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In the wake of suicide: Developing guidelines for suicide postvention in fire service

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ABSTRACT
This project aimed to develop a standard operating procedure (SOP) for suicide postvention in Fire Service. First, an existing SOP was refined through expert review. Next, focus groups were conducted with fire departments lacking a peer suicide postvention SOP; feedback obtained guided revisions. The current article describes the iterative process used to evaluate and revise a Suicide Postvention SOP into a Postvention guideline that is available for implementation and evaluation. Postventions assist survivors in grief and bereavement and attempt to prevent additional negative outcomes. The implementation of suicide postvention guidelines will increase behavioral wellness within Fire Service.

According to Crosby and Sacks (2002), approximately 400 people are exposed to the aftermath of a single suicide and as many as one in 30 exposed to suicide may be significantly and negatively affected, resulting in approximately 13 survivors from each suicide. Most concerning for the survivor is an adverse reaction that may exacerbate their own suicidal ideation and/or behaviors (Jordan & McIntosh, 2010). For example, Hedstrom, Liu, and Nordvik (2008) found that men who lost a coworker to suicide were 3.5 times more likely to die of suicide than those without exposure. Moreover, specific to firefighters, recent reports of suicide clusters in fire service (e.g., Armstrong, 2014; Finney, Buser, Schwartz, Archibald, & Swanson, 2015; Gliha, 2010; Miller, 2015; Peluso, 2010) underscore the importance of prevention, postvention, and intervention strategies.

Firefighters have a unique culture, in part because they work in 24–48 hr shifts, living together at the station. In this sense, they form a culture different from other occupational groups. Military culture shares some of the features of fire culture in that high exposure to possible trauma, and cohabitation in shifts are common factors, yet most firefighters stay in service for longer than military, with professional firefighters frequently retiring with 25 years on the job.

Because of the nature of the job, many of the 1.1 million firefighters in the United States are routinely exposed to high levels of traumatic and occupational stress (Beaton & Murphy, 1993; Haynes & Stein, 2014; Kimbrel et al., 2011), both of which are associated with mental health problems such as PTSD, alcohol use, and depression (e.g., Byrne & Espnes, 2008; Corneil, Beaton, Murphy, Johnson, & Pike, 1999; Kimbrel et al., 2011; Murphy, Beaton, Pike, & Johnson, 1999; North et al., 2002; Tak, Driscoll, Bernard, & West, 2007). Of most relevance to the current project is that these disorders are associated with increased risk for suicide (e.g., Cougle, Keough, Riccardi, & Sachs-Ericsson, 2009; Kessler, Borges, & Walters, 1999; Nock et al., 2009). Thus, the stresses of the job and frequency of these high-risk disorders among emergency responders has led to the rising concern about suicide in fire service (Armstrong, 2014; Dill & Lowe, 2012; Finney et al., 2015; Gliha, 2010; Miller, 2015; Peluso, 2010).

Although the exact rate of suicide in firefighters is not currently known (Gist, Taylor, & Raak, 2011), the National Fallen Firefighters Foundation has acknowledged that suicide is a serious problem in fire service (National Fallen Firefighter Foundation, 2014). In fact, they estimate that a fire department is three times more likely to experience a

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suicide death than a line-of-duty death just based on the general population rate of suicide (National Fallen Firefighters Foundation, 2014). In addition, Dill and Lowe (2012) found that 25.1% of firefighters had considered suicide during their career and 12.1% had made a suicide plan. These numbers are significantly higher than the prevalence found in the general population (Nock et al., 2008; Weissman et al., 1999), highlighting the importance of creating postvention guidelines to help firefighters deal with suicide loss within the department.

In fact, the National Action Alliance for Suicide Prevention: Clinical Workforce Preparedness Task Force (2014) has recently released national guidelines on suicide prevention for those who work with persons at risk for suicide, which note that the Suicide Attempt Survivors Task Force and the Survivors of Suicide Loss Task Forces are also in the process of developing suicide postvention guidelines.

