

The Leaders' Post-Tragedy Care Checklist: Step-by-Step Guidance to Lead Your Team through the Aftermath of High Impact Events

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INTRODUCTION

Attention agency leader: this Leader's Care Checklist is written directly to you or your designee who will oversee providing staff support when High Impact Events (HIE) happen in your agency. *If you are facing a tragedy right now, proceed now to the CARE CHECKLIST on page 2.*

User Notes:

1. **Optimal preparation** for post-tragedy care of personnel requires fore knowledge of this resource tool and pre-planning to ready your team for implementation. So as able, for best results, please read this document thoroughly *including the footnote explanations*, and Appendices information before using these materials.
2. Beyond the main document, there is more key information to become familiar with, including:
 - **Background and Rationale for the Leader's Post-Tragedy Care Checklist**, page 10
 - **Appendix A**, page 13: Preparing Your Agency for Postvention Support after Employee Suicides
 - **Appendix B**, page 15: Recognizing and Responding to Signs and Symptoms of Traumatic Stress
 - **Appendix C**, page 16: Agency Leader's Sample Letter Informing Staff of Tragedy

This plan will help you respond to a variety "High Impact Events" (HIE) among your employees. 911 Training Institute defines High Impact Events as...

...those events which involve actual or perceived risk of serious injury or death to self or others, and which may therefore activate feelings of intense fear, helplessness or horror in the involved personnel. Those exposed to HIE's may be at varying levels of risk for development of PTSD and stress-related health impacts. Accordingly, strategic support assuring HIE risk education, assessment and management should be provided to employees by emergency response agencies.¹

Examples of high impact events include (but aren't limited to) the following:

- Acts of Terrorism
- Events involving Multiple Fatalities
- Natural Disasters
- Officers Killed
- Structure Fires with multiple deaths
- Planned School Attacks with multiple deaths
- Homicide of agency employees or significant others
- Suicide of agency employees or significant others

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¹ Marshall, J. and Laorenza, T. (editors). *The Resilient 9-1-1 Professional: A Comprehensive Guide to Surviving and Thriving Together in the 9-1-1 Center* (pp. 338-339). South of Heaven Publishing. (Amazon.com). 2018, Charlevoix.

THE LEADER'S POST-TRAGEDY CARE CHECKLIST

Document Purpose: this tool is designed to assist the agency leader in overseeing all aspects of support to your personal in the aftermath of a High Impact Event (HIE). It recognizes that your two objectives as a leader during and after HIE are 1) to sustain operations of the agency, and 2) support the wellbeing of all personnel.

Note about Supporting responders *during* the High-Impact Event

Responders may not be able to stop working during a line-of-duty or personal tragedy as it unfolds in real-time. In such cases, their immediate emotional support will occur “organically” as they, their peers, and supervisors working the incident pursue their tasks together. Agency leaders and all other personnel can also provide a *supportive presence* that fortifies the ability of these team members to retain their composure and focus on their work, by providing the following:

1. Simple recognition of the challenge *and* affirmation of the good job they are doing
2. Invitation to provide backup, breaks, or full relief from the tasks as needed²
3. Offering acceptance and comfort when strong emotions are expressed³
4. Remaining present near-by for venting, encouragement during “in-between” moments
5. Providing nourishment and plenty of water
6. Assurance that support is available during, and will be offered after, the event

* COPY, CLIP, AND SHARE WITH SUPPORT TEAM/PEER SUPPORT TEAM

Checklist Instructions: Follow or revise steps below *as fits your agency and the incident*; check-off tasks as completed and record key notes as helpful. For explanations related to recommended steps, see footnotes when provided. Guidance is written to “you” as if speaking directly to agency leader.

PHASE 1: First 48-Hours Post-Event

- Step 1: Gather info about HIE** (4Ws: What happened to Whom, When and Where)

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² In the event of an ongoing HIE, members of the peer support team may be needed to provide real-time operational support help at the console. In such cases, it should be clear to all parties, and specified to on-duty personnel that these peer support team members are not, in those moments, operating as peer supporters but as co-workers. (911Training Institute does not consider such operational assistance as peer support per se, yet highly important.)

³ While supporting coworkers who spontaneously express feelings while working the incident, refrain from probing their emotions since this can be destabilizing, thereby impairing their ability to retain composure. Those directly involved in working the incident who feel compelled to immediately process their distress should be provided relief from their posts so this can occur with a support person in a private setting, engaging professional care when indicated.

