

DEVELOPMENT OF SUICIDE PREVENTION STRATEGIES

Development of Suicide Prevention Strategies to Reduce Death and Injury

In Communities Served by Littleton Fire Rescue

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CERTIFICATION STATEMENT

I hereby certify that this paper constitutes my own product, that where the language of others is set forth, quotation marks so indicate, and that appropriate credit is given where I have used the language, ideas, expressions, or writings of another.

Signed: _____

Abstract

The problem was Colorado has the sixth highest suicide rate in the nation. Littleton Fire Rescue, located in Littleton, Colorado regularly responds to individuals in suicidal crisis but the fire department had no suicide intervention plan or prevention strategy to help reduce injuries and deaths caused by suicide. The purpose of this action research was to develop a new suicide prevention strategy for Littleton Fire Rescue by answering three research questions. The three research questions were: (a) How often did emergency responders encounter suicidal situations in their communities, (b) What strategies did first responders use to reduce injuries and deaths from suicide, and (c) What strategies are used outside emergency responder groups to reduce suicide and how have they been integrated with local first responders. Five research procedures were performed to answer the three research questions. Those procedures included (a) analysis of cause of death statistics from local coroner's reports, (b) survey Littleton firefighters, (c) survey Littleton police officers, (d) survey national first responders, and (e) interview directors of local suicide prevention programs in Colorado. Results from this research indicated that Littleton Fire Rescue was not well prepared to respond to suicide situations, had no plan or strategy in place and first responders were not trained in suicide awareness. Recommendations from this research were used to enhance the standard of care provided by Littleton Fire Rescue. The result of this research produced a new comprehensive suicide prevention strategy which included collection of accurate data on suicide in the Littleton community, educating first responders in suicide awareness, implementing a new standard operating procedure, provide suicide prevention brochures to the public and collaborate with local suicide prevention programs currently in the community.

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Introduction

Suicide, a preventable and often predictable self imposed, untimely death, is extremely costly to modern society. Suicide is defined as death from injury where there is evidence that a self-inflicted act led to the death. Every year over 32,000 people will take their lives by suicide in America and another 500,000 will visit emergency rooms from intentional self-inflicted injuries. Suicide statistics are staggering and the emotional toll of suicide on friends and families is often overwhelming and eternal. Every 17 minutes another life is lost to death by suicide. These acts of self-destruction rob society of talented people. No culture, religion, class, gender, profession, degree of wealth, success, fame or level of intellect is exempt from death by suicide.

Police officers, firemen and emergency medical services (EMS) personnel dedicate a lot time and countless resources to interacting with suicidal people. Responding time and again to completed suicides can be dangerous, physically demanding and emotionally draining. Emergency responders can carry intrusive sights, sounds, smells and memories of these violent and often gruesome suicide deaths with them for much of their careers. The grief and sorrow of the survivors can also take an emotional toll on emergency personnel and manifest into emotional distress or physical illness after experiencing suicide deaths. Suicide survivors are defined as family members, significant others and friends who have experienced the loss of a loved one due to suicide.

The problem was Colorado has the sixth highest suicide rate in the nation. Littleton Fire Rescue (LFR), located in Littleton, Colorado regularly responds to individuals in suicidal crisis. LFR had no crisis intervention plan or suicide prevention strategy to help reduce the number

preventable deaths by suicide in the Littleton community. This problem has led to unnecessary suicide deaths in the Littleton community and many put first responders at risk from both physical injury and psychological harm while responding to people in suicidal crisis.

The purpose of this applied research project (ARP) is to identify and develop strategies to reduce deaths by suicide in the communities served by LFR. Through this applied research this researcher will formulate an action plan for LFR to reduce preventable deaths of people in the Littleton community from suicide.

This ARP will utilize action research methodology to investigate and develop a new suicide prevention strategy. The following research questions will be answered to cultivate a new crisis management plan and suicide prevention strategy: (a) How often did emergency responders encounter suicidal situations in their communities, (b) What strategies did first responders use to reduce suicide deaths in their communities, and (c) What strategies are used outside emergency responder groups to reduce suicide deaths and how have these strategies been integrated with first responders?

Background and Significance

Suicide is the act of taking one's own life and by definition it is always fatal. Death by suicide is a complex problem that is difficult to understand and often hard to predict. Suicide is an awful way to die and leaves many victimized people in its path. The mental suffering leading up to death is private, inexpressible, intense and prolonged. It is often rationalized by the person as the only solution to intolerable psychological pain. The common emotion leading up to death is usually hopelessness while a common state of mind of most suicidal people is ambivalence about their life. The individual may feel a tunneling or narrowing of choices with death by suicide seen as the only logical, rational answer and escape from the pain.

Suicide is rarely spontaneous. It is often a result of a long-term wearing away of an individual's ability to cope. The inability to cope usually involves some form of personal loss. The loss may be status, self-image or self-esteem. People attempt suicide over loss of health, financial security or personal freedom. Loss of a significant other by separation, divorce or death has been known to lead to suicide. A significant sudden and unexpected personal loss or several crucial losses occurring in rapid succession have pushed people to the final breaking point of taking their own life by suicide.

Certain conditions or factors, coupled with environmental events, are known to predispose people to a higher rate of suicide. Even though suicide affects most age and gender groups, men are four times more likely than women to die by suicide while three times more women than men attempt suicide. A previous history of suicide attempts or a family history of suicide can increase one's risk. Alcoholism and substance abuse add to one's inability to cope and may lower inhibitions and allow someone to move forward with a suicide plan. Mental health disorders such as schizophrenia, anxiety, mood disorders and depression can also increase the risk. Depression is the leading psychiatric diagnosis associated with people attempting and completing suicide. Treatment for depression is highly effective but many people never seek help prior to their suicide death.

While there are no official national statistics on attempted suicides it is generally estimated that there are 25 attempts for each death by suicide. A suicide attempt is defined as potentially self-injurious behavior with a non-fatal outcome where there is evidence that he or she intended to kill themselves. The risk of attempted suicides is highest among females and adolescences. The vast majority of individuals who are suicidal often exhibit warning signs. Social isolation, expression of a plan and access to lethal means or methods are important

warning signs. Suicide ideation, defined as self reported thoughts of engaging in suicidal behavior, can be a precursor to a suicide attempt. Dramatic mood changes, withdrawing from society, uncontrollable anger, recklessness, hopelessness and anxiety are all signs which may lead up to a suicide attempt.

Suicide is a serious public health concern that crosses many boundaries of society and affects people in all age groups. Many experts believe suicide deaths are widely under reported and extent of the problem is much larger than described. Those who attempt suicide and don't complete their plan often have serious injuries that result in thousands of dollars of expenses from hospital admission, physical therapy and mental rehabilitation. He or she may have lingering depression or other mental health problems following a suicide attempt. Survivors of suicide are often left in shock with years of anger and guilt to work through. Suicide survivors are defined as family members, significant others and friends who have experienced the loss of a loved one to suicide. Medical costs, lost wages and loss of talented people associated with suicide are a tremendous burden on society and local communities.

Nationally more than 32,000 people will kill themselves each year in the United States (U.S.). Rates of suicide are the highest in the intermountain states which includes Colorado. An estimated 89 people complete suicide per day in the U.S. or roughly one person dies by suicide every 17 minutes. It's the eleventh leading cause of death in the U.S. These statistics translate to a national suicide rate of 10.85 deaths per 100,000 people.

Colorado has the sixth highest suicide rate in the nation. In Colorado, 722 people died by suicide in 2005 making suicide the second leading cause of death among young people in Colorado. The rate of death from suicide in Colorado is 17.5 deaths per 100,000 people, a much higher suicide rate than the national average.

Founded in 1890, Littleton Fire Rescue (LFR), located in Littleton, Colorado, has been providing fire and emergency services for 117 years. The fire department has been responding to suicidal situations in the community longer than most responders can remember. The fire department protects 225,000 residents in an 86 square mile fire district located south of Denver, Colorado in the shadow of the Rocky Mountains. LFR employs 125 cross-trained-dual-role career firefighters who are trained as emergency medical technicians. Half of the firefighters are trained to the advanced level of paramedic. LFR responded to 13,697 incidents in 2007, 62% of which were emergency medical service (EMS) calls. LFR provides advanced life support (ALS) on every incident with paramedic firefighters responding on each of the seven engine companies, five transport ambulances and one ladder company.

In 1973, inspired by a television show about paramedics called *Emergency*, then Deputy Fire Chief Pete Cernich traveled to both coasts to investigate how to develop a paramedic program in Littleton. In 1974, in conjunction with a local hospital, 14 Littleton firefighters went to school to become paramedics before there was an official paramedic curriculum or paramedic text books. These original paramedic firefighters learned many new medical skills and graduated as the first official paramedics in the State of Colorado. LFR is one of the first fire based EMS services in the country. LFR has a proven history of providing high quality EMS. The department is known locally and regionally for outstanding patient care with a staff of very experienced paramedics. LFR gained national exposure in 1999 in the wake of the Columbine High School shooting, a mass homicide-suicide mission, executed by two local high school students that killed 15 people including themselves.

LFR has been responding to suicides and attempted suicides in the community for many years. As the EMS Chief, this researcher reviews patient care report (PCR) written by LFR

firefighters on all deaths in the fire district prior to faxing the PCR to the county coroner. Stories of suicide deaths, often violent and macabre, are distressing and the numbers are shocking for an affluent community like Littleton, Colorado. Each suicide is unique in its own way from the senior citizen who duct taped a bag over his head to a middle-aged man who put rocks in his pockets then cut a hole in the ice while standing on a local reservoir and drowned. From the war veteran who dressed up in his old military uniform and shot himself to the 26 year-old man who hung himself in the commons area of his apartment complex. In late 2007, LFR had two similar suicides on opposite ends of the fire district on the same day. Both were middle-aged men, fathers and husbands, found by their wives after hanging themselves in their garages just hours apart. All suicides have the potential to take a mental or physical toll on both emergency dispatchers, who often talk to suicidal people, to first responders who arrive at the scene to provide medical care.

On October 29, 2007 a suicidal person came to Littleton's Firehouse 13. The elderly man parked his car on the front lawn of Firehouse 13 just feet from the front door. He got out of his car, removed a large hand gun from the vehicle and shot himself in the chest. He survived the first gun shot and then shot himself again in the head leaving him unconscious, barely breathing in a large pool of blood on the firehouse sidewalk. The crews of Engine 13 and Medic 13 had just finished a medical call when the shooting occurred and were not in Firehouse 13 at the time of the suicide. They quickly responded back to the firehouse to render aid to the victim and transport him to a local trauma center. He died from his self-inflicted gun shot injuries.

This individual was no stranger to the members of Firehouse 13. Just five months earlier he had attempted suicide using carbon monoxide poisoning in his home. The crews from Firehouse 13 found him in his garage with his car running. He was semi-unconscious, barely

breathing and mumbling that he wanted to “kill himself.” He had written a suicide note, collected his personal belongings and provided his insurance papers for whoever would find him. The crew transported him to a hospital where he survived and was later released after spending time in intensive care and receiving mental health counseling for depression.

His suicide at the firehouse was not the first completed suicide death of this type in the Littleton area. In 2007, a man died by suicide in the parking lot of a South Metro Fire Rescue (SMFR) firehouse in Centennial, Colorado while talking with a dispatcher on the telephone. He died from a self-inflicted gun shot wound. The crews from SMFR were in the firehouse at the time of the shooting.

Another incident in Denver, Colorado, involved a 36 year-old woman with a history of suicide attempts who jumped out of the back of a moving ambulance during a routine patient transfer. The private ambulance was driving on a busy interstate at expressway speeds when she leaped to her death. The deceased removed her cot straps, distracted the attendant and jumped out of the moving ambulance. Her family sued the private ambulance company for damages.

The problem was LFR emergency responders have had no training on how to interact with suicidal people and had no crisis intervention plan to effectively care for suicidal people. Even though suicide incidents occur frequently in the fire district there was no response guidelines or standard operating procedures (SOP) to support and direct first responders on what to do and how to react in these situation.

This is a serious problem in the Littleton community. First, by ignoring the suicide problem like LFR has done will not reduce the number of frequent completed suicides that kill contributing members of society and talented people of the local community. Firefighters, “gatekeepers” of the community, are trusted and respected members of society and can make a

difference in the lives of suicidal people through education and prevention programs.

Gatekeepers are defined as individuals in the community who have daily face-to-face contact with large numbers of community members. LFR has been providing effective prevention programs to reduce injuries and deaths to members of the Littleton community for years, but suicide awareness or prevention has not been one of these programs.

A second problem related to responding to suicidal people is that LFR firefighters may become victims of suicidal people. Responders around the country have been killed or seriously injured by homicidal-suicidal people. The physical danger associated with responding to suicide calls looms on every suicide incident. There's also the psychological baggage responders carry with them for years after seeing the dead, who often have died in a traumatic manner, and dealing with the surviving friends and family. In one incident, LFR firefighters responded to a homicide-suicide of a father who killed his entire family before taking his own life. The deaths were discovered by the grandparents who were overwhelmed with shock and grief and had to be transported to a hospital by LFR. Responding to repeated suicide death scenes or mass homicide-suicide incidents, like the Columbine High School shooting, can cause high levels of stress in responders and may lead to Post Traumatic Stress Disorder (PTSD) over time.

The impact of suicide on society is substantial. It's estimated that each suicide intimately affects a minimum of six people who may suffer subsequent mental health problems, guilt, pain and personal agony after experiencing a suicide of a loved one. Lives are changed forever following often traumatic, unexpected, untimely deaths. The impact of suicide on emergency responders is difficult to measure. First responders don't usually talk about their feelings and may carry critical incident stress with them for years without seeking help. "Each one of these suicides leaves a small mark on your soul," stated LFR Paramedic Captain Monte Fleming. "You

can't help but feel sorry for each of these families and the reality that they face after losing a loved one to suicide (M.M. Fleming, personal communication, January 5, 2008). No one is immune from becoming a victim of a successful suicide of a family member or friend.

This research project is related directly to the National Fire Academy's *Leading Community Risk Reduction* course, unit 2, *assessing community risk* (LCRR-Student Manual, 2007, p.SM 2-58). As an Executive Fire Officer and the EMS Chief with Littleton Fire Rescue, it's this researchers duty as a community leader in emergency medical services to analyze common risk problems affecting people in the Littleton community and create education and prevention programs to reduce injuries and loss of life. For years the fire service has been fixated on post-event response instead of pre-event education and prevention. The future of the modern day fire service relies on the concept that more lives may be saved through education and prevention efforts than through emergency response, once the problem has occurred. This problem is also linked directly to the United States Fire Administration's (USFA) strategic plan and operational objective number five, "appropriately respond in a timely manner to emergent issues (USFA Web page, 2008)." A new suicide prevention strategy to reduce injuries and deaths in the Littleton community has emerged as an important community health project. Education and prevention programs should be introduced to reduce the number of suicide attempts and deaths in the Littleton community.

Literature Review

A literature search was conducted to acquire information from the existing body of knowledge in suicide, emergency response to suicidal situations and suicide prevention strategies provided by emergency services. The intent of the search was to determine what research had already been done on the topic of suicide prevention and what strategies were currently in place

in the fire service for responding to and preventing suicide. It is important to identify what information has already been discovered by other researchers which may have an impact on this applied research project (ARP).

