. Grant programs should support the implementation of safe practices and/or mandate safe practices as an eligibility requirement.
11. National standards for emergency response policies and procedures should be developed and championed.
12. National protocols for response to violent incidents should be developed and championed.
13. Firefighters and their families must have access to counseling and psychological support.
14. Public education must receive more resources and be championed as a critical fire and life safety program.
15. Advocacy must be strengthened for the enforcement of codes and the installation of home fire sprinklers.
16. Safety must be a primary consideration in the design of apparatus and equipment.

Learn more at www.EveryoneGoesHome.com

Funding provided by the Department of Homeland Security, Assistance to Firefighters Grant, and the generosity of Fireman's Fund Insurance Company.



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