Indeed, there is growing recognition that fire departments must be prepared to intervene on behalf of those left behind when a firefighter dies by suicide (Rawles, 2003), as personnel are vulnerable to complicated grief. The bereavement process for a suicide survivor is very different from normal bereavement associated with other forms of death. Society often reacts to suicide with judgment, criticism, and blame toward the deceased and survivors (Cvinar, 2005; Dyregrov, 2011; Rawles, 2003). Postvention responses are designed to restore functionality and reach affected members who may feel some responsibility. Postvention should facilitate grief and mitigate the impact of the trauma to prevent future suicides (Berkowitz, McCauley, Schuurman, & Jordan, 2010). To facilitate grief, survivors need to feel supported without feeling judged to integrate the loss into their lives (Hurtig, Bullitt, & Kates, 2010). Cerel, McIntosh, Neimeyer, Maple, and Marshall (2014) suggested that community-level postvention be provided to anyone who has been exposed to the suicide, because we cannot yet accurately predict who among the exposed will experience more long-term reactions.

McMenamy, Jordan, and Mitchell (2008) studied the needs of suicide survivors and found that many experienced distress and suffered from feelings of guilt, anxiety, and depression. These reactions were exacerbated by social difficulties stemming from the survivor's hesitancy to talk about the suicide, yet many participants reported peer support to be beneficial (McMenamy et al., 2008). Firefighters commonly cope by using social support, depending on leaders, relying on past trainings, and using available rituals (Fullerton, McCarroll, Ursano, & Wright, 1992; Lyons, 1991; Regehr, Hill, & Glancy, 2000). Given the draw that firefighters have to their peers, peer support interventions are a logical response for suicide postvention. However, peer postventions have not been widely implemented because most postsuicide interventions have been conducted by professionals (Barlow et al., 2010).

Barlow et al.'s (2010) study on a peer suicide postvention illustrated positive outcomes for both the peers leading the group and the participants. This study assessed helpfulness of peer support, comfort level of the participants, whether participant expectations were met, and how the program affected participants' grief and healing. Participants rated all sessions as helpful and comfortable, while suggesting that talking to someone who understands his or her situation and can share coping strategies contributed to these ratings. Participants' levels of despair, blame, and anger all decreased following the program, whereas scores on personal growth increased. This study highlighted the benefits of peers collaborating with professionals to provide postvention services (Barlow et al., 2010). Based in part on the literature for postvention and the empirical basis of peer-support, the New York City Fire Department (FDNY) developed an excellent peer standard operating procedure (SOP). The objective of the project described here was to subject the FDNY SOP to an iterative process in order to develop a national guideline for suicide postvention.

Methods

Expert review

In Phase 1 of the project, our internal grant team composed of three clinical experts and two peer experts reviewed the original FDNY SOP for postvention. The original SOP covered notification procedures and response procedures, including immediate response, operations, and follow-up. Next, an expert review group was used to gather additional suggestions for improvement to the manual. This group was convened on a single day, consisting of two officers, one line-duty firefighter, a social worker within the Family Assistance Unit, and a medical doctor in Health Services, all members of the FDNY. Thus, there were a total of five participants, including one female. Each expert reviewer had a minimum of 2 years' experience in fire service.

Participants were given the initial SOP and asked to speak candidly about their reactions to the material. The group meetings were recorded, and notes of specific suggestions were summarized from the audiotapes. The expert review group discussed going more in depth in many areas of the FDNY SOP as well as adding more information and procedures. Responding to the family and responding to the department members were major themes in the discussion. The valuable information

gained from the expert review group was used to expand the original SOP from two to 14 pages.

Focus groups

The research team then took the outline of topics from the expert review group and created an expanded and revised SOP that also included educational information on suicide and postvention. Editing occurred over 2 months, and when consensus was reached within the research group that all feedback had been satisfactorily incorporated into the expanded document, Phase 2 of the project commenced. Three test cities, each with solid peer programs but no current SOP for suicide postvention, agreed to participate in the study.