The literature review began in the Learning Resource Center (LRC) at the National Fire Academy in March, 2008 to locate any Executive Fire Officer (EFO) research papers on the topic of suicide prevention provided by emergency responders. No EFO papers were located that addressed the topic of responding to suicidal situations, crisis intervention by first responders or suicide prevention strategies in the fire service. The literature search then expanded to include all documents, publications, books and materials in the LRC relevant to answering the research question.

An Internet search was performed in April and May, 2008. The results did yield information on suicide prevention strategies but few resources were located that indicated the fire service was actively involved in suicide awareness training or suicide prevention programs. Key words used in the search were suicide, suicide rates, emergency response to suicide, suicide prevention strategies, education and prevention in the fire service, mental health disorders, depression, and public health.

Examining national and local statistics on suicide answered the first research question how often first responders were exposed to suicidal situations. At the local level, medical protocols used by LFR firefighters require paramedics to examine all patients, evaluate their medical and mental condition and make base hospital contact with a physician for consultation. Protocol also states that “if the situation appears to be a potential crimes scene, EMS providers should disturb the scene as little as possible” (Denver Metro Protocols [DMP], 2007).

The Colorado Department of Health estimates that 80% of completed suicide deaths in Colorado necessitate an emergency response by local fire and EMS agencies (H.B. Hedegaard, personal communication July 10, 2008). In Littleton, the fire department responds to all completed suicide deaths and individuals threatening or attempting suicide. By protocol, all deaths should be investigated by a paramedic to determine if the patient is viable and could possibly be resuscitated. Paramedics contact medical control for time of death and prepare a patient care report (PCR) explaining the circumstances of the incident. The PCR is used by law enforcement officials and the county coroner during the investigation of the death.

The best resource for cause of death statistics that answered the first research question were injury and mortality reports from the Center for Disease Control (CDC). The Web-based Injury Statistics Query and Reporting System (WISQARS) managed by the CDC, compiles and reports injury and mortality data. The system generates tables on the number of deaths and death rates by causes of injury. Tables are created based on geographical region, year, age, race and sex. Suicide data from WISQARS is only current thru 2005 because mortality reports produced by WISQARS are from individual death certificates reported to the National Center for Health Statistics (NCHS). The NCHS collects, compiles, verifies and prepares mortality data reports which are then released to the public on WISQARS. The data collection process takes approximately 18 months after the end of any given year. The most current data and statistics available from the CDC on suicide deaths are from 2005.

The CDC (2008) reported that 32,637 people died by suicide in the United States in 2005. Suicide was the 11th leading cause of death for all combined age groups. The national suicide rate for all races and sexes combined was 10.85 deaths per 100,000 people. There were 25,907 men who completed suicide in 2005 producing a suicide rate of 17.96 deaths per 100,000 men

while 6,730 women chose death by suicide at a rate of 4.37 deaths per 100,000 women. Suicide is the second leading cause of death in the age group 25-34 (4,990 deaths) and the third leading cause of death in adolescence 10-14 (270 deaths) and 15-24 (4,212 deaths). The highest number of suicide deaths occurred in the age group 45-54 (6,991 deaths) while in the older population, 55-64 (4,210 deaths), suicide was the eight leading cause of death. Nationally, firearms caused 50% of the deaths in most age groups followed by poisoning or suffocation.

The CDC (2008) reported that in Colorado a total of 800 people died by suicide in 2005. Suicide was the 7th leading cause of death for all age groups. The suicide rate in Colorado for all races and sexes was 17.05 deaths per 100,000 people in 2005. In Colorado, 634 men killed themselves resulting in a suicide rate of 27.79 deaths per 100,000 men. Many women (166) also chose death by suicide at a rate of 6.92 deaths per 100,000 women. Suicide is the 2nd leading cause of death in ages 15-24 (135 deaths), 25-34 (114 deaths) and 35-44 (166 deaths). Suicide is the sixth leading cause of death in the age group 55-64 (194 deaths). Firearms in Colorado cause an average of 50% of the suicide deaths followed by poisoning and suffocation.

LFR serves three counties in Colorado; Arapahoe County, Douglas County and Jefferson County. The CDC (2008) reported that locally 188 people died by suicide in 2005 in the three Colorado counties combined. The suicide rate for all races and sexes collectively was 14.4 deaths per 100,000 people and suicide was the seventh leading cause of death in the three counties.

The research data discovered from the CDC revealed that emergency responders are being exposed to suicidal situations on a frequent basis. This data has influenced this researcher to survey local and national first responders to see if they know the extent of the suicide problem in their communities. This researcher questions if most emergency responders realize the scope of the suicide problem they respond to in their communities.

While answering the first research question a limiting factor was discovered. The limitation was there had not been a national data collection effort for EMS data and statistics that could be accessed for this research data. The National Fire Protection Association (NFPA) has been collecting national fire service data on fire injuries and deaths for many years but EMS data collection has just recently begun.

A new national EMS data collecting effort has recently started with the National Emergency Medical Information System (NEMSIS) project. The NEMSIS project focuses on collecting national EMS data to add to the body of knowledge in pre-hospital medicine. This data will be used in developing nationwide EMS training curriculum, facilitating research efforts such as this one, establishing national fee schedules and reimbursement rates, coordinating disaster resources and evaluating domestic preparedness needs in emergency medicine. Currently 48 states support the NEMSIS project but presently data needed for this ARP on suicide is not available.

The second research question examined what strategies were used by first responders to reduce suicide deaths and how had these strategies been implemented in the community. The literature reviewed started by examining what suicide awareness training was taught during initial paramedic training. Paramedic text books follow Department of Transportation (DOT) standard curriculum and are the basis of emergency medical training and education.

Reviewing a widely circulated emergency medical care text book titled *Paramedic Textbook* by Sanders (2007) found only two pages out of 1,500 dedicated to evaluating and interacting with a suicidal patient. The material was limited to national facts about suicide, suicide myths, risk factors and a few basic questions to ask suicidal people. Sanders listed six steps in his book that paramedics can use to reduce the potential of suicide in the community.

The six steps started with listening carefully to the suicidal person and acknowledging their feelings without being judgmental. Sanders recommended providing honest assurance about the individual's long term well-being. A third supportive step was to provide for the person's physical safety as well as their emotional security. The fourth step was to determine who the suicidal person's support system was and get them to the scene to communicate and calm the person. The last two recommendations by Sanders were to continue to encourage and reassure the person during the immediate crisis and transport him or her to the proper facility for emergency crisis intervention. A reference to "suicide prevention program" did appear in a chapter of the book titled *Injury Prevention* (Sanders, 2007, chap.3) but no strategy, prevention programs or implementation methods were offered.

A very good resource that answers the research question on what strategies are used by first responders to reduce suicide deaths was a training manuscript written years ago in Colorado. The training manual titled *Suicide First Response; A Training Manual for Professionals Who Respond to Suicides* was written in 1996 (Swink, 1996). This work was a collaborative effort between the City of Colorado Springs, Colorado, Colorado Springs Police and Fire Departments, American Medical Response, Centura Health, Memorial Hospital and the Colorado Department of Health. The Colorado Springs ranked number two in the nation for suicide deaths in 2004 with 26 deaths for every 100,000 people (National Association of County and City Health Officials, 2007). While the training manual was dated at 12 years old it was well written.

The goal of writing the training manual was focused on helping primary victims (parents, siblings, spouses and children), secondary survivors (friends, neighbors, other relatives) and tertiary victims (professionals who respond to the scene of a suicide) who all interact at suicide

incidents. It emphasized that first responders should have an acute awareness of the potential impact responding to suicide situations can have on their personal lives and careers.

The manual provided this researcher with a historical perspective of the suicide problem in the U.S. and provided statistics that were current in 1996. It examined ten commonalities about suicide, reviewed risk factors and universal myths about suicide. The manual had a section on how first responders should handle the scene, what to expect from the survivors, and the most compassionate way to notify the survivors of a death. It had important resources and telephone numbers to obtain police and coroner's reports, make funeral arrangements, find advocacy and support groups, mental health assistance and survivor benefit information. The manual covered cultural diversity and religious views related to suicide. One chapter explored the toxic impact suicide has on first responders, recognizable signs and symptoms of excessive stress in emergency workers and self-care techniques to use following exposure to a suicide death.

After completing a literature search to answer research question two, very few sources of information were located. It appears, from the lack of supporting literature, that there were very few strategies used by emergency responders to prevent suicide deaths. This information directly influenced this researcher to survey first responders to discover what they were doing about suicide in their communities.

Suicide strategies and established prevention programs were discovered while researching an answer to research question three. While some strategies and programs were located, little information was discovered as to how these programs were being integrated with local first responders.

Historically, researchers have been studying suicide and evidence based prevention strategies for decades. Emile Durkheim (1858 – 1917) was an early researcher in suicide and

examined risk factors associated with people in suicidal crisis. A French social scientist, Durkheim was an early author of a scientific study on suicide. Durkheim (1951) discovered risk factors for suicide by comparing sociological characteristics among people who were suicidal with those who were not. His early study was one of the first to identify common risk factors of suicidal people.

The first collaborative prevention efforts in the United States occurred around 1958 with the creation of the first suicide prevention center based in Los Angeles, California. Three early suicide researchers, Edwin Shneidman, Norman Farberow and Robert Litman, studied suicide at the prevention center with the idea of providing a community based service and crisis intervention location for those in need of mental and emotional help. Other crisis intervention centers began popping up around the country based on the work of these three pioneers.

The United States government got involved in suicide prevention in 1966 with the formation of the Center for Studies of Suicide Prevention which was established at the National Institute of Mental Health. Early work at this national center helped identify additional risk factors used to develop suicide prevention programs. In the 20 years that followed the American Association of Suicidology and the American Foundation of Suicide Prevention were established. In 1983, the Centers for Disease Control and Prevention (CDC) uncovered a disturbing increase in youth suicide rates. Shortly after the information was made public, a private-public task force was developed to establish suicide intervention strategies directed at saving our youth from death by suicide.

In 1996, the World Health Organization urged its members to get involved in suicide prevention after recognizing a growing suicide problem worldwide. They produced a document titled *Prevention of Suicide: Guidelines for the Formation and Implementation of National*

Strategies. This original document was very influential in developing a collaborative effort to get individuals from different professions, all who had a stake in suicide prevention, to come together to create a national strategy for the United States.

In October, 1998 the first National Suicide Prevention Conference convened in Reno, Nevada. This conference brought together researchers from around the country including public health experts, mental health clinicians, politicians, policy makers, suicide survivors and community leaders to help identify what was known about suicide. As a result of this conference a document titled *Surgeon General's Call to Action* introduced a blue print program for immediate actions to reduce suicide, mental health disorders and substance abuse. Fifteen key recommendations are the foundation of the plan and were divided into three categories; Awareness, Intervention and Methodology (AIM).

Awareness called for reducing suicide by increasing public awareness of the problem. One recommendation was to use current facts and statistics to promote suicide as a public health problem and develop programs that support the idea that suicide is preventable, as other health problems (U.S. Public Health Services, 1999). The next recommendation was to expand awareness that local communities need more resources. The last recommendation related to public awareness were to develop and implement strategies to reduce the stigma associated with suicidal behavior, substance abuse, mental illness and shame people may feel when seeking help.

The next eight recommendations related to suicide interventions. The report encouraged the government to find the means to enhance services, programs and clinical care based on the needs of the population. One recommendation was for public and private sectors to come together in a collaborative effort to complete a National Strategy for Suicide Prevention. Another recommendation was to improve the ability of primary care providers to recognize and treat

disorders associated with suicide while increasing their ability to refer suicidal people to the proper care. Another recommendation was to eliminate barriers in the insurance industry to quality mental health care and substance abuse programs regardless of income and create incentives to treat people with coexisting disorders.

The next recommendation called for instituting training programs for all health providers, mental health clinicians, substance abuse counselors, and human service professionals in suicide risk assessment, recognition and management. A fifth recommendation also supported developing and implementing effective training programs for family members and community helpers (clergy, teachers, coaches, hairdressers). The another recommendation suggested implementation of safe and effective programs in schools which incorporate peer support to help address adolescent suicide.

The U.S. Public Health Services (1999) seventh recommendation was to enhance community care resources by making schools and workplaces referral points for mental health services. The report encouraged the development of support networks for suicide survivors.

The final recommendation related to interventions was to promote public-private collaboration with the media to assure that all news coverage and entertainment programs represent a balanced and informed portrayal of suicide and its associated risk factors.

The final recommendations from the Surgeon General's Call to Action related to the category of suicide methodology and the advancement of suicide prevention. The first recommendation was to enhance suicide research to understand the risks factors and how they affect suicidal behavior. Another recommendation was to develop additional scientific strategies for evaluating suicide prevention interventions. A third recommendation was to establish mechanisms for federal, regional and state monitoring systems of suicide and suicidal behavior

and promote standard terminology for these systems. The final recommendation of methodology was to develop and evaluate new prevention technologies, including firearms safety equipment, to reduce access to lethal means of suicide.

One of the key recommendations from experts who attended the 1998 Reno conference was the emphasis on completing a national prevention strategy. Just three years later, in 2001, the U.S. Department of Health and Human Services (2001) released the *National Strategy for Suicide Prevention, Goals and Objectives*. This 206 page document was a milestone in suicide awareness, prevention and public health. Then Surgeon General David Satcher wrote in the preface “The National Strategy for Suicide Prevention (NSSP) is not the Surgeon General’s strategy or the Federal government’s strategy; rather it is the strategy of the American people for improving their health and well-being through the prevention of suicide” (U.S. Department of Health and Human Services, 2001). The NSSP was designed to bring about change in how people view suicide.

The NSSP outlines eleven goals. Each goal had objectives and ideas for action. The first goal was to promote awareness that suicide is a public health problem that is treatable and preventable. The objectives included increasing the number of states with public information campaigns designed to increase public awareness. Other objectives were to establish regular national congress meetings on suicide prevention and convene national forums on issues that influence the effectiveness of prevention messages. The last objective was to increase the number of public and private institutions which are active in suicide prevention and to disseminate the information on the World Wide Web.

The second goal was to develop broad-based support for suicide prevention. The goal had four objectives which included improving coordination on suicide prevention to help implement

NSSP and establishing a national coordinating body. The NSSP recommended increasing the number of groups that integrate suicide prevention activities into their programs and increase the number of nationally organized faith communities adopting policies promoting suicide prevention.

The third goal of NSSP was to develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services. Objectives included increasing the public perception that mental and physical health are equal and inseparable components of overall health and view mental health disorders as real illnesses that respond to specific treatment.

The fourth goal called for the development of community-based suicide prevention programs. The objective was to increase the proportion of states with comprehensive suicide prevention plans that; a) coordinate across government agencies, b) involve the private sector, and c) support plan development, implementation, and evaluation in the community. This involves increasing the number of school districts, private schools, colleges and universities with evidence-based programs designed to address childhood and adolescent suicide. The NSSP recommended correctional institutions have suicide prevention programs to help adult and juvenile offenders. Another objective was to increase the number of state aging networks designed to identify, refer and treat the elderly who demonstrate suicide behavior.

The fifth goal of the NSSP was to promote efforts to reduce access to lethal means and methods of self harm. Two objectives were to educate health care providers, who access the home, on how to take actions to reduce the availability to lethal means. This included improving firearm safety designs, safer dispensing for medications and improving automobile design to impede carbon monoxide-mediated suicide.

The sixth goal was to implement training for the recognition of at-risk behavior and delivery of effective treatment to suicidal people. The recognition training was aimed at key gatekeepers in our society; teachers, school staff, schools health personnel, clergy, police officers, correctional personnel, natural community helpers, hospice and nursing home volunteers, primary health care providers, mental health care professionals, substance abuse treatment providers and emergency health care personnel. In each of these groups suicide awareness and identification training should be incorporated in basic educational and training curriculum. Another objective was to increase educational programs available for friends and family members of those at risk.