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- Step 2: Inform your superiors** of event and steps you'll take (below)/note input:

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- Step 3. Engage HR Department, report event and seek input to assist in planning⁴**

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Step 4: Call A Briefing of Your Agency Leadership Team (include Peer Support Team, and members of Critical Incident Stress Management Team (CISM), if exists⁵)

Inform them of event⁶ (if not already common knowledge)

Preface that this will be difficult to hear

Share the Brief 4Ws about the event

Acknowledge and normalize emotional distress among those present

Urge all present to practice self-care and seek needed support

Emphasize they to seek relief from their duties if significantly struggling⁷

Assure them you (or designee) will lead in creating a agency Care Plan ASAP

Appoint, recruit, seek volunteers to help you build the Care Plan

⁴ This step is per the leader's discretion according agency requirements and the perceived value of support experienced by your agency's HR personnel.

⁵ Your center may have personnel who serve as members of an area Critical Incident Stress Management (CISM) team; or employees may be invited to participate in CISM services when offered after HIEs. In such cases, you as leader can seek involvement of CISM personnel in your agency care planning meetings and include CISM group defusing and debriefing sessions in your checklist planning. Research on effects of participation in debriefing sessions shows value when qualified facilitators follow training and practice guidance of the International Critical Incident Stress Foundation. Therefore, it can be valuable to include your local CISM team in care planning if you trust their credentials and competence in delivery of support. Note that per ICISF, group debriefing should never be mandatory for personnel. Debriefing sessions improperly conducted may do more harm than good.

⁶ Depending on the nature of the event, it is possible that only one or a few people will know it has occurred (e.g., suicide of a peer). Other events such as mass casualties may become common knowledge immediately to all personnel on and off duty. The principle at stake here is to carefully manage dissemination of information about the event for best management of emotional and performance impacts.

⁷ Members of the agency peer support teams will be naturally dedicated to supporting their peers in the aftermath of an HIE. Yet, it is not preferable for those directly impacted by High Impact Events to serve in *primary* roles delivering emotional care for prolonged periods to their peers, for several reasons: serving in such dual roles can place an excessive emotional demand on them; their own ability to process trauma in the hours and days following the event can be impaired by undue focus on caring for others when they themselves equally need support.; while supporting their fellow agency members can boost their sense of empowerment versus helplessness, serving excessively in official/primary emotional support roles when also affected by HIE's can limit their personal opportunities to seek support, rest, with freedom from care-giving (to the extent possible); finally, their ability to tend to their peers may be compromised by attempting such demanding care giving while also striving to maintain their own emotional stability, job performance and personal responsibilities. Accordingly, when an agency is directly involved in response to an HIE, 911TI encourages the agency's personnel to seek Mutual Aid Peer Support (MAPS) from a Peer Support team uninvolved in service to the HIE *whenever MAPS is available*. The impacted agency leaders can share the Care Checklist to these MAPS partners and seek their help in its implementation, then burden-share in jointly monitoring the wellbeing of the agency's leaders and Peer Supporters and CISM team members assuring a better balance between caregiving to others and self-care.

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- Advise team to notify you if any updates about the HIE, or if complications arise
- Request they maintain confidentiality to assure careful disclosure of event to staff
- Invite input from team re: their greatest concerns for personnel/ideas for planning
- Assign PS Coordinator to engage Mutual Aid Peer Support (MAPS) Team(s)⁸

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Step 5: Inform and seek guidance from your EAP in care planning and implementing plan (or other trusted mental health professionals if not EAP).⁹

1. Define your intent to build a Care Plan for initial, intermediate, long-term support
2. Define EAP's Role: if, when and how EAP counselors will be available onsite @agency:
 - Floating for informal support: all shifts beginning immediately, wk. 1, then tapering
 - Offering personnel brief confidential on-site 1:1 check-ins in subsequent weeks
 - Immediately and thereafter offering in-office 1:1 counseling
 - Define how your team can make immediate urgent and emergent referrals as need upon informing personnel (name of clinicians, fail-proof phone numbers to call)

NOTE 1: the intensity and length of EAP care planned will depend on the magnitude of the HIE/number of personnel impacted. Discuss this with your EAP representative. **NOTE 2:** if your EAP does not respond and is not able to provide 24/7 clinical support to your personnel and or is not trained and experienced to deliver trauma therapy, assign a team member to seek the names of local clinicians specializing in traumatic stress; contact them; determine if they can partner with your agency in fulfilling Step 5.