To be included, participants interested in the study must have been a firefighter at some point during their career. Firefighters also needed to be willing to learn about suicide postvention procedures and practices and able to complete all study procedures. Firefighters were excluded from the study if they (a) were unable to complete the study procedures; (b) exhibited psychotic symptoms, evidenced current suicidal behavior or current ideation, evidenced current alcohol or substance abuse, or evidenced severe organic impairment at the time of the assessment, as these issues would be expected to interfere with the assessment and training procedures; or (c) were currently awaiting the outcome of litigation involving exposure to traumatic events through the fire department. Participants were given the SOP draft (by e- or snail-mail) prior to the focus group. The 90-minute focus group was manual-guided and co-led by a firefighter and a counselor skilled in fire service culture. All groups were videorecorded. After the focus groups, the tapes were transcribed and themes were identified. Themes that had concurrence between the groups in each city were added to the SOP manual, and the next city was given the edited manual. Six focus groups within the three test cities reviewed the SOP manual and provided feedback on the barriers to implementation, using the same focus group format. In all, 61 participants were recruited for Phase 2 of this study.

As can be seen in Table 1, the sample was 75.4% male, with a mean age of 47 years ($SD = 7.0$). Participants were 22.9% Hispanic, 9.8% African American, and 72.1% Caucasian. Rank in fire service ranged from line-duty firefighters through Staff Chief (54.1% firefighter, 16.4% Lieutenant, 9.8% Captain, 6.6% Battalion Chief, 1.6% Staff Chief, 6.6% Fire Marshal, 4.9% administration). Most participants had completed high school (mean education: 14.5 years; range 10 to 20 years), and 68.8% were married or cohabitating. Notably, all participants had witnessed or learned about at least one suicide attempt or completion in their lifetime and 75.4% of participants had known at least one firefighter co-worker that had attempted or completed suicide. Thus, focus group participants were in an excellent position to provide feedback regarding the development of a suicide postvention protocol.

In Phase 2, the first two focus groups in City 1 provided the research group with much valuable feedback. They suggested making the SOP more operational and directive and breaking it up into two separate documents, one that contained the educational material and one that was more specific to the nature of an SOP. They also suggested calling it a guideline rather than an SOP, since every department is different and will mold it to fit their needs. These were the largest modifications made at this stage. Next, the focus groups in City 2 received copies of both the SOP used in City 1 and a copy that had been revised by the research team based on the feedback from City 1. These groups approved the changes made after the City 1 focus groups and suggested many smaller modifications. After this, the focus groups in City 3 received copies of an SOP that was revised to incorporate City 2's suggestions on top of those from City 1. City 3 suggested a few minor changes. Both the focus groups in Cities 2 and 3 suggested shortening the educational materials into a pamphlet format. After these last two focus groups,

Table 1. Demographic characteristics of the focus groups ($n = 61$).

Characteristic	City 1 ($n = 24$)	City 2 ($n = 22$)	City 3 ($n = 15$)	All participants ($N = 61$)
Age (*M* years ±*SD*)	43.7 ± 6.2	49.3 ± 6.3	48.3 ± 7.7	46.7 ± 7.0
Female	54.2 (13)	4.5 (1)	6.7 (1)	24.6 (15)
Caucasian	79.2 (19)	77.3 (17)	53.3 (8)	72.1 (44)
African American	8.3 (2)	18.2 (4)	0.0 (0)	9.8 (6)
Latino	41.7 (10)	4.5 (1)	20.0 (3)	22.9 (14)
Years of education (*M* years ±SD)	15.0 ± 1.9	13.8 ± 2.2	14.7 ± 1.5	14.5 ± 2.0
Married or cohabitating	58.3 (14)	81.8 (18)	66.7 (10)	68.8 (42)
Rank				
Firefighter	41.7 (10)	45.5 (10)	46.7 (7)	44.3 (27)
Officer	50.0 (12)	22.7 (5)	20.1 (3)	32.7 (20)
Fire Marshall	0 (0)	0 (0)	13.3 (2)	3.3 (2)

Note: Data presented as % (n), except where otherwise noted.

the feedback was incorporated into the final version of the SOP guidelines with supplementing educational materials.