The next goal of the NSSP was to develop and promote effective clinical and professional practices that support care and treatment. One objective was to increase the number of patients treated for self-destructive behavior by hospitals that have a mental health follow-up plan for patients. The NSSP recommended that facilities develop guidelines, protocols and procedures for the assessment and treatment of suicidal people. Another objective was to provide more training to those who provide key services to suicide survivors; emergency medical technicians, firefighters, law enforcement officers, funeral directors and the clergy. Training should also address their personal exposure to suicide. Another object was to increase screening for depression, substance abuse and suicide risk as a minimum standard of care in all primary care settings, hospice and skilled nursing facilities.

The eighth goal was to improve access to community mental health and substance abuse services. An objective of this goal was to increase the number of states where health insurance plans cover mental health and substance abuse services on par with coverage for physical health

problems. The NSSP recommended increasing social service out reach programs for the at-risk population and defining national standards for effective support programs for suicide survivors.

The ninth goal of the NSSP was to improve portrayals of suicide behavior, mental illness and substance abuse in the entertainment world. The NSSP called for accurate and responsible representations of suicide behavior and mental illness in television programs and movies. A second objective was to increase the number of journalism schools that include guidance on the portrayal and reporting of mental illness and suicide behavior.

The tenth goal was to promote and support research on suicide and suicide prevention. Two objectives were to develop national suicide research agendas with input from survivors, practitioners, researchers and advocates while increasing funding for research in Suicidology. NSSP recommended maintaining a registry of prevention activities with demonstrated effectiveness in reducing suicide behavior.

The eleventh goal was improving and expanding surveillance systems to systematically collect reliable suicide data. The objectives of this goal were to enhance the quality and quantity of data available at the national, state and local levels. This goal recommended development of standardized protocols for death scene investigations. Also recommended was an increase in the number of hospitals that collect reliable uniform data on suicide behavior and code the cause of injuries utilizing categories in the International Classification of Diseases. The NSSP recommended implementing a national violent death reporting system that includes suicides. The final objective was to implement pilot projects in several states that link and analyze information related to self-destructive behavior derived from separate data base systems including law enforcement, emergency medical services and hospitals.

The NSSP serves as a model that can be adopted or modified by states, communities and tribes as they develop their own local suicide prevention programs. This document is the foundation for national suicide prevention efforts and makes suicide prevention a high priority public health issue in the United States.

In 2002 the Suicide Prevention Resource Center (SPRC) was created to fulfill the goals of the National Strategy for Suicide Prevention (NSSP). The mission of SPRC is to promote the implementation of the NSSP. SPRC provides prevention support, training and resources to assist organizations and individuals in the development of prevention programs. SPRC provides information, resources and technical assistance in suicide prevention and supports statewide suicide prevention plans. The SPRC lists 52 states involved in state suicide prevention planning and implementation.

It was discovered that the SPRC does provide information to first responders on their role in preventing suicide. The SPRC (2005) suggested that first responders can help suicidal people by being sincere during care and treatment, showing respect for the person and their situation, show them empathy but be firm and concrete in decision making. SPRC provided information on helping suicide survivors and helping yourself, as a first responder, and fellow responders after particularly bad suicide incidents.

The literature search discovered three suicide prevention programs that were local to Colorado and Littleton Fire Rescue. The three Colorado programs were a) The Office of Suicide Prevention run by the State of Colorado, b) the Yellow Ribbon Suicide Prevention program and c) Carson J. Spencer Foundation.

On the regional level it was discovered that Colorado had an Office of Suicide Prevention which was established in March of 1998 by former Governor Roy Romer. Governor Romer

formed a commission to investigate suicide prevention strategies in response to the growing concerns over the increasingly high rate of suicide in Colorado. After the commission finished their work in 2000 newly elected Governor Bill Owens directed the Colorado Department of Public Health and the Department of Human Services to create the Office of Suicide Prevention to address the problem. The Office of Suicide Prevention is funded by the State and authorized to accept gifts, grants and donations. It acts as the state coordinator for suicide prevention programs and activities across Colorado.

A local suicide prevention program was started in Westminster, Colorado by Dale and Dar Emme in 1994. The Yellow Ribbon Suicide Prevention Program (YR) was established after the Emme's son, Mike Emme, took his life at age of 17. Out of their personal tragedy the Emme's started YR. Over the last 13 years the program has successfully spread across the United States and into several foreign countries.

The goal of the YR program, first and foremost, is to save lives. YR strives to do this by integrating sustainable suicide prevention programs and provide education for the community. Other goals included changing the public's attitude toward suicide and increasing people's willingness to seek help or refer others to get help. YR encouraged all stakeholders in the community to get involved. The community stakeholders included schools (school boards, administrators, teachers, and counselors), community resources (clergy, service organization, and youth groups), grassroots (youth, parents, elders, survivors) and support teams (medical society, mental health, hospitals, firefighters, police officers and EMS personnel).

The YR implementation model had seven steps. YR recommended establishing a task force and identifying a local coordinator, community resources, funding sources, community support teams and cultural resources. Presentations included *Be a Link Training* for adults, *Ask 4*

Help for youth and teens and *Ask 4 Help – E: elementary school*. YR teaches *Lifeskills Training* and help-seeking behavior to young adults and is a source of support for survivors of suicide by providing friendship and unity through *Survivors-in-Action*.

Another Colorado organization leading suicide prevention efforts was the Carson J. Spencer Foundation. The non-profit foundation was established in 2005 to preserve the memory of Carson J. Spencer who took his life after an acute cycle of bipolar disorder on December 7, 2004.

The vision of the Foundation was to remove the stigma of mental health disorders and prevent suicide. Their mission was to support programs and services dedicated to developing effective intervention strategies and treatment plans for people with bipolar disorders and suicidal ideation. The Foundation provides grants to suicide prevention programs and promotes early identification and intervention. They also try to reduce the stigma of mental health disorders through education and training. The Foundation provides funding for mental health research, treatment and dissemination of effective suicide prevention programs. The Foundation was a charitable non-profit organization that is funded by donations, grants, endowments and fund-raising events. Examining their web site and written literature revealed no indication that the Foundation has collaborated with local responders on suicide awareness and prevention.

The literature search discovered information that supports that suicide prevention programs are active at national, regional and local levels. While there was some information discovered by this researcher on how these programs are implemented in the community, little information was located to support that these programs had been integrated with local first responders. The literature search has influenced this researcher to survey local police officers and

firefighters to discover if they are aware of local suicide prevention programs in their communities.

Procedures

Five different research procedures were used to answer the three research questions asked. The procedures included a retrospective analysis of coroner's reports, a survey of LFR firefighter, a survey of Littleton Police Department (LPD) officers and a national first responder's survey. The last research procedure was personal interviews with local experts who run suicide prevention programs in Colorado.

The first procedure was a retrospective examination of coroner's reports. The coroner's offices in Jefferson County, Arapahoe County and Douglas County were contacted for cause of death reports. All data was extracted from year-end reports and examined to determine how many people died in the three counties, how they died, how many died by suicide and what methods of suicide were used. Data was entered into a spreadsheet during July, 2008 for evaluation.

The second research procedure, a survey of LFR firefighters, was developed to answer the first two research questions. The survey was used to get a firefighter's perspective on how often they encountered suicidal situations locally and what strategies had they learned to reduce suicide in the community. The sample size included all one hundred twenty LFR firefighters. The survey was developed and distributed using Survey Monkey, an Internet company specializing in surveys and data analysis (see Appendix A). The surveys were distributed electronically through the LFR email system in July 2008.

The third research procedure was the development of a survey for all Littleton Police Department (LPD) officers. This survey was used to get a local law enforcement perspective of

the suicide problem in Littleton, Colorado. The sample size was seventy LPD officers. The surveys were developed and distributed using Survey Monkey (see Appendix B). The surveys were distributed electronically through the LPD email system in July 2008.

The fourth research procedure was the development of a national survey for emergency responder's around the country. The surveys were distributed via email link in two batches using Survey Monkey. The first group of sixty surveys was emailed on July 8, 2008 and a second group of sixty on July 9, 2008.

The national survey requested information on agency demographics, injury prevention programs, suicide deaths, suicide attempts, awareness training, standard operating procedures and suicide referral information. The respondents were asked about the National Strategy for Suicide Prevention and the implementation of suicide prevention programs in their local communities (see Appendix C). The respondents were requested to email this researcher a copy of any response policies or standard operating procedures they used for suicide. The survey was open for data collection for 30 days. All results were collected anonymously through the internet site and the data was entered into a spreadsheet for analysis.

The last research procedure involved interviewing local suicide prevention organizations. This researcher telephoned local suicide prevention programs and interviewed the directors to discover when their program started, if the program followed the National Strategy for Suicide Prevention, how their program was funded and if they provided suicide awareness training to local emergency responders. The sample size was 3 suicide prevention programs

located in Colorado. The interview questions (see Appendix D) were discussed by telephone with the program directors in August, 2008.

Results

The data from the first research procedure resulted from a retrospective analysis of cause of death statistics for Arapahoe County, Douglas County and Jefferson County, all located in Colorado. All three county coroners submitted 2006 year-end cause of death reports for their respective counties. The data for each county and a summary for all three counties were put into a spreadsheet for analysis (see Appendix E). This data demonstrates how often LFR firefighters may encounter completed suicide deaths in the fire district.

In Arapahoe County, the total population in 2006 was 537,197 people. The total number of deaths from all causes was 3,772 people. Death by suicide accounted for 2% of the overall causes of death (77 people). Of those who took their lives 82% were male and 18% were female. The top three methods of suicide in Arapahoe County in 2006 were gunshot (51%); hangings (25%) and drug overdose (13%).

In Douglas County, the total population in 2006 was 263,621 people. The total number of deaths from all causes was 620 people. Death by suicide accounted for 4% of the overall causes of death (22 people). Of those who took their lives 82% were male and 18% were female. The top three methods of suicide in Douglas County in 2006 were gunshot wounds (46%); hangings (36%) and drug overdose (14%).

In Jefferson County, the total population in 2006 was 526,994 people. The total number of deaths from all causes was 3,263 people. Death by suicide accounted for 3% of the overall causes of death (92 people). Of those who took their lives 75% were male and 25% were female.

The top three methods of suicide in Jefferson County in 2006 were gunshot wounds (51%); hangings (25%) and drug overdose (11%).

The summary of the 2006 data for all counties showed there were a total of 1,327,812 people that lived in the three counties combined. The total number of deaths from all causes was 7,655 people. Death by suicide accounted for 2% of the overall causes of death (191 people). Of those who took their lives 79% were male and 21% were female. The top three methods of suicide in the three counties were gunshot wounds (50%); hangings (26%) and drug overdose (12%).

The results from the second research procedure came from the Littleton Fire Rescue (LFR) firefighters survey (see Appendix F). One hundred twenty surveys were sent via email link to each firefighter's email address on July 12, 2008. The survey link was open for data collection for 19 days. The survey yielded a 58% return rate (N=70). Most surveys were returned by paramedic firefighters (54%) followed by EMT-basic (44%) and EMT-intermediates (2%). The years of fire and EMS experience of the respondents varied from less than one year to over 25 years.

All firefighter (100%) indicated that he or she had been on a call where someone had attempted suicide and most (97%) indicated they had responded to a death by suicide. Many firefighters' (34%) estimated that they had responded to over 25 suicide deaths during their career while few (2%) had never been on a suicide death. Some firefighters (36%) had felt personally threatened during a suicide call and many (63%) had experienced a disruption in their normal lives after responding to a suicide situation. This disruption involved some change in their sleeping or eating habits, change in emotion, intrusive images or thoughts of the suicide

event. The survey found most LFR firefighters (97%) remember specific details of the suicide deaths long after they're over, often days, months and even years later.

Many firefighters (61%) indicated that they had never received any formal suicide awareness training during their career and most (84%) were unaware of other fire departments that have implemented suicide training. Nearly all LFR firefighters (96%) indicated they were unaware of other fire or EMS agencies that provide suicide prevention resource brochures to suicidal people. The materials asked about included referral cards, pamphlets or public health information. The majority of LFR firefighters (90%) were not familiar with the National Strategy for Suicide Prevention and most (93%) didn't know that Colorado had a state suicide prevention strategy. Most firefighters (72%) were not sure if the City of Littleton had a suicide prevention program for the city's seniors, adults and teens.

The results of the third research procedure came from surveys sent to Littleton Police Department (LPD) officers (see Appendix G). Surveys were sent via email to seventy police officers on July 14, 2008. The survey link was open for data collection for 17 days. The survey yielded a 40% return rate (N=21). The years of law enforcement experience of the police respondents varied from less than one year to over 25 years of experience.

All police officer (100%) indicated that he or she had been on a call where someone had attempted suicide and most officers (95%) indicated they had responded to a completed suicide. Some who responded (20%) estimated that they had been involved in over 25 suicide deaths during their career while very few (less than 5%) had never responded to a suicide death. Some of the police officers (30%) felt that they were personally threatened during a suicide response and just under half of the officers (47%) have experienced a disruption in their normal lives after

a suicide incident. The survey found most Littleton police officers (95%) remember very specific details of the suicide deaths for days, months and even years later.

Most LPD officers (75%) indicated that they had received formal suicide awareness training and many (65%) were unaware of other police agencies that have implemented suicide prevention programs. Most LPD officers (79%) were not familiar with the National Strategy for Suicide Prevention and the majority (79%) didn't know that Colorado had a suicide prevention strategy. A large number of officers (84%) were unsure if the City of Littleton had a suicide prevention program for the city's seniors, adults and teens.

The data from the fourth research procedure came from surveys sent to emergency responders around the country (see Appendix H). A total of one hundred twenty five surveys were sent out nationally via email link to fire and EMS responders yielding a 79% survey return rate (N-99). Surveys were returned from 31 different states. Respondents from combined fire and EMS services returned most of the surveys (71%) followed by fire service only agencies (9%) while other types of EMS services accounted for just a few (6%) of the returned surveys.

Responders to the national survey reported that most of their agencies (86%) send their EMS run data and statistics to their respective state agencies. Few agencies (12%) track the number of times they respond to people attempting suicide and few (12%) track actual suicide deaths. The highest number of suicide deaths was reported from an agency in Florida (32) and the lowest number of deaths was reported from an agency in California (2). The highest number of suicide attempts came from an agency in Colorado (estimated around 5,000) while the lowest number of suicide attempts (5) reported came from an agency in Oregon.

A few of the respondents (15%) had an incident where an individual had successfully completed suicide in or on a city or county owned building or on the property, similar to what

happened at LFR Station 13. The respondents described a suicide in a city owned park, jumping off a city parking structure, completed suicide in the police department's parking lot and two suicides on fire department property.

The national survey revealed that many of the respondent's agencies (60%) provided injury prevention programs but few (6%) had implemented any type of suicide prevention programs. The surveys showed that many of the respondents (77%) had never had formal suicide awareness training and most (88%) of their respective agencies do not have standard operating procedures (SOP) for responding to suicide related calls. The respondents were asked to email a copy of their suicide response SOP to this researcher but only one was returned. The respondents indicated that most of their agencies (85%) do not provide prevention resources to suicidal people they encounter.

Nearly all the respondents (91%) to the national survey had no familiar with National Strategy for Suicide Prevention and over half (56%) were unsure if their own individual state had a suicide prevention program. The majority indicated (89%) that their agency had not been involved with state or local officials in developing suicide awareness training or suicide prevention programs. Nationally, most respondents (85%) replied that their respective agency did not provide suicide prevention information (referral cards, brochures, public health telephone numbers) to the public.

The results of the last research procedure came from personal interviews with three local suicide prevention programs in Colorado. The researcher interviewed the directors of the Colorado Office of Suicide Prevention, Yellow Ribbon Suicide Prevention Program and Carson J. Spencer Foundation.

A personal interview was conducted on August 11, 2008 with the director of the Office of Suicide Prevention in Colorado. The Office was formed ten years ago in 1998 to coordinate state wide efforts to reduce suicide. Colorado does follows guidelines recommended by the National Strategy for Suicide Prevention and the program is funded by the general fund of the State and federal grants. “The Office of Suicide Prevention currently provides four to five suicide awareness trainings yearly for police officers but firefighters and EMS personnel have not yet been incorporated into prevention efforts. Colorado’s strategy does address suicide prevention for all age groups but the plan has not yet been collaborated with specific local fire and EMS responder groups (J. Hindman, personal communication, August 11, 2008).”

A personal interview was conducted on August 21, 2008 with the founder and executive director of the Yellow Ribbon Suicide Prevention Programs (YR). YR was created in 1994 and follows the guidelines recommended by the National Strategy for Suicide Prevention (NSSP). YR has been involved with the NSSP from its inception and is a technical adviser to the government and State of Colorado on suicide prevention and education. YR is funded by grants, private donors and fund raising events. “A goal of YR is to involve all disciplines in community suicide prevention efforts; police, fire, EMS, family parishioners, clergy, etc. YR is culturally inclusive of everyone” stated Dale Emme, Executive Director of YR. “We encourage all YR chapters to involve local first responders in the development of the community suicide prevention strategy and prevention programs (D. Emme, personal communication, August 21, 2008).”

A personal interview was conducted on August 12, 2008 with the founder of the Carson J. Spencer Foundation. The foundation was created in 2005 and follows the guidelines recommended by the National Strategy for Suicide Prevention. The program is funded by grants,

private donors and special fund raising events. “Prevention efforts of the foundation currently target at risk adults in the community, not teens or senior citizens. We have not yet integrated our prevention efforts with local emergency responders and currently don’t provide them with suicide awareness training” stated Sally Spencer-Thomas, founder of the Carson J. Spencer Foundation (S. Spencer-Thomas, personal communication, August 12, 2008).

Discussion

By comparing the results of the literature review with first responder’s surveys, the results clearly demonstrated that emergency responders encounter suicidal situations in their communities frequently during the course of their careers. Injury and mortality reports referenced in the literature review illustrated that suicide was a quiet epidemic in America that kills more than 32,000 people annually at a rate of 10.85 deaths per 100,000 people (CDC, 2008). In Colorado the death rate was even higher with 17.05 deaths per 100,000 people. Results from Littleton firefighters and police officer supported that public safety workers had recurring exposure to individuals, attempting and completing suicide. As an example, many Littleton firefighters (34%) and police officers (20%) have responded to more than 25 suicide deaths during their careers. The results from the CDC compared with data from the national and local surveys verified that emergency responders have continuous exposure to suicidal situations.

Survey results from local police and firefighters in Littleton confirmed that exposure to suicidal situations may also have long lasting effects on emergency workers. Some police officers (30%) and firefighters (36%) had felt personally threatened when during a suicide incident in Littleton. This researcher interpreted the data to show that exposure to traumatic suicide deaths and the emotional aftermath of the survivors had personally affected responders and disrupted many of their personal lives due to *splash over*. *Splash over* is defined as when the

pain, agony and grief of the victim “splashes over” onto the responders, adding stress to the responders daily life. Most responders (95%) indicated that they can remember specific details of suicide deaths for days, months and even years after the incident. The data indicated that responding to suicide can have profound long lasting effect on emergency workers.

The literature review found very few current resources to answer the second research question on what strategies were used by first responders to reduce suicide deaths. The lack of supporting literature demonstrated that few responders had studied the suicide problem in their community and developed strategies and prevention plans to address the issue. The *Suicide First Response* training manual, written in Colorado in 1966, had a wealth of valuable information for emergency responders but the reference had never been published and had limited circulation.

The national survey also supported that few fire or EMS agencies had developed a response plan or strategy for suicidal situations. Only a small number of agencies (8%) had a standard operation procedure that addresses emergency response to suicidal situations. Most agencies (94%) had not implemented suicide awareness training for first responders or suicide prevention programs in their community. Over half of the respondents (59%) indicated that their agencies did provide injury prevention programs but suicide prevention doesn't appear to be a targeted.

The sixth goal in the National Strategy for Suicide Prevention calls for implementing suicide awareness training for all gatekeepers in the community but the results demonstrated that few emergency responders, gatekeeper of society had been trained in suicide awareness. The national survey found that most first responders (77%) had never had awareness training even though they interact with suicidal people frequently. Even the most current paramedic text book in circulation had little information to training first responders about suicide.

The lack of supporting literature on emergency response to suicide combined with the data from the surveys showed proof that few fire departments or EMS agencies had developed strategies, response plans and prevention programs for suicidal situations. It is apparent to this researcher that with education and training Littleton firefighters can improve medical care, provide better customer service and enhance emotional support for suicidal people. Littleton firefighters can also become a vital link, a referral point, to get suicidal people the specialized care they need.

Many suicide strategies were discovered from the literature review that highlighted suicide prevention activities that were occurring outside the public safety sector. The literature search found national, regional and local suicide strategies and prevention programs. The responder's surveys demonstrated that prevention programs had not been implemented in conjunction with most first responders.

The National Strategy for Suicide Prevention (NSSP) is this country's foundation for suicide prevention in America and was established 7 years ago. Data from the national and local surveys found that most responders were not familiar with the plan. Nationally, the majority of the respondents (91%) had not heard of the plan and locally most Littleton's firefighters (90%) and police officers (78%) hadn't either. This researcher interpreted these results to show that the implementation of the NSSP has not occurred at the first responder level. While NSSP goals mentioned first responders and health care workers, most emergency responders had been omitted in the implementation plan. The literature and research data discovered that necessary training and education for first responders in suicide awareness and prevention had not occurred national, regionally or locally.

The literature search to locate regional suicide prevention programs and strategies in Colorado discovered the Office of Suicide Prevention operating under the Department of Public Health and Environment. The Office of Suicide Prevention was created eight years ago to coordinate state wide suicide prevention efforts in Colorado. Local responder surveys uncovered that there had been little collaboration in Colorado between the state office and most fire and EMS agencies. Few local firefighters (8%) or police officers (21%) knew that Colorado had a state office coordinating suicide prevention. This trend was also discovered nationally. Few respondents (20%) knew that their state had a suicide prevention strategy even though 52 states have prevention strategies.

On July 10, 2008, at the request of the Colorado Office of Suicide Prevention, this researcher appeared in front of the State Emergency Medical and Trauma Services Advisory Council (SEMTAC). The Office of Suicide Prevention was seeking funding and support from the SEMTAC for training dollars to educate prehospital providers on suicide prevention. The SEMTAC unanimously voted to financially and politically support suicide education for emergency responders in Colorado.

Locally, in Littleton, Colorado collaborative suicide prevention efforts for firefighters and police officers appeared to be just as disconnected. The City of Littleton, Littleton Public Schools and the Greater Littleton Youth Initiative implemented the Yellow Ribbon Suicide Prevention (YR) program in the Littleton school curriculum in 2005. For the last three years the YR program has been teaching Littleton school children that it's always alright to *Ask4Help* when you're feeling down, depressed or suicidal. YR cards (see Figure 1) have been distributed in Littleton schools. The YR card instructs the student to give the card to a trusted adult in the community if you're ever contemplating suicide. If an adult receives a YR card they should

recognize the card as a cry for help and become a link between the suicidal person and the care they need. The YR card instructed the adult to stay with the person, listen, take them seriously and call help immediately.

Even though YR program had been active in Littleton schools for 3 years, few Littleton firefighters (17%) or police officers (30%) knew about the YR program. Firefighters and police officers, some of the most trusted adults in the Littleton community hadn't ever heard of the YR program and may not know what to do if they were presented with a YR card. YR is also active in suicide prevention for adults and senior citizens. The results indicate that the implementation of the YR program was effective in Littleton schools and but the program had never been integrated with responders from Littleton Fire Rescue or Littleton Police Department.

Littleton Fire Rescue should be a link for the members of the community to the mental health resources they need in a crisis. Nationally, few emergency responders (12%) provide referral information to people in crisis. Littleton firefighters can become that important link by providing suicide resources brochures on suicide prevention and crisis intervention.

The Carson J. Spencer Foundation, another local Colorado suicide prevention resource, was established in 2005 and had not yet integrated its prevention efforts with local responders. The Foundation was testing new prevention and education ideas with the hope to get local responders more involved with their suicide prevention efforts in the future.

In summary, the literature review and research data discovered during this ARP clearly showed that first responders had frequent contact with suicidal situations in the course of their careers. Responders also had little or no education, training or direction on how to provide emotional support for suicidal individuals or the surviving family and friends of suicide victims. Due to lack of education, responders may feel they have few tools in their medical bags and little

to offer a suicidal person since most Littleton firefighters had not been effectively trained to provide the proper care and emotional support. There was little evidence uncovered through this research that demonstrated that responders were actively involved in suicide prevention and education. While there were suicide strategies and prevention programs discovered, the results clearly demonstrated that prevention and education efforts had not been well integrated with emergency responders locally across the country.

Recommendations to improve the standard of care provided by Littleton firefighters and provide better customer service in suicidal situations have resulted from this research project. The recommendations are based on the findings described in this ARP and the work of other researchers who have developed effective suicide prevention programs. As a result of this study it was revealed that Littleton Fire Rescue should implement a new comprehensive strategy to help reduce injuries and deaths from suicide in the Littleton community. Recommendations resulting from this ARP will greatly benefit the community served by Littleton Fire Rescue.

The organizational implications resulting from this research are substantial and will have an impact on how Littleton Fire Rescue provides medical care and emotional support to suicidal community members. By collecting accurate data on suicide related incidents, Littleton Fire Rescue will have a better understanding of the suicide problem facing the community. A new strategy will provide direction for Littleton firefighters when they encounter suicidal situations and this will improve the standard of care and level of customer service for the people of the Littleton community.

Recommendations

Recommendations resulting from this research project fall into two categories; emergency response and suicide prevention. The first recommendation is for Littleton Fire

Rescue (LFR) to start collecting accurate data on attempted suicides and deaths by suicide in the Littleton community. Firefighters will record all suicide related information in the patient care report to acquire accurate information to measure the scope of the suicide problem in the community. A new record management system (RMS) is being implemented in August, 2008 and will be configured to track all suicide attempts, self-inflicted injuries and deaths by suicide. The data will be used to identify suicide trends and the information electronically transferred to the Colorado Department of Health and be forwarded to support the NEMESIS project. This recommendation correlates directly to the eight goal of the National Strategy for Suicide Prevention (NSSP) which calls for improving surveillance systems by enhancing the quality and quantity of available data at the national, regional and local levels.

The second recommendation is to examine the statistical information gathered from the RMS system on suicide. As the EMS Chief, this researcher will scrutinize all suicide encounters by reading the patient care reports and note if they have exposed Littleton Fire Rescue firefighters to critical incident stress situations which may affect their job performance and personal lives. The data discovered from this ARP demonstrates that first responders can be profoundly affected by responding to suicide situations and may need personal support or counseling. A firefighter support network should be established which may include peer-to-peer counseling, critical incident stress debriefings or defusing, referral to the employee assistance program or a telephone call or personal follow-up visit from the fire department leadership. This recommendation correlates directly to the third goal of the NSSP which emphasizes that we must reduce the stigma associated with asking for help or being a consumer of mental health services.

The third recommendation is the development of a suicide awareness training program for emergency responders. An outline of a training program titled *Until Death Do We Part*:

Emergency Response to Suicidal Crisis was developed by this researcher from the best practices discovered as a result of this APR (see Appendix I). The objectives of the program center on educating first responders on the scope of the suicide problem, understanding myths and commonalities of suicide, identifying risk factors, learning how best to support survivors and what suicide prevention programs are available locally and nationally to provide direction. Suicide awareness training will be given to all LFR firefighters using a PowerPoint presentation made from this researcher's training outline. The awareness training is scheduled for December of 2008. Feedback from LFR firefighters will be used to refine the presentation before making it available to other responders. This recommendation correlates directly to sixth goal of the NSSP which advocates implementing suicide awareness training for all community gatekeepers in recognition of at-risk suicide behavior.

The fourth recommendation is the adoption of a new standard operating procedure (SOP) for Littleton firefighters which will standardize emergency response procedures to suicidal situations (see Appendix J). The SOP will outline response procedures, review risk factors, address interaction by emergency dispatchers with suicidal callers and improve scene management in suicidal situations. The SOP will be reviewed by Littleton firefighters then submitted to the Medical Director and LFR command staff for approval and implemented immediately. This recommendation correlates directly to the seventh goal of the NSSP which suggests development of guidelines, protocols and procedures for response, assessment and treatment of suicidal people.

The fifth recommendation is the development of two resource brochures. The first brochure is a suicide prevention and mental health referral brochure titled *Because Littleton Firefighters Care* (see Figure 2). This brochure is for people attempting suicide and provides

them with resources when they need to access to a crisis line or other mental health services. The theme of this brochure is that Littleton firefighters care about the people in their community and firefighters wants to link them with the resources they need to get through their crisis. It encourages the reader to ask for help when they're sad, depressed considering suicide. National and local suicide prevention hot lines and reference web sites are listed on the brochure. A second brochure, titled *Recovering After Suicide*, will be given to the surviving family and friends of suicide victims (see Figure 3). Survivors are usually in shock, feel lost and helpless and don't know what to do after the suicide of a loved one. This brochure contains information on recovering after a suicide, national and local survivors support groups and important telephone numbers and web sites for further support. This recommendation correlates directly to the eighth goal of the NSSP which calls for improving community access to mental health counseling and substance abuse treatment.

The sixth recommendation is that Littleton Fire Rescue collaborates on suicide prevention efforts currently established in the Littleton community. Firefighters should have an operational awareness of suicide prevention programs used in local schools, businesses and retirement communities. As an example, the Yellow Ribbon Suicide Prevention program and LFR firefighters should work together to deliver a consistent suicide prevention message in local schools. This recommendation correlates directly to the fourth goal of the NSSP which proposes that community-based suicide prevention programs coordinate with government agencies.

The last recommendation is educate emergency responders to understand that they play a very important role in community risk management, injury prevention and the health of the community they serve. This recommendation correlates directly to the first goal of the NSSP which advocates that suicide, like many other public health problems, is treatable and

preventable. Changing firefighters from response mode to prevention mode may be difficult task since some may not see suicide prevention as a part of their fundamental mission. Suicide is preventable problem in the community and LFR firefighters and should embrace suicide prevention efforts like it they have fire prevention, cooking safety, car seat safety, elderly fall prevention and other important community prevention programs that firefighters have supported. LFR firefighters have always believed in being a value added service to the community.

In conclusion, future researchers may wish to perform a similar risk assessment in their communities to improve the health and welfare of the people they serve by using the information in this applied research project (ARP). This researcher hopes the comprehensive suicide prevention strategy presented in this ARP will be a model for other agencies to build upon to improve the standard of patient care and customer service provided to the people in their communities. This researcher also encourages other fire and EMS professional to aggressively pursue research and supporting data to identify the health risks that influence the welfare of the people in their community. Emergency responders are a vital link in the medical community to solving community health issues.