Results

After the focus groups were completed, the feedback from the firefighters was used to create the final version of the SOP guideline (see the appendix), which was designed to reduce the trauma of the loss, reduce stigma, increase firefighter coping skills, and prevent cluster suicides among firefighters. The final version of the SOP is broken into several sections. The first section discusses notification procedures, where we recommend that departments follow chain-of-command and existing policies. We further recommend that firefighters should be briefed as soon as possible and provided with resources, referrals, and helpline numbers for themselves and others, as well as directions on how to help the family and each other. Finally, we recommend that if the family provides permission, the facts of the suicide should also be clearly stated so as to limit rumors.

The next section of the SOP guideline determines who will be involved in the department response to the suicide. We recommend that a leader be appointed to coordinate the response. We further recommend appointing a liaison for the families and a team of support for liaisons and firefighters who need help dealing with the loss. All key departmental teams should be given specific duties and directions for their part of the response.

Section 3 of the SOP guideline discusses how response to the suicide will differ depending on whether or not the suicide took place in quarters or out of quarters. In the event that the suicide takes place in quarters, we recommend that the response be treated like any other type of emergency situation (i.e., call 911, assess vitals, attempt resuscitation, etc).

Section 4 considers how the department should respond to the family. We recommend that one or two people be assigned as liaisons for the family. We further recommend that a document outlining what financial benefits the family will receive after the suicide be prepared ahead of time. Ideally, the funeral would be no different from a Member of Service funeral and members should be encouraged to attend.

Section 5 describes procedures for responding to firefighters in the both short term and long term. We recommend that the department determine the "family tree" of firefighters close to the member who died of suicide, in order to provide mental health resources to those who may be most vulnerable. We further recommend that several different methods of follow-up be provided in order to maximize the probability that the affected firefighters will seek out mental health resources if they need them.

The last section of the SOP discusses concluding the postvention, including setting up meetings with firefighters and family members to have closing discussions, to ensure that sufficient resources are currently available, and to set up future check-in times by peer counselors and team leaders. We further recommend that it should be made clear that grief following suicide can take a longer time to process and that help will be available at any time.

Finally, based on the suggestions from Cites 2 and 3, the educational materials were transformed into a pamphlet by the research team. These groups indicated that a firefighter is much more likely to read a short pamphlet of information than a nine-page document. This pamphlet pulls the most important information from the educational materials document and presents it in a brief and concise fashion. This pamphlet includes "Do's and Don'ts of Suicide Postvention" (Salvator, 2009), "Facts and Myths about Suicide" (Leenaars, 2010), "Warning Signs for Suicide" (National Institute of Mental Health, 2012), "Online Resources for Suicide Prevention/Postvention", and information on ways to improve the odds of preventing a suicide. This is available by request from the first author.

Conclusion

The literature on the devastating consequences of suicide to those left behind points to the necessity of developing suicide postvention standards of care (cf. Cougle et al., 2009; Crosby & Sacks, 2002; Hedstrom et al., 2008; Kessler et al., 1999; Nock et al., 2009). The FDNY has been ahead of its time on producing and piloting a number of policies to improve behavioral health and wellbeing. The aim of the current project was to develop a national guideline for suicide postvention in Fire Service based on the FDNY's existing SOP. We believe that we have successfully refined and expanded the FDNY SOP through expert review and focus group, and we are hopeful that the resulting SOP guideline will be helpful to departments around the world.