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Appendix A

Demographics – LFR Responders Survey

1. Are you a paramedic or EMT? (Highest level ever practiced at?)

- Paramedic
- EMT – Intermediate
- EMT – Basic

2. How many years of experience do you have in fire/EMS?

- I'm a rookie (less than a year)
- 1-5 years of experience
- 6-10 years of experience
- 11-15 years of experience
- 16-20 years of experience
- 21-25 years of experience
- Over 25 years of experience

Research Question #1 - How often do first responders encounter suicidal situation in their community?

3. Have you ever responded to a call where a person had threatened or attempted suicide?

- Yes
- No

4. Have you ever responded to a call where a person has died by suicide?

- Yes
- No

5. Can you remember specific details of a suicide call you responded to days, months, even years later?

- Yes
- No

6. How many suicide deaths would you estimate that you responded to during the length of your career?

- I have not yet responded to a suicide death yet
- 1-5 deaths
- 6-10 deaths
- 11-15 deaths
- 16-20 deaths
- 21-25 deaths
- Over 25 deaths

7. Have you ever experienced a disruption in your normal life after responding to a suicide death? (sleeping, eating, change in emotions, intrusive images or thoughts)

Yes

No

8. Have you ever felt personally threatened during a suicide call?

Yes

No

Research Question #2 - What strategies do first responders use to reduce suicide in their communities and how are they implemented?

9. Have you ever received any type of formal suicide awareness training during your career?

Yes

No

10. Do you know of any fire department or EMS agency that has implemented any form of suicide prevention program in their community?

Yes

No

11. Do you know any fire or EMS agency that provides suicide prevention information (Referral cards, pamphlets, public health information) to suicidal people?

Yes

No

Research Question #3 - What strategies are used outside emergency responder groups to reduce suicide deaths and how have these strategies been integrated with first responders?

12. Are you familiar with the National Strategy for Suicide Prevention?

Yes

No

I don't know

13. Do you know if the State of Colorado has a state suicide prevention strategy or program currently in place?

Yes

No

I don't know this information

14. Do you know if the City of Littleton has a suicide prevention program or plan for the following groups?

Seniors

Adults

Teens/Young adults

Appendix B

Demographics – Law Enforcement

1. How many years of experience do you have in law enforcement?

- I'm a rookie (less than a year)
- 1-5 years of experience
- 6-10 years of experience
- 11-15 years of experience
- 16-20 years of experience
- 21-25 years of experience
- Over 25 years of experience

Research Question #1 - How often do first responders encounter suicidal situation in their community?

2. Have you ever responded to a call where a person had threatened or attempted suicide?

- Yes
- No

3. Have you ever responded to a call where a person has died by suicide?

- Yes
- No

4. Can you remember specific details of a suicide call you responded to days, months, even years later?

- Yes
- No
- I have never responded to a suicide incident yet

5. How many suicide deaths would you estimate that you responded to during the length of your career?

- I have not yet responded to a suicide death yet
- 1-5 deaths
- 6-10 deaths
- 11-15 deaths
- 16-20 deaths
- 21-25 deaths
- Over 25 deaths

6. Have you ever experienced a disruption in your normal life after responding to a suicide death? (Sleeping, eating, change in emotions, intrusive images or thoughts)

- Yes
- No

7. Have you ever felt personally threatened during a suicide call?

- Yes
- No

Research Question #2 - What strategies do first responders use to reduce suicide deaths in their communities and how are they implemented?

8. Have you ever received any type of formal suicide awareness training during your career?

- Yes
- No

9. Do you know of any law enforcement agency that has implemented any form of suicide prevention program in their community?

- Yes
- No

10. Do you know any law enforcement agency that provides suicide prevention information (referral cards, pamphlets, public health information) to suicidal people?

- Yes
- No

Research Question #3 - What strategies are used outside emergency responder groups to reduce suicide deaths and how have these strategies been integrated with first responders?

11. Are you familiar with the National Strategy for Suicide Prevention?

- Yes
- No
- I don't know

12. Do you know if the State of Colorado has a state suicide prevention strategy or program currently in place?

- Yes
- No
- I don't know this information

13. Do you know if the City of Littleton has a suicide prevention program or plan for the following groups?

- Seniors
- Adults
- Teens/Young adults

Appendix C

National Demographics

1. What type of agency are you affiliated with?

- Fire Service only
- Fire and EMS service combines
- County EMS service
- City EMS service (separate from fire)
- Hospital EMS service
- Private EMS service
- Air Ambulance
- Other

2. What State is your agency in?**3. Does your agency report yearly EMS data and run statistics to your State?**

- Yes
- No
- I don't know this information

4. Does your agency provide injury prevention programs to the community?

- Yes
- No
- I don't know this information

Research Question #1 - How often do first responders encounter suicidal situation in their community?

5. How many suicide deaths did your agency respond to in 2007? (Patient was dead on arrival or died later at a hospital)

- My agency does not track these statistics
- I do not know this information
- I know the number of suicide deaths my agency responded to in 2007
- Enter number

6. How many suicide attempt calls did your agency respond to in 2007? (Patient was threatening suicide or survived a suicide attempt)

- My agency does not track these statistics
- I do not know this information
- I know the number of suicide deaths my agency responded to in 2007
- Enter number

7. Has your agency ever had a suicide death on their property or in a City/County owned building/facility?

- Yes
- No

Research Question #2 - What strategies do first responders use to reduce suicide deaths in their communities and how are they implemented?

8. Has your agency ever had any type of formal suicide awareness training?

- Yes
- No
- I don't know this information

9. Does your agency have a Standard Operating Procedure (SOP) for responding to suicide calls?

- Yes
- No
- I don't know

10. Has your agency implemented any type of suicide awareness or suicide prevention programs for your community?

- Yes
- No
- I don't know this information

11. If your agency has suicide awareness or suicide prevention programs to reduce suicide deaths in your community, how were they implemented?

- We don't have a program
- We do have a program

12. Does your agency provide suicide prevention information (referral cards, pamphlets, public health information) to suicidal people?

- Yes
- No
- I don't know this information

Research Question #3 - What strategies are used outside emergency responder groups to reduce suicide deaths and how have these strategies been integrated with first responders?

13. Are you familiar with the National Strategy for Suicide Prevention?

- Yes
- No

14. Does your State have a suicide prevention strategy or program that you are aware of?

- Yes
- No
- I don't know

15. Does your local community have a suicide prevention program for the following groups?

Seniors

Adults

Teens/Young Adults

16. Has your agency been involved in suicide awareness training or suicide prevention programs with your State or local officials?

Yes

No

I don't know this information

Appendix D

Interview Questions

1. What is the name of your suicide prevention program?
2. What year did your suicide prevention program get started?
3. Does your suicide prevention program follow the recommendations of the Nation Strategy for Suicide Prevention?
4. How is your suicide prevention program funded?
5. Is your suicide program integrated with first responders?
6. How have you integrated your suicide prevention program with first responders?
7. Does your suicide prevention program provide suicide awareness training for first responders?
8. How many suicide awareness programs does your program do for first responders in a year?
9. Does your suicide program address the suicide problem in the following age groups?
10. Has your suicide program been implemented with local communities?

Appendix E

Table E1

Arapahoe County (Colorado) - 2006 Statistics		
Population	537,197	Percent
Total Number of Deaths	3772	
Death by Suicide	77	2%
Males	63	82%
Females	14	18%
Suicide by Age		
Age 11-20	6	7%
Age 21-30	14	18%
Age 31-40	13	17%
Age 41-50	19	25%
Age 51-60	12	16%
Age 61-70	7	9%
Age 71-80	3	4%
Over 81	3	4%
Top Three Methods		
Gunshot Wounds	39	51%
Hanging	19	25%
Overdose	10	13%

Table E2

Douglas County (Colorado) - 2006 Statistics		
Population	263, 621	Percent
Total Number of Deaths	620	
Death by Suicide	22	4%
Males	18	82%
Females	4	18%
Suicide by Age		
Age 11-20	1	5%
Age 21-30	5	23%
Age 31-40	6	27%
Age 41-50	6	27%
Age 51-60	3	14%
Age 61-70	1	5%
Age 71-80	0	0%
Over 81	0	0%
Top Three Methods		
Gunshot Wounds	10	46%
Hanging	8	36%
Overdose	3	14%

Table E3

Jefferson County (Colorado) - 2006 Statistics		
Population	526,994	Percent
Total Number of Deaths	3263	
Death by Suicide	92	3%
Males	69	75%
Females	23	25%
Suicide by Age		
Age 13-18	3	3%
Age 19-30	12	13%
Age 31-40	18	20%
Age 41-50	23	25%
Age 51-60	26	28%
Age 61-70	5	5%
Age 71-80	1	1%
Over 81	4	4%
Top Three Methods		
Gunshot Wounds	47	51%
Hanging	23	25%
Overdose	10	11%

Table E4

All Counties - 2006 Statistics		
Population	1,327,812	Percent
Total Number of Deaths	7,655	
Death by Suicide	191	2%
Males	150	79%
Females	41	21%
Suicide by Age - All Counties		
Age 13-18	10	5%
Age 19-30	31	16%
Age 31-40	37	19%
Age 41-50	48	25%
Age 51-60	41	22%
Age 61-70	13	7%
Age 71-80	4	2%
Over 81	7	4%
Top Three Methods - All Counties		
Gunshot Wounds	96	50%
Hanging	50	26%
Overdose	23	12%

Appendix F

Table F1

Are you a paramedic or EMT? (Highest level of certification you have ever practiced at?)	
Answer Options	Response Percent
Paramedic	54.3%
EMT-Intermediate	1.4%
EMT-Basic	44.3%

Table F2

How many years of experience do you have in fire/EMS?	
Answer Options	Response Percent
I'm a rookie (less than a year)	1.4%
1-5 years of experience	10.0%
6-10 years of experience	21.4%
11-15 years of experience	18.6%
16-20 years of experience	11.4%
21-25 years of experience	12.9%
Over 25 years of experience	24.3%

Table F3

Have you ever responded to a call where a person had threatened or attempted suicide?	
Answer Options	Response Percent
Yes	100.0%
No	0.0%

Table F4

Have you ever responded to a call where a person has died by suicide?	
Answer Options	Response Percent
Yes	97.1%
No	2.9%

Table F5

Can you remember specific details of a suicide call you responded to days, months, even years later?	
Answer Options	Response Percent
Yes	97.1%
No	1.4%
I have never responded to a suicide incident yet.	1.4%

Table F6

How many suicide deaths would you estimate that you responded to during the length of your career?	
Answer Options	Response Percent
I have not yet responded to a suicide death yet	1.4%
1-5 deaths	10.0%
6-10 deaths	20.0%
11-15 deaths	12.9%
16-20 deaths	8.6%
21-25 deaths	12.9%
Over 25 deaths	34.3%

Table F7

Have you ever experienced a disruption in your normal life after responding to a suicide death? (sleeping, eating, change in emotions, intrusive images or thoughts)	
Answer Options	Response Percent
Yes	62.9%
No	37.1%

Table F8

Have you ever felt personally threatened during a suicide call?	
Answer Options	Response Percent
Yes	36.2%
No	63.8%

F9

Have you ever received any type of formal suicide awareness training during your career?	
Answer Options	Response Percent
Yes	39.1%
No	60.9%

F10

Do you know of any fire department or EMS agency that has implemented any form of suicide prevention program in their community?	
Answer Options	Response Percent
Yes	15.7%
No	84.3%

F11

Do you know any fire or EMS agency that provides suicide prevention information (referral cards, pamphlets, public health information) to suicidal people?	
Answer Options	Response Percent
Yes	4.3%
No	95.7%

F12

Are you familiar with the National Strategy for Suicide Prevention?	
Answer Options	Response Percent
Yes	1.4%
No	90.0%
I don't know	8.6%

F13

Do you know if the State of Colorado has a state suicide prevention strategy or program currently in place?	
Answer Options	Response Percent
Yes	8.6%
No	48.6%
In don't know this information	42.9%

F14

Do you know if the City of Littleton has a suicide prevention program or plan for the following groups?			
Answer Options	Yes	No	I don't know
Seniors	1.4%	21.7%	76.8%
Adults	1.5%	22.1%	76.5%
Teens/Young Adults	17.9%	17.9%	64.2%

Appendix G

Table G1

How many years of experience do you have in law enforcement?	
Answer Options	Response Percent
I'm a rookie (less than a year)	4.8%
1-5 years of experience	14.3%
6-10 years of experience	19.0%
11-15 years of experience	19.0%
16-20 years of experience	14.3%
21-25 years of experience	14.3%
Over 25 years of experience	14.3%

Table G2

Have you ever responded to a call where a person had threatened or attempted suicide?	
Answer Options	Response Percent
Yes	100.0%
No	0.0%

Table G3

Have you ever responded to a call where a person has died by suicide?	
Answer Options	Response Percent
Yes	95.0%
No	5.0%

Table G4

Can you remember specific details of a suicide call you responded to days, months, even years later?	
Answer Options	Response Percent
Yes	95.0%
No	0.0%
I have never responded to a suicide incident yet.	5.0%

Table G5

How many suicide deaths would you estimate that you responded to during the length of your career?	
Answer Options	Response Percent
I have not yet responded to a suicide death yet	5.0%
1-5 deaths	25.0%
6-10 deaths	25.0%
11-15 deaths	15.0%
16-20 deaths	10.0%
21-25 deaths	0.0%
Over 25 deaths	20.0%

Table G6

Have you ever experienced a disruption in your normal life after responding to a suicide death? (sleeping, eating, change in emotions, intrusive images or thoughts)	
Answer Options	Response Percent
Yes	47.4%
No	52.6%

Table G7

Have you ever felt personally threatened during a suicide call?	
Answer Options	Response Percent
Yes	30.0%
No	70.0%

Table G8

Have you ever received any type of formal suicide awareness training during your career?	
Answer Options	Response Percent
Yes	75.0%
No	25.0%

Table G9

Do you know of any law enforcement agency that has implemented any form of suicide prevention program in their community?	
Answer Options	Response Percent
Yes	35.0%
No	65.0%

Table G10

Do you know any law enforcement agency that provides suicide prevention information (referral cards, pamphlets, public health information) to suicidal people?	
Answer Options	Response Percent
Yes	50.0%
No	50.0%

Table G11

Are you familiar with the National Strategy for Suicide Prevention?	
Answer Options	Response Percent
Yes	15.8%
No	78.9%
I don't know	5.3%

Table G12

Do you know if the State of Colorado has a state suicide prevention strategy or program currently in place?	
Answer Options	Response Percent
Yes	21.1%
No	47.4%
In don't know this information	31.6%

Table G13

Do you know if the City of Littleton has a suicide prevention program or plan for the following groups?			
Answer Options	Yes	No	I don't know
Seniors	5.3%	10.5%	84.2%
Adults	15.0%	10.0%	75.0%
Teens/Young Adults	30.0%	10.0%	60.0%

Appendix H

Table H1

What type of agency are you affiliated with?	
Answer Options	Response Percent
Fire service only	9.3%
Fire and EMS service combined	71.1%
County EMS service	5.2%
City EMS service(separated from fire)	4.1%
Hospital EMS service	1.0%
Private EMS service	5.2%
Air ambulance EMS service	0.0%
Other	4.1%

Table H2

What State is your agency in?	
Answer Options	Response Percent
State:	100.0%

Table H3

Does your agency report yearly EMS data and run statistics to your State?	
Answer Options	Response Percent
Yes	85.9%
No	12.1%
I don't know this information	2.0%

Table H4

Does your agency provide injury prevention programs to the community?		
Answer Options	Response Percent	Response Count
Yes	59.6%	59
No	34.3%	34
I don't know this information	6.1%	6

Table H5

How many suicide deaths did your agency respond to in 2007? (patient was dead on your arrival or died later at a hospital)	
Answer Options	Response Percent
My agency does not track these statistics	44.4%
I do not know this information	43.3%
I know the number of suicide deaths in 2007	12.2%

Table H6

How many suicide attempt calls did your agency respond to in 2007? (patient was threatening suicide or survived a suicide attempt)	
Answer Options	Response Percent
My agency does not track these statistics	42.5%
I do not know this information	44.8%
I know the number of suicide attempt calls that my agency responded to in 2007	12.6%

Table H7

Has your agency ever had a suicide death on their property or in a City/County owned building/facility?	
Answer Options	Response Percent
No	84.8%
Yes (please describe)	15.2%

Table H8

Has your agency ever had any type of formal suicide awareness training?	
Answer Options	Response Percent
Yes	18.5%
No	77.2%
I don't know this information	4.3%

Table H9

Does your agency have a Standard Operating Procedure (SOP) for responding to suicide calls?	
Answer Options	Response Percent
Yes (If yes, please email me a copy at wzygowicz@littletongov.org)	8.7%
No	88.0%
I don't know	3.3%

Table H10

Has your agency implemented any type of suicide awareness or suicide prevention programs for your community?	
Answer Options	Response Percent
Yes	3.3%
No	94.6%
I don't know this information	2.2%

Table H11

If your agency has suicide awareness or suicide prevention programs to reduce suicide deaths in your community, how were they implemented?	
Answer Options	Response Percent
We don't have a program	97.8%
We do have a program	2.2%

Table H12

Does your agency provide suicide prevention information (referral cards, pamphlets, public health information) to suicidal people?	
Answer Options	Response Percent
Yes	12.1%
No	85.7%
I don't know this information	2.2%

Table H13

Are you familiar with the National Strategy for Suicide Prevention?	
Answer Options	Response Percent
Yes	8.9%
No	91.1%

Table H14

Does your State have a suicide prevention strategy or program that you are aware of?	
Answer Options	Response Percent
Yes	20.7%
No	22.8%
I'm not sure	56.5%

Table H15

Does your local community have a suicide prevention program for the following groups?			
Answer Options	Yes	No	I don't know
Seniors	1.4%	21.7%	76.8%
Adults	1.5%	22.1%	76.5%
Teens/Young Adults	17.9%	17.9%	64.2%

Table H16 w

Has your agency been involved in suicide awareness training or suicide prevention programs with your State or local officials?	
Answer Options	Response Percent
Yes	5.4%
No	89.1%
I don't know this information	5.4%

Appendix I

Slide 1

Until Death Do We Part
Emergency Response to Suicidal Crisis

Slide 2

Suicide affects people of all ages, races, both sexes, all nationalities, religions, and social-economical backgrounds
No Group is Immune

Slide 3

Class Outline

- Class objects
- References and terms
- Scope of the problem
- Choosing death by suicide
- Myths and commonalities of suicide
- Risk factors
- Emergency response
- Survivors
- Suicide prevention
- Lessons Learned

Slide 4

Class Objectives

By the end of this presentation the student will:

- Understand the scope of the suicide problem
- Identify risk factors
- Remember emergency response procedures
- Recall how to effectively help survivors
- Have an understanding of the NSSP plan
- Identify five lesson learned

Slide 5

References

- Surgeon Generals Call to Action
- National Strategy for Suicide Prevention: Goals and Objectives for Action (NSSP)
- Centers for Disease Control (CDC)
- Suicide First Response – A Training Manual for Professionals who Respond to Suicides

Slide 6

References

- **Suicide Prevention Resource Center**
www.sprc.org
- **American Foundation for Suicide Prevention**
www.afsp.org
- **American Association of Suicidology**
www.suicidology.org
- **Office of Suicide Prevention – Colorado**
www.cdphe.state.co.us/pp/suicide
- **Yellow Ribbon Suicide Prevention**
www.yellowribbon.org

Slide 7

Glossary of Terms

- **Depression** – a constellation of emotional, cognitive and somatic signs and symptoms including sustained sad mood and lack of pleasure
- **Gatekeepers** – individuals in a community who have daily face-to-face contact with large numbers of community members
- **Intentional** – injuries resulting from purposeful human action, self-directed or assaultive
- **Means** – instrument or object whereby a self-destructive act is carried out
- **Methods** – actions or techniques which result in an individual inflicting self-harm (jumping, overdose)

Slide 8

Glossary of Terms

- **Postvention** – a strategy that is implemented after the crisis or traumatic event
- **Prevention** – a strategy or approach that reduces the likelihood of risk or onset
- **Risk Factors** – factors that make it more likely that individuals will develop a disorder
- **Stigma** – an idea or label associated with disgrace
- **Suicidal Behavior** – a spectrum of activities related to thoughts and behaviors (thinking, attempts or completed suicide)

Slide 9

Glossary of Terms

- **Suicidal Ideation** – self-reported thoughts of engaging in suicidal behavior
- **Suicide** – death from injury where there is evidence that a self-inflicted act led to the death
- **Suicide Attempt** – a potentially self-injurious behavior with a non-fatal outcome which there is evidence that the person intended to kill themselves
- **Suicide Attempt Survivors** – people who have survived a prior suicide attempt
- **Suicide Survivors** – family members, significant others, friends who have experienced the loss of a loved one due to suicide

Slide 10*National Facts*

- Every 17 minutes another life is lost to suicide
- 86 Americans take their lives every day
- 1,500 will attempt suicide every day
- 32,000 will die by suicide yearly
- 11th leading cause of death in America
- Over half the suicides occur in men (25-65)
- More males take their lives than females

Slide 11*National Facts*

- 72% of all suicides are white men
- 79% of firearm suicides are white men
- Many who attempt never seek professional care and counseling
- Second leading cause of death for teens
- Between 1952 and 1995, suicide among adolescences nearly tripled

Slide 11*National Facts*

- Elderly American's account for 20% of the nation's suicides (13% of population)
- Numbers don't account for passive suicide
- 75% of elderly victims had visited a physician the month prior to their death
- 85% of elderly suicides are men and are most likely to involve a gun

Slide 12*Colorado Facts*

- 6th leading cause of death in Colorado
- 47 suicide deaths per month in Colorado
- Colorado residents kill themselves at a rate of 15.8 per 100,000 (National rate = 11.3)
- Colorado seniors (65+) die by suicide at a rate of 26.1 per 100,000

Slide 13**Center for Disease Control**

- Web-based Injury Statistics Query and Reporting System (WISQARS)
- Contains injury mortality data - generates tables of injury deaths and death rates
- By geographical region, year, age, race and sex.
- Current to 2005

Slide 14*Death by Suicide*

- Very Complex
- Difficult to understand and difficult to predict
- Many deaths could be prevented if people would seek mental health care
- Seeking help is "stigmatized" by society

Slide 15

Suicide

- Awful way to die
- Suffering is private and inexpressible
- Mental suffering leading to death is usually prolonged and intense
- Not uncommon for death to be violent
- Families are left with unfathomable loss
- Guilt
- *“Confusions and devastation are beyond description”*

Slide 16

What’s Known

- Certain conditions predispose people
- Add certain environmental conditions/events
- Certain sectors of society are more vulnerable
- Socioeconomic background
- Age
- Gender
- Cultural

Slide 17

15 Suicide Myths

Suicide Myths

Myth #1 - Suicide survivors are somehow the cause of the suicide death

- Grave misconception
- Society’s need to blame someone
- Multitude of factors

Slide 18

Suicide Myths

Myth #2 – A lot of suicides turn out to be homicides

- Approximately, only 8% of apparent suicides end up actually being homicides

Slide 19

Suicide Myths

Myth #3 – Suicide death is a crime

- No states in the U.S. have laws making suicide a crime

Slide 20

Suicide Myths

Myth #4 – People who commit suicide are failures

- Many highly successful, famous and intelligent people have chosen death by suicide

Slide 21

Suicide Myths

Myth #5 – Suicide is inherited or genetic

- Suicide is NOT inherited - nor genetic
- Suicide is a learned behavior – perpetuates within families
- Behavioral disorders have a genetic predisposition

Slide 22

Suicide Myths

Myth #6 – All people who choose suicide are insane

- Not all people who choose suicide have a behavioral disorder

Slide 23

Suicide Myths

Myth # 7 – Suicide is usually unpredictable

- Suicidal people often give many clues and warning signs regarding their intent

Slide 24

Suicide Myths

Myth #8 – People who talk about suicide usually don't follow through

- To the contrary, 75% of the people who complete suicide gave clues and warnings

Slide 26

Suicide Myths

Myth #9 – Suicidal people intend to die

- Most people are ambivalent about dying and hope someone will save them

Slide 27

Suicide Myths

Myth #10 – If a person ever becomes suicidal, they are suicidal forever

- A suicidal state of mind is almost always temporary

Slide 28

Suicide Myths

Myth #11 – After a suicidal crisis has occurred, outward improvement in the suicidal person means the risk of suicide no longer exists

- Most suicides occur about three months after improvement, people get renewed energy to kill themselves

Slide 29

Suicide Myths

Myth #12 – Those who try and fail, will not try again

- Attempts increase the risk that the people will attempt again

Slide 30*Suicide Myths***Myth #13 – People with substance abuse problems generally don't kill themselves**

- One-third of all suicides are completed by persons with alcohol dependency
- ETOH is a “dis-inhibitor”
- Impulsive suicide

Slide 31*Suicide Myths***Myth #14 – Asking if someone feels suicidal or talking to someone about suicide increases the risk that the person will take their life**

- Just the opposite is true
- Talking eases the anxiety of the person
- Allows an opportunity to talk about their feelings

Slide 32*Suicide Myths***Myth #15 – There is little help possible for those contemplating suicide**

- Seeking therapeutic advice and guidance can greatly reduce suicide and speed recovery
- Early recognition
- Referrals

Slide 33*Commonalities of Suicide*

- Common purpose of suicide is to seek a solution
- Common goal of suicide is cessation of consciousness
- Common stimulus in suicide is intolerable psychological pain
- Common stressor in suicide is frustrated psychological needs
- Common emotion in suicide is hopelessness and helplessness

Slide 34*Commonalities of Suicide*

- Common cognitive state in suicide is ambivalence
- Common perceptual state in suicide is constriction, tunneling, narrowing of choices
- Common action in suicide is escape
- Common interpersonal act in suicide is communication of intention
- Common consistency in suicide is lifelong coping patterns

Slide 35**Risk Factors for Suicide****Bio-psychosocial Risk Factors**

- Mental disorder, particularly mood disorders, schizophrenia, anxiety and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness

- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- A major physical illness
- Previous suicide attempt
- Family history of suicide

Slide 36

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Slide 37

Socio-cultural Risk Factors

- Lack of social support - sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing quality mental health care and substance abuse treatment
- Certain cultural and religious beliefs (example: the belief that suicide is a noble resolution of a personal dilemma)
- Exposure through the media
- Influence of others who have died by suicide

Slide 38

Depression

- Major cause of suicide
- Serious, life-threatening illness
- Can occur for no apparent reason at all
- 10-15% of the population suffer
- Estimated 30 million Americans suffer
- Any age, race, religion or education
- Treatment is highly effective
- Nearly all suicidal people are depressed

Slide 39

Symptoms of Depression

- Inability to concentrate
- Poor memory
- Inability to experience pleasure
- Apathy
- Irritability
- Self-blame
- Insomnia
- Weight-loss

- Loss of sex drive
- Headaches
- Backaches
- GI problems
- Impulsiveness
- Alcohol and drug use

Slide 40*Stress*

- Natural, ongoing state of being
- Produces a biological reaction in the body
- “Fight or flight”
- Designed to protect, defend or escape
- High levels of stress over prolonged periods causes the body to act negatively
- Suppression of the immune system
- Change in thought process

Slide 41*Post-Traumatic Stress Disorder*

- Results from exposure to a major crisis
- Prolonged exposure to critical incidents
- People with PTSD at greater risk of suicide
- Leads to depression and alcohol abuse

Slide 42*Erosion*

- Suicide is rarely spontaneous
- A long-term wearing-away of an individual’s ability to cope
- “The last straw”
- Narrowing of choices

Slide 43*Inability to Cope - Loss*

- Loss of self-esteem, status or self-image
- Loss of health, financial security or freedom
- Loss of a significant other through separation, divorce or death
- Significant loss which occurs suddenly and unexpectedly
- Several crucial losses occurring in rapid succession

Slide 44*Additional Factors*

- Alcoholism
- Recent suicide attempt
- Previous history of suicide attempts
- Major crisis or transition

- Loss of independence
- Intractable, unremitting PAIN
- Feeling unnecessary, useless and devalued

Slide 45

Additional Factors

- Social isolation
- Lack of family support
- Expression of a plan for committing suicide
- Access to a means for completing suicide
- Mental health disorders – schizophrenia, anxiety, mood, substance-related, sleep, personality and impulse disorders

Slide 46

Suicide by Cop

- Estimated one-in-ten fatal shootings are provoked by the desire to die (LA)
- Overwhelming the deaths are males
- History of domestic violence, substance abuse, previous suicide attempts

Slide 47

Suicide by Cop – Implications

- A threat to the life of the officer and others
- Officers “second guess” their decision making
- Coroners do not record these deaths as suicides
- News media reporting the event as “death by cop” opens the officers decision to public scrutiny

Slide 48

Communication Specialists

- Communication Specialists will try to stop all suicidal persons who call the center
- All suicidal situations are volatile
- Take all suicidal threats seriously
- Determine their location if unknown
- Understand that every individual has the responsibility for their final actions

Slide 49

Communication Specialists

- Build a rapport or a bond with the caller:
- Use their first name
- Gather as much information as possible
- Talk specifics – means, method, plan and suicide note
- Discuss the reality/finality of their potential decision
- Bring positive reinforcements into the discussion

Slide 50

Suicide Attempters

- Estimated 6-25 attempters for every completed suicide
- Establishing a rapport with the patient
- Show compassion for the individual and their situation
- Be genuine and show sincerity
- Do not blame the person
- Question the patient directly about their plan, lethal means, method
- Transport
- Discuss with the family removing lethal means

Slide 51

Assessing Lethality

- Question the person directly
- Is the person talking about suicide?
- Is there a specific suicide plan?
- Are there previous suicide attempts?
- Is there a suicide note?
- Are there means for self injury?
- Is there evidence of injury?
- Has the person made final arrangements?
- Are there signs of depression or substance abuse?