A significant limitation of the current project was our choice to limit our focus groups to career firefighters from major metropolitan departments. As a result, the type of feedback that we received from these focus groups may not have been as diverse as it would have been if firefighters from rural departments had been included. Metropolitan departments were chosen because many of them already have solid peer programs

in place, whereas such programs are less common in rural departments. Furthermore, these departments consisted entirely of career firefighters, thus no feedback was gleaned from volunteer firefighters, which make up a significant portion of fire service (Haynes & Stein, 2014). We hope to address this important issue in future projects by including a greater proportion of firefighters from rural and volunteer departments. Future research is also needed to gather empirical data on the impact of this and other postvention SOP guidelines on mental health and suicidality. Additional research aimed at developing postvention models for other high-risk occupations, such as law enforcement, paramedics, and veterans is also needed. As it stands, our working group is confident that the SOP guidelines detailed within this manuscript will provide useful initial steps in aiding firefighters and ultimately those they serve and protect.

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Appendix

A suicide postvention protocol for fire service

Preparing for the possibility of suicide and having a pre-established SOP for postvention ready is critical to helping individuals cope in the aftermath of a suicide. Although every Fire Department's SOP may need to be modified to remain in compliance with existing departmental policy, the following protocol was designed to serve as a general guide for suicide postvention within Fire Service. This first document is intended to be a "how-to" SOP, and it is supported by an educational document with "Do's and Don'ts", suicide myths, and online resources.

Purpose/objectives for suicide postvention

The goals and objectives for suicide postvention for department members include the following:

- Ease the trauma and related effects of the loss
- Prevent the onset of adverse grief/complicated grief, defined as feelings of loss that are debilitating and do not improve over time
- Reduce stigma and social isolation that can result from suicide loss
- Minimize the risk of new suicidal behavior

Suicide Postvention Steps

1. Notification Procedure
   a. The notification procedure should follow existing chain-of-command and have protocol instructions for who is required to be involved. The suicide death should be precisely in keeping with any other death in fire service, and notification procedures would follow existing policies (Reference policy #___, LODD).
   b. There are no universal rules for who should do what, as each department will differ with respect to what types of individuals are available and willing to be involved in the postvention process. It is recommended that a company meeting be called as soon as possible (within 24 hours, certainly) where firefighters can be briefed and provided resources, referrals, directions as to how they can help

family members and fellow co-workers, and time to process the information.

   c. With the permission of the family, the facts of the suicide should be stated as clearly as possible so as to limit the incidence of rumors; however, this information should be provided in a respectful and unglorified manner (see Do's and Don'ts in educational materials).
   d. The announcement to the department should be accompanied with a phone number or helpline for firefighters to call for help.
   e. Determine protocol regarding social media. Decide what is acceptable for the department to post and what is acceptable for individual firefighters to post.

2. Determine who will be involved
   a. Designate a team leader to coordinate the response to the suicide in the fire department, perhaps someone with counseling experience or a long history in fire service.
   b. Physicians, counseling units, Employee Assistance Programs, chaplains, officers, police, union officials, safety, and other key departmental teams should be assigned specific roles and given directions for what activities they should be involved with as part of the development of each specific Department's SOP.
   c. Designate a department liaison for responding to the families.
   d. Designate a team of support or peer counselors for liaisons and firefighters where they can get help if needed.

3. Responding after a Suicide: Response to suicide will depend on where the suicide took place and the characteristics of the member involved. For example, although it happens rarely, the procedures will be very different if the suicide took place in quarters by an active member than if they took place out of quarters by an active member or a retiree.
   a. In Quarters
      i. Response to suicide death in quarters will be treated similarly to response to any other type of emergency situation. Firefighters will call 911, assess vitals, and attempt resuscitation if possible.
   b. Out of Quarters
      i. Response to an out of quarter's suicide death will involve notification procedures and protocols for response at the department, hospital or victim's home.