Slide 52

Interaction With Mentally Ill

- Don't join in disturbed thinking/behavior
- Don't stare or confuse the person
- Don't whisper, joke or laugh
- Don't give the person choices, be in control
- Don't deceive the person or touch them

Slide 53

Completed Suicide

- The scene should be secured by law enforcement
- All deaths should be considered a crime scene
- Restrict access
- Do not disturb potential evidence
- Do not disturb the body except to declare death
- Confirm the identity of the person, DOB, time, place and manner of death
- Contact Medical Control for time of death
- Write a detailed patient care report of the circumstances of the death

Slide 54*On Arrival*

- Introduce yourself and your organization
- Assign someone to family members
- Determine who each person is on scene
- Secure the scene
- Restrict pets
- Assist with children

Slide 55*Pets*

- Confine pets so they can't reach the incident area until cleaned

Slide 56*Small Children*

- Frightened and in need of being comforted
- Help arrange for care while adults can not respond to their needs
- Short term task for responders

Slide 57*Suicide Notes*

- Don't destroy – it's evidence
- Do not remove from the scene
- May further the pain and suffering of the family or survivors
- Share your concerns with the family

Slide 58*Survivors and Victims*

- **Primary Survivors** – parents, siblings spouses and children
- **Secondary Survivors** – friends, neighbors and other relatives
- **Tertiary Victims** – professionals who respond to the scene of the suicide

Slide 59*Survivors - Family, Friends. Loved Ones*

- Each suicide intimately affects a minimum of 6 other people
- 31,000 suicides = 186,000 survivors yearly
- 6 new survivors every 17 minutes
- 4.4 million (1998)
- 1 of every 62 Americans (1998)

Slide 60*Survivors and Victims*

- Do not overlook the survivor's emotional trauma
- Insure survivors are not further traumatized
- **Responders must realize the impact of their actions will have on survivors**

- **Slide 61**

“Post-vention”

Dr. Edwin Schneidman

- An impact, positive or negative, that effects the survivors ability to cope
- Minimize the affect of post traumatic stress
- Validate the grief reaction
- Support healthy mourning
- Helps avert suicide among the bereaved

Slide 62

Survivor’s Emotional Response

Five Stages of Loss

- **Denial** – Refusal to accept the reality of what has occurred
- **Anger** – Manifestation of the victim’s inability to control the situation
- **Bargaining** – Victim’s attempt to put off or change the expected outcome
- **Depression** – Being sad, feeling despair, mourning dreams that will not come true
- **Acceptance** – Achieving a level of comfort with what is

Slide 63

Not All Loss is the Same

- Age of the deceased
- Was the death was sudden or expected
- Was the death peaceful or violent
- Was the death random or intentional
- Was the death preventable
- Was the cause of death appropriate or inappropriate

Slide 64

Working with Distressed Adults

- Remove from the immediate death scene
- Try to make them comfortable
- Display calmness and self-control
- Use soft, even voice tones
- Crouch or kneel near, when appropriate
- Maintain distance with highly the agitated
- Allow a survivor to protest the death
- Draw the family together in physical proximity for reinforcement and begin grieving
- Listen earnestly to everyone at the scene
- Try to appear comfortable, even if your not
- Courtesy and calmness go along way

Slide 65

Death Notice

- Confirm the identity of the person, DOB
- Confirm time, place and cause of death

- Confirm the location of the deceased
- Identify the immediate family members
- Receive authorization to release the facts
- A team of two should do the notification

Slide 66*Notification*

- In person, face-to-face
- Assess the situation
- Introduce yourself and your partner
- Show your identification or badge
- Only notify primary family members
- Show compassion
- Move to a private place
- Be directive, not suggestive (“*you need to sit down*”)
- Get right to the point
- Confirm with the survivors what their relationship is with the deceased
- Use the deceased person’s name
- Include the facts
- Use gentle eye contact
- Use the power of touch, if appropriate

Slide 67*Notification*

- *“There is no easy way to tell you this”*
- *“I’m afraid I have some bad news for you”*
- *“I wish I didn’t have to tell you this”*
- *“I’m sorry for your loss”*
- **Use the word “died” or “dead”**
- *“The person has died”*
- *“There is nothing anyone could have done”*

Slide 68*Notification*

- Answer the survivor’s questions
- Be prepared for any kind of reaction
- Seeing or holding the body
- Try to assess the stability of the person to whom the news was delivered
- Give them control back in an uncontrollable situation
- Spend time with the survivors
- If alone, offer to call someone for them
- Before you leave, check to see if the family has any further question
- Identify a contact person and leave follow-up information with them
- Remember “What would my family want done at a time like this?”

Slide 69

Things to Say

- *“I’m so sorry”*
- *“Dealing with the death of a loved one is harder than most people could ever imagine”*
- *“Is there something I can get for you?”*
- *“Is there someone I can call for you?”*
- *“I’ll check back with you to see how you are doing and if there’s anything more I can do for you”*

Slide 70

What NOT to Say

- *I know how you feel*
- *Time heals all wounds*
- *You must go on with your life*
- *You’ll get over this*
- *You must focus on your precious memories*
- *They are in a better place*
- *You must get a hold of yourself*
- *You must be strong for your children*

Slide 71

Survivors have a right...

- To be treated with dignity
- To be treated with compassion/understanding
- To be supported
- To grieve and be allowed to grieve
- To be a survivor

Slide 72

Survivors Need...

- Someone to be there for them
- To be allowed to feel, cry and be sad
- To grieve at their own pace
- To be alone, yet not be abandoned
- To say how they feel, but not be forced to clarify their feelings
- To be told of assistance and social services available and how to contact them
- To be provided a private area while being interviewed about the suicide

Slide 73

Survivors Don’t Need...

- To be treated as though they are part of this terrible act
- Being lied to
- To be treated without compassion
- To feel intimidated

Slide 74

What to Expect - *Grief*

- Response to a great loss of life
- Sudden, acute grief comes unannounced
- Leaves survivors battered and shaken

Slide 75

What to Expect – *Guilt*

- Survivors of suicide carry a special burden
- Shame and anger
- Why did this happen?
- Was there anything I could have done to prevent this?

Slide 76

What to Expect - *Shock*

- First stage of acute grief
- Feeling numb and cold
- “Just can’t believe this”
- Physical symptoms are common – tightness in their throat/chest, upset stomach, SOB, general feeling of slowness

Slide 76

What to Expect – *Depression*

- After the shock, depression sets in with the reality
- Some withdraw and isolate themselves
- Physical symptoms include fatigue, nervousness, rash, hives, GI problems

Slide 77

Effects on Children

- Telling a child of a death is one of the most difficult things to do
- Children are often very confused but know something is horribly wrong
- Not well equipped to express their emotions
- Honesty is the best policy
- Guide them through the time of loss

Slide 78

Strategies for Surviving Children

- Be aware of the child’s level of understanding or misunderstanding
- Explain the truth on a level they can understand
- The more they understand the less fearful they will be
- Listen carefully, answer questions honestly
- Talk about the deceased family member
- Do not be afraid to show emotion
- Involve the child in memorials or tributes
- Children may temporarily regress emotionally and developmentally

- Don't go it alone – counselor, pastor, trusted friend or family member
- Children do not heal quickly

Slide 79

Cleaning Up

- The gore should be shielded from the public and family
- Cleaning companies
- Some families may prefer to clean themselves
- Remove blood from public areas
- Develop a SOP
- Use body substance isolation

Slide 80

Commonly Asked Questions

- **Where will my relative be taken?**
To the county morgue
- **Is it necessary to go to the morgue to identify the body?**
No, visual identification is not necessary
- **Is viewing allowed?**
No, viewing is not allowed
- **Why is the coroner involved?**
State law requires the coroner to be notified
- **Will an autopsy be performed?**
When there is an additional need to establish the cause and manner of death
- **What about organ donation?**
Depending on the circumstances of death
- **How long will it be before the body is released?**
Usually within 72 hours
- **What should I do now?**
Contact a funeral home within 48 hours

Slide 81

Organ Donation

- Bereaved may find comfort in donation
- Depends on body condition
- Expense is not the responsibility of the donor's family
- Colorado law requires hospital personnel to counsel families of donor options
- Colorado Organ Recovery

Slide 82

Funeral Arrangements

“What do I need to do now?”

- Many find comfort in calling a Clergy person
- Victims advocates
- Make appointment to meet with the Funeral Director to explore options
- Coroner must give authorization to release the body to the funeral home

Slide 83**Provide Survivor Resources**

- Littleton Fire Rescue
303-795-3800 www.littletongov.org/fire
- Arapahoe County Sheriff's Department
303-795-4711 www.co.arapahoe.co.us/departments/SH
- Arapahoe County Coroner's Office
720-874-3625 www.co.arapahoe.co.us.departments/CO
- Douglas County Sheriff's Department
303-660-7505 www.dcsheriff.net
- Douglas County Coroner's Office
303-814-7150 www.douglas.co.us/coroner
- Jefferson County Sheriff's Department
303-277-0211 www.co.jefferson.co.us/sheriff
- Jefferson County Coroner's Office
303-271-6480 www.jeffco.us/coroner
- Suicide Prevention Resource Center
334-206-5226 www.sprc.org
- American Foundation for Suicide Prevention
Toll-free 1-888-333-AFSP www.afsp.org
- American Association of Suicidology
202-237-2280 www.suicidology.org
- Office of Suicide Prevention – State of Colorado
303-692-2539 www.cdphe.state.co.us/pp/suicide
- Yellow Ribbon Suicide Prevention Programs
303-429-353 www.yellowribbon.org
- Heartbeat – Peer support
<http://heartbeatsurvivorsaftersuicide.org>

Slide 84**Responding Professionals**

- Wave after wave of traumatic deaths

Slide 85***“Splash Over”***

When the pain, distress, agony and grief of the primary and secondary victims “splashes over” onto the responders adding stresses of the emergency to the responder’s own set of normal everyday stressors

Slide 86**Support First Responders**

- Provide immediate emotional support when needed
- Critical incident stress management

- Fire Department Chaplin
- Employee Assistance Program
- Administrative leave

Slide 87

**Suicide Prevention
National Strategy for
Suicide Prevention (NSSP)
National Strategy for Suicide Prevention
*Key Elements***

- Engage partners
- Functional operating structure with authority,
- Funding, responsibility, and accountability
- Agreements among agencies coordinating segments of the plan
- Summary of the scope of the problem and consensus on prevention priorities
- Specified aims, goals and measures for suicide prevention
- Appropriate activities for practitioners, communities, and other partners
- A data collection and evaluation system to track information and benchmarks for progress

Slide 88

Aim of NSSP

- Prevent premature deaths due to suicide across a life span
- Reduce the rates of other suicidal behaviors
- Reduce the harmful after-effects of suicidal behaviors and their impact on family and friends
- Promote opportunities and settings to enhance resiliency, resourcefulness and respect

Slide 89

Goal #1

Promote Awareness that Suicide is a Preventable Public Health Problem

- Increase number of campaigns for public awareness, reach at least 50% of public in each state
- Establish national congresses on prevention, foster collaboration across disciplines and with the public
- Convene national forums to focus on effectiveness of prevention messages
- Increase number of public and private institutions active in providing information on the internet

Slide 90

Goal #2

Develop Broad-Based Support for Suicide Prevention

- Expand and improve Federal coordination to implement the NSSP
- Establish a national coordinating body to advance and implement the NSSP
- Increase professional and voluntary groups that integrate prevention programs and activities
- Increase number of faith communities adopting policies of prevention

Slide 91

Goal #3

Reduce Stigma Associated with Mental Health, Abuse and Prevention Services

- Increase proportion of public that views mental and physical health as inseparable from overall health
- Increase proportion of public that views mental disorders as real treatable illnesses
- Increase proportion of public that views prevention services as helpful in care/treatment for overall health
- Increase proportion of suicidal persons with underlying disorders who receive appropriate mental health treatment

Slide 92

Goal #4

Develop and Implement Community Based Suicide Prevention Programs

- Increase the proportion of states with comprehensive prevention plans
- Coordinate government agencies
- Involve private sectors
- Support plan development, implementation, and evaluation in the community
- Develop training and technical resource centers to implement the NSSP
- Increase number of programs that address distress and prevention among...
- School districts and private schools for children and adolescents
- Colleges and universities
- Employers that ensure availability for employees
- Correctional institutions, jails and detention centers for adults and juveniles
- State Aging Networks for elderly people
- Family, youth and community organizations

Slide 93

Goal #5

Reduce Access to

Lethal Means and Methods of Self-Harm

- Increase number of health care officials who assess the presence of lethal means and education on associated risks
- Expose more households to campaigns on reducing access to lethal means in the home
- Develop improved firearm safety design using technology
- Develop guidelines for safer dispensing of medication to those at high suicide risk
- Improve auto design to impede carbon monoxide-mediated suicide
- Introduce incentives for discovery of new technologies to prevent suicide

Slide 94

Goal #6

Training for Recognition of At-Risk Behavior and Effective Treatment

Increase the proportion of people in the following areas who have training on suicide management and risks...

- Nursing care providers
- Medical residency programs

- Graduate programs in social work, counseling, and psychology
- Clergy
- Educational faculty and staff
- Correctional workers
- Divorce, family law, and criminal defense attorneys

Slide 95***Goal #6*****Training for Recognition of At-Risk Behavior and Effective Treatment**

- Increase proportion of counties with educational programs available to the family members of those at risk
- Increase recertification or licensing programs for depression assessment and suicide prevention

Slide 96***Goal #7*****Develop and Promote Effective Clinical and Professional Practices**

- Increase number of patients with self-destructive behavior that pursue follow-up programs
- Develop guidelines for assessing suicide risk for persons living in health care settings
- Increase number of centers for mental health and abuse that assess risk of suicide
- Develop guidelines for aftercare treatment programs for those with suicidal behavior
- Increase number of people who provide services to suicide survivors
- Increase number of patients with mood disorders who complete treatment courses
- Increase immediate post-trauma support in hospitals for victims of sexual assault
- Help educate family members of those receiving mental health treatment
- Incorporate screening for suicide risk for all Federally-supplied healthcare programs
- Include screening for depression and suicide risk in the Health Plan Employer Data and Information Set

Slide 97***Goal #8*****Improve Access to Mental Health and Substance Abuse Services**

- Increase number of states that require health insurance plans to cover mental health services on par with physical health
- Increase number of school districts with school-based clinics that incorporate mental health care into their activities
- Increase number of counties with health and/or social outreach programs
- Define guidelines for mental health screening of students in schools and colleges
- Develop guidelines for schools on appropriate linkage with mental health treatment services
- Define national guidelines for assessment and treatment of suicide for incarcerated individuals
- Define guidelines for comprehensive support programs for suicide survivors
- Create guidelines for effective responses to suicidal risk and implement these in health insurance plans

Slide 98

Goal #9

Improve Reporting and Portrayal of Suicide in the News Media

- Establish association for promoting accurate representation of suicidal behaviors in the movies and on TV
- Increase proportion of movies and TV programs that accurately depict related issues
- Increase news reports that follow reporting recommendations on suicidal behavior
- Increase journalism schools with curricula that include guidance on mental health reporting

Slide 99

Goal #10

Promote and Support Research on Suicide and Prevention

- Develop national research agenda with input from survivors, practitioners and researchers
- Increase funding for suicide prevention research (public and private)
- Establish a registry of demonstrated prevention activities and their effectiveness
- Perform scientific evaluation studies of new or existing prevention interventions

Slide 100

Goal #11

**Improve and Expand
Surveillance Systems**

- Develop and implement protocols for death scene investigations
- Increase jurisdictions that regularly collect and provide info for follow-back studies
- Increase number of hospitals that collect reliable data on suicidal behavior by coding external injuries
- Implement national violent death reporting system that collects info not available from death certificates
- Increase number of states that produce annual reports on suicide and attempts, integrating multiple state data systems
- Increase number of national surveys that include questions about suicidal behavior
- Implement pilot projects that link and analyze info from several medical and law systems

Slide 101

Lesson Learned

- Suicide is a public health problem
- Suicide is treatable and preventable
- No group of people are immune to suicide
- Use the CDC website to examine the suicide problem in your community
- Understand and identify all risk factors
- Mental health problems and substance abuse are the leading factors
- Train communication specialists how to interact with suicide callers
- Develop a standard operating procedure (SOP) for responding to suicidal incidents
- Develop skills for treating suicide attempters
- Remember the impact first responders have on the survivors of suicide
- Remember common emotions survivors display

- Provide survivors with available resources they may need
- Train first responders on suicide awareness
- Be familiar with the National Strategy for Suicide Prevention
- Support local suicide prevention programs in your community

Appendix J

Littleton Fire Rescue	SOP # Draft
Response to Suicidal Crisis Situations	Implementation – Revised -

Response to Suicidal Crisis Situations

Purpose: The purpose of this SOP is to outline response procedures for suicidal situations; threats of suicide, attempts or completed suicide.