4. Responding to the Family
   a. Financial questions
      i. The identified liaison person should have a document prepared that outlines benefits the family will receive after the death of their loved one. Insurance and line of duty benefits are often a source of stress after a suicide and having clear information at hand will help to dispel anxiety and provide family members with clear expectations. Because suicide is not consistently ruled a LODD, certain benefits may be limited.
   b. Funeral Details
      i. Turnout following a suicide death would ideally be no different than other types of death for firefighters. However, the funeral is an extremely critical time for grieving both for the family and for members of the department, and special care to respect the feelings of family needs to be taken. Funerals are opportunities to provide social support and reduce stigma if handled well. Although isolation for the grief stricken is ill advised, care must be taken to ensure that vulnerable grieving family members are not intruded upon. If possible, provide ceremonial options to the family that they can choose from and encourage members of the department to attend.
   c. Departmental Help
      i. The protocol established at FDNY following 9/11 was to assign one or two members to be liaisons or contacts for grieving families to help meet the needs of the family from the department. This wisdom led to better adaptation to loss for both family and brother/sister firefighters. Departments including this in an SOP should set boundaries and expectations so the liaisons can maintain balance in their own lives and establish protocols to deal with any difficult interactions (e.g., when and where to recommend that family members seek mental health treatment if they are having a particularly difficult time adjusting to the loss).

5. Responding to Department Members
   a. Short term vs. long term support
      i. Short term
         1. Officers go out to the firehouse with a chaplain, ceremonial officer, and peer counselors and do an umbrella overview of what is going to transpire over the next couple of days and check in with the members and captain.

ii. Longer term
   1. Match a peer counselor to the firehouse. During the first week the peer checks in with the members of the firehouse regularly, in an attempt to touch base with as many affected members as possible. Over the next several months they go once a week or every 2 weeks to do outreach. There may be a critical time period between 2–4 months when clinical symptoms develop.

b. Determine the "family tree" within the department—the network of those who were closest to the firefighter who died of suicide. This could be the current house or the shift of the firefighter. It could also be a previous station. Establishing this list will aid in connecting those who may be the most vulnerable following the suicide with resources and support.

c. Establish methods of follow-up after the suicide. There are several means that can be used to check-in with firefighters following a suicide in order to evaluate how they are doing. Using self-assessment handouts, leaving business cards for peer counselors at the firehouse, displaying resources for emergency hotlines or telephone therapy or websites for online help can all be useful. If the results of any questionnaires or assessments indicate a potential behavioral health problem, there must be the appropriate support in place for connecting that firefighter to treatment. In all cases it is essential to maintain a connection with firefighters after suicide loss. The more that peer counselors and other mental health support staff engage with firefighters after a suicide, the more likely it is that the affected firefighters will get help if they need it.

d. Prepare for and address potential emotions, behaviors, and beliefs that may arise after a suicide (all of the following are normal and to be anticipated):
   i. Anger and shame
   ii. Frustration/lack of understanding
   iii. Guilt
   iv. Grief
   v. Self-medicating behaviors
   vi. Belief that suicide is a sign of weakness

e. Responding to firefighters at-risk
   i. There are times when the signs of a behavioral health problem after a suicide are more difficult to handle. For example, a positive drug screen, an act of aggression, alcohol abuse, or demonstrating poor work performance all suggest that a firefighter may be having difficulty coping with the loss. Responding in these situations with the knowledge that such behaviors could be related to the firefighter's difficulty coping with the loss can potentially deter unnecessary disciplinary action and instead connect a firefighter to treatment that he or she may desperately need.

6. Concluding the Postvention
   a. After several weeks (or as determined by the department), phase out the postvention process.
   b. Set up meetings with firefighters and family members to have a closing discussion and provide resources if they need help in the future.
   c. If desired by firehouse or family, plan future check-in times by peer counselors or team leaders on a periodic or monthly basis between 6 months and a year after the suicide.
   d. Reinforce the fact that grief following suicide can take a longer time to process, and help will be available at any time.
   e. Have postvention coordinator continue to record and track any follow-up services to the family provided by the department.