Scope: This SOP applies to all Littleton Fire Rescue (LFR) employees.

Introduction: More than 30,000 Americans die by suicide each year and another 500,000 will be transported to emergency rooms from self-inflicted injuries. Colorado has the 6th highest suicide rate in the nation. Suicide is the second leading cause of death in the State in people 15-55. Suicide attempts and deaths are often violent and may pose a risk to LFR responders physically or emotionally.

Definition of Terms

- Depression – a constellation of emotional, cognitive and somatic signs and symptoms including sustained sad mood and lack of pleasure
- Gatekeepers – individuals in a community who have daily face-to-face contact with large numbers of community members (firefighters, emergency services dispatchers)
- Means – instrument or object whereby a self-destructive act is carried out
- Methods – actions or techniques which result in an individual inflicting self-harm
- Postvention – a strategy or approach that is implemented after the crisis or traumatic event
- Prevention – a strategy or approach that reduces the likelihood of risk or onset
- Risk factors – factors that make it more likely that individuals will develop a disorder
- Stigma – an idea or label associated with disgrace
- Suicidal behavior – a spectrum of activities related to thoughts and behaviors (thinking, attempts or completed suicide)
- Suicide – death from injury with evidence that a self-inflicted act led to the death
- Suicide attempt – self-injurious behavior with a non-fatal outcome with evidence that the person intended to kill themselves
- Suicide survivors – family members, significant others, friends who have experienced the loss of a loved one due to suicide

Response to Suicidal Situations**SOP # Draft**

Suicide Risk Factors - Awareness: LFR responders should be alert to the following risk factors associated with suicidal behavior while interacting with patients of all ages;

Bio-psychosocial Risk Factors

- Depression
- Mental disorder, particularly mood disorders, schizophrenia, anxiety disorder and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- A major physical illness
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Socio-cultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, mental health and substance abuse treatment
- Certain cultural and religious beliefs (example: the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to the influence of others who have died by suicide, including through the media

Policy:**Emergency Services Dispatchers****1. Interaction with Suicidal Callers**

1. Dispatch will utilize the Medical Priority Dispatch System
2. Dispatchers will try to stop all suicidal persons who call
3. All suicidal situations are volatile. Take all suicidal threats seriously.
4. Determine the exact location of the caller if unknown
5. Build a rapport or a bond with the caller
 - Use their first name
 - Gather as much information as possible
 - Talk specifics -- means, method and plan

Response to Suicidal Situations**SOP # Draft**

- Discuss the reality and finality of their potential decision
- Bring positive reinforcements into the discussion

Responding to Threats or Attempts of Suicide**1. Managing Suicide Threats or Attempts**

- Introduce yourself and state the reason for your presence
- Take charge of the situation
- Observe body language; keep the persons hands in view
- Maneuver the person to a safe area, separate people in conflict
- Do not violate personal space, avoid physical confrontations
- Establishing a rapport with the patient. Use good listening skills
- Show compassion, be understanding not judgmental
- Be genuine, show sincerity and empathy, show respect

2. Assessing Lethality

- Question the person directly
- Is the person talking about suicide?
- Is there a specific suicide plan?
- Are there previous suicide attempts?
- Is there a suicide note?
- Are there means for self injury?
- Is there evidence of injury?
- Has the person made final arrangements?
- Is there signs of depression or substance abuse?

3. Interaction with the mentally ill

- Don't join in disturbed thinking/behavior
- Don't stare or confuse the person
- Don't whisper, joke or laugh
- Don't give the person choices, be in control
- Don't deceive the person and only touch them as needed for medical care

4. Transport Decisions

- Transport anyone who has threatened or attempted suicide to the emergency room. A primary risk factor for completing suicide is previous suicide attempts
- Develop a plan with the family to ensures someone is with the patient on there return from the hospital

C. Discuss with the family removal of lethal means from the home, especially firearms and medications

D. Leave the LFR Prevention Resource Brochure – *Because Littleton Firefighters Care*

Response to Suicidal Situations**SOP # Draft****Responding to a Completed Suicide****1. Scene Management**

- A. All suicide death should be considered a crimes scene
- B. The scene should be secured by law enforcement prior to entering
- C. Restrict and secure pets from the immediate area of the death
- D. Do not disturb evidence or the body unless it is necessary to declare death
- E. Two LFR responders will enter the scene together to assess the situation
- F. Confirm the identity of the person, DOB, time, place and manner of death
- G. Contact medical control for consult and time of death

2. Managing Suicide Survivors – Family and Friends

- A. Realize the impact your actions will have on the surviving family and friends
- B. Insure survivors are not further traumatized
- C. Do not overlook the survivor's emotional trauma
- D. Introduce yourself and your organization
- E. Assign a crew member to assist the family members
- F. Validate the family's grief reaction and support their immediate needs
- G. Help survivors mobilize their own support network; family, friends, clergy
- H. Prepare survivors for what will occur; interaction with law enforcement and the coroner
- I. Leave the LFR Prevention Resource Brochure – *Recovering After Suicide*

3. Documentation

- A. A detailed patient care report (PRC) will be completed on every death in the district
- B. All PCRs related to death investigations will be completed by the end of the 24 hour shift and not left incomplete
- C. Contact Medical Control for consultation and time of death
- D. All death related PCRs will include time of death, environmental conditions, body position, presence and location of weapons, injury type and location, presence of a suicide note and any information that will aid in the investigation
- E. Notify the EMS Chief via email of all deaths in the fire district

Prevention**1. Suicide Prevention**

- A. Littleton Firefighter will be trained in suicide awareness and prevention
- B. Littleton Fire Rescue will support local suicide programs
- C. Littleton Fire Rescue will educate the community on suicide awareness

2. Littleton Fire Rescue Firefighters Support Network

- A. Littleton Fire Rescue will support all employees who are psychologically affected during or after interaction with suicidal situations
- B. If in need of immediate support notify your supervisor or Battalion Chief
- C. Notify the EMS Chief for postvention follow-up

Figure 1

BE-A-LINK® – SAVE A LIFE!
If you have received this Card, it is a Cry for Help:

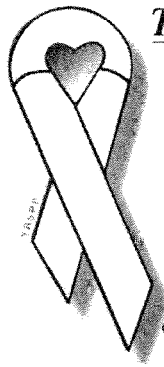
- Stay with the person - you are their *lifeline!*
- Listen, *really listen. Take them seriously!*
- Get, or call, help *immediately!*

It's OK to Ask 4 Help!®

1-800-SUICIDE (1-800-784-2433) 1-800-273-TALK (1-800-273-8255)

YELLOW RIBBON SUICIDE PREVENTION PROGRAM® • 303-429-3530 • www.yellowribbon.org

Figure 1. The Yellow Ribbon Card Front



THIS RIBBON IS A LIFELINE!®

It carries the message that there are those who care and will help! If you are in need and don't know how to ask for help, take this card to a counselor, teacher, clergy, doctor, parent or friend and say:


“I NEED TO USE MY YELLOW RIBBON”

The Yellow Ribbon Program is in loving memory of Michael Emme

Figure 1. Yellow Ribbon Card Back

Figure 2

because Littleton
Firefighters care



We care about you, your family, your friends and our community. Firefighters know how precious life is. As community health care providers, Littleton Firefighters recognize that mental illness, depression and suicidal thoughts can be successfully treated like any other health problem in our community.

**Littleton Firefighters care about you!
It's OK to ask for help!**

1-800-273-TALK (1-800-273-8255)
1-800-SUICIDE (1-800-784-2433)
TTY: 1-800-799-4TTY (1-800-799-4889)

Suicide is not a solution to your problems; suicide is an end, before a solution is found. People turn to suicide when their pain exceeds the ability to cope. You're not a bad person, or crazy, or weak and you're not alone. Reach out and let caring people help you through a rough time. Littleton Firefighters care and we want to be a link to resources you may need for help and recovery.

Local Crisis Line

Arapahoe and Douglas Counties Emergency Service 24 hours/7 days a week 303-795-6187	Jefferson County Emergency Service 24 hours/7 days a week 303-425-0300
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Figure 2. Because Littleton Fire Fighters Care Brochure Front

Figure 2

because Littleton Firefighters care

Mental Health Resources

American Psychiatric Association
Toll-free 888-357-7924 • www.psych.org

American Psychological Association
Toll-free 800-374-2721 • www.apa.org

National Foundation for Depressive Illness
Toll-free 800-239-1265 • www.depression.org

Depression and Bipolar Support Alliance
410-955-4647 • www.dbsalliance.org

National Alliance for the Mentally Ill
Toll-free 800-950-6264 • www.nami.org

Carson J. Spencer Foundation – Westminster, Colorado
www.carsonjspencer.org

Suicide Prevention Resources

Office of Suicide Prevention – State of Colorado
303-692-2539 • www.cdphe.state.co.us/pp/suicide

Yellow Ribbon Suicide Prevention Programs - Westminster, Colorado
303-429-3530 • www.yellowribbon.org

Suicide Prevention Resource Center
334-206-5226 • www.sprc.org

American Foundation for Suicide Prevention
Toll-free 888-333-AFSP(2387) • www.afsp.org

American Association of Suicidology
202-237-2280 • www.suicidology.org

City of **Littleton**

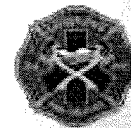


Figure 2. Because Littleton Fire Fighters Care Brochure Back

Figure 3

Because Littleton Firefighters Care...we want to link you to the resources you need to move your life forward again.

Suicide Prevention Resource Center
334-206-5226 • www.sprc.org

American Foundation for Suicide Prevention
Toll-free 1-888-333-AFSP (2387) • www.afsp.org

American Association of Suicidology
202-237-2280 • www.suicidology.org

Office of Suicide Prevention – State of Colorado
303-692-2539 • www.cdph.state.co.us/pp/suicide

Yellow Ribbon Suicide Prevention Programs
303-429-3530 • www.yellowribbon.org

Heartbeat – Peer support offering empathy and encouragement
<http://heartbeaturvivorsaftersuicide.org>

Littleton Fire Rescue
303-795-3800 • www.littletongov.org/fire

Arapahoe County Sheriff's Department
303-795-4711 • www.co.arapahoe.co.us/departments/SH

Arapahoe County Coroner's Office
720-874-3625 • www.co.arapahoe.co.us/departments/CO


Douglas County Sheriff's Department
303-660-7505 • www.dcsheriff.net

Douglas County Coroner's Office
303-814-7150 • www.douglas.co.us/coroner

Jefferson County Sheriff's Department
303-277-0211 • www.co.jefferson.co.us/sheriff

Jefferson County Coroner's Office
303-271-6480 • www.jeffco.us/coroner

Recovering after Suicide



Recovering After Suicide....

If you have lost someone to suicide, realize that you are not alone. Each year in the United State 32,000 people die by suicide. Every 17 minutes another person will takes their life leaving family and friends, known as "survivors," in shock and devastation.

Because Littleton Firefighters care


City of Littleton 

Figure 3. Recovering After Suicide Brochure Front - Back

Figure 3

Why Suicide?

No matter how long and hard you search for a reason, you may not be able to answer "WHY." People of all ages complete suicide: men and women, children and seniors, the rich and the poor. No one is immune to this tragedy.

As you look for answers and understanding you may experience a range of intense emotions. The intensity of your feelings will depend on how close you were to the deceased and the amount of involvement you had in their life. As each suicide is individual, so will your reactions, healing and coping process be.

Survivors may experience a wide range of grief reactions, including some or all of the following:

- Shock – "This isn't happening" is a common immediate reaction. You may feel numb or disoriented and may have trouble focusing. These feelings, and the helplessness that comes with them, will eventually pass. Try to understand and accept the things you feel. It's o.k. and it is all a part of the healing and coping process.
- Anger – Toward the deceased "How could she do this to me" or the anger maybe self directed, "Why wasn't I there?" Your anger feelings are normal especially when the manner of death is suicide. Don't try to deny or hide anger. It's a natural consequence of the hurt and rejection you may feel. Find someone you can talk to, perhaps a close friend or clergy person. Talk about it, think about it, and try to constructively cope with your anger.
- Guilt – "If only I'd done something more." Your anger may be closely linked with feelings of guilt. As you are trying to cope with your guilt feelings, try not to criticize yourself too harshly. Rather than letting the hurt isolate you, share your time and feelings with someone else who is hurting. You can provide friendship and support to others during a difficult time. Get involved with others by actively supporting suicide prevention services in your area.
- Relief – "I'm almost glad it's over." You may be feeling a sense of relief that you don't have to worry any more, especially after a long and difficult mental illness. A sense of relief when a difficult situation ends in normal. Accept your relief and don't let it grow into inappropriate guilt.
- Stigma – "What do I tell people?" Because suicide is often poorly understood, survivors may feel unfairly victimized by the stigma. If you are not comfortable relating the circumstances of the death to others, don't! Your close friends will already know. You don't need to share the complete story with those who are not close to you. It is very important, however, that you do confront the word "suicide." Let friends and family help you. No one will have the magic answer for you but the healing and coping process requires that you talk about your feeling. Talk about the sadness, anger, hurt and guilt you may carry inside.

because Littleton Firefighters care

Talking with Children

Talking with children about death maybe one of the most difficult tasks you may face. Children need information, comfort and understanding during a difficult time. Even young children will be aware of the death of someone in their lives and they need the opportunity to ask questions and get truthful answers. If you're reluctant to talk about suicide, what it means and why it happened, children are likely to hear about it from other sources.


Whether the child is pre-school or a teen, be honest and listen to what they have to say. Make time to be with them. Accept their feelings and share your own. Their reactions may be similar to yours. They may seem insensitive or they may show anger, hurt and guilt. You need to accept their reactions, whatever they are, even if you don't fully understand them. The greatest gift you can give them is your assurance of love and support. Allow them to express their feelings, answer their questions and provide them with support.

Moving Forward After Suicide

Your grief and sadness will eventually subside over time and you will be able to move forward. There will be times, however, when these feelings will resurface very strongly. Ask for help from your friends and family, a support group or counseling service. It's o.k. It can be very powerful to connect with other survivors and it may be a relief to be able to talk openly about suicide with people who really understand. It is natural to feel a bit unsure about going to your first support group meeting and it may take a few meetings to get comfortable with the experience. New people realize that they are not alone. More than 300 support groups are listed on the American Foundation for Suicide Prevention web site (www.afsp.org).

Surviving a loss to suicide is more difficult, more intense and more complicated than any other loss. People all around you care. Reach out to them for their support.

IF YOU ARE IN CRISIS AND NEED IMMEDIATE HELP
Please call 1-800-273-TALK (1-800-273-8255)



because Littleton Firefighters care

Figure 3. Recovering After Suicide Brochure Inside