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Step 6: Reconvene your agency Leadership Team to set Care Plan per Steps 1-5.

1. Acknowledge emotional distress among those present, share support as needed

⁸ Per footnote 7 explanation, the agency leader or designee should then include a representative of the MAPS team in subsequent planning throughout Phase 2 and direct the PS Coordinator to recruit MAP members to assist in the support activities described related to each Step to avoid emotionally overwhelming the in-house PS team.

⁹ Preferably, you (or your designee) will have already worked to build a relationship with the EAP and determined their capability to provide urgent and crisis support to your comm center. For specific agency guidance in pursuit of optimal EAP services, see *The Vital Role of Your EAP: How Employee Assistance Programs Can Help 9-1-1Pros*. In *The Resilient 9-1-1 Professional* (pp.257-269). It is also important to pre-identify at least a short list of mental health clinicians in the area who are qualified and known to be helpful to first responders. Go to www.911training.net and, under the *Resources* tab, see *f*, for assistance in identifying qualified clinicians. Such preparation of clinical relationships makes emergency coordination with EAP and clinicians much easier when High Impact Events occur.

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2. Gain agreement that leadership team members will seek their *own* support as needed
3. Identify need for backfill to support on-duty personnel when relief needed
4. Share overview of steps taken thus far, input from HR, Plans for EAP/clinical support, and assistance of a Mutual Aid Peer Support team(s) identified in Step 4.
5. Define how news media requests will be handled (e.g., by you or designee only) I.D. most deeply impacted personnel; I.D./assign who best to inform them (if not leader)¹⁰

Personnel to Inform First	On/Off Duty?	Designee to inform:
1.		
2.		
3.		
4.		
Others:		
Special Considerations:		

- Step 7. Designees inform most affected survivors¹¹** (identified above):
 - Inform survivors in-person if possible; if not, by phone with personal follow-up ASAP
 - (If by phone, verify they are at, or encourage them to seek, a good place to talk)
 - Preface that this will be difficult to hear...
 - Share the Brief 4Ws of the event
 - Allow time for survivor to react/vent
 - Empathize with distress, without urging emotion; don't try to fix, just be present
 - Help survivor plan to connect with supportive others (PSs, friends, family, Pros).
 - Assure stability and safety of survivor before ending meeting
 - If immediate need, bridge to EAP or other designated mental health clinicians

NOTE: Steps 7 and 8 may occur almost simultaneously depending on circumstances

- Step 8. Designees inform remainder of On-Duty Personnel of Event:**
 - Inform them in-person, if possible
 - Strive for a supporter-to-worker ratio of 1 to 2 or 3, for adequate support¹²
 - Preface that this will be difficult to hear
 - Share the Brief 4Ws of the event
 - Assure that those closest to [the victim(s)] have been notified
 - Acknowledging how distressing this may be
 - Urging employees to seek relief from console if having difficulty operating
 - Advise Employees not to notify their off-duty peers until leadership team indicates they have informed all personnel, to assure careful handling.

¹⁰ In many cases, news of the tragedy will originate from personnel and reach those working the floor prior leaders' awareness. In such unavoidable cases, leaders will adopt their care planning defined here the best they can to "come along side" their employees with support fitting their current status.

¹¹ A key concept in post-tragedy support: those survivors most personally related to the victims should be informed by the most personal means possible to assure most careful management of potential psychological fallout.

¹² This ratio may not be realistic to achieve in many cases. It is encouraged per the key concepts in footnote 10 above and assumes a HIE of potentially devastating magnitude for all personnel (e.g., mass casualty event). This ratio of supporters-to-employees makes it more feasible to manage the individual and group emotional fallout posing risk to sustaining operations. Whether the recommended ratio can or cannot be achieved, agency leaders are urged to recruit mutual aid from neighboring agencies since supporters from your agency are also impacted by the event.

- Encouraging them to follow-up with supporters as needed and stand by for update on formal support planned

Step 9. Designees inform Remainder of Off-Duty Personnel:

Inform off-duty personnel by phone; include the following:

1. The Brief 4Ws of the event
2. Assuring that those closest to [the victim(s)] have been notified
3. Acknowledging how distressing this may be
4. Welcoming them to come to agency if preferred, to give and receive support
5. Requesting, as you deem necessary, for them to return to work
6. Encouraging them to identify and use their natural support system (family/friends) while still off work
7. Assuring them you will be sending email updates to all personnel as able and deemed helpful

Step 10 (Day 2): Consider sending E-mail and “Signs to Look For” resource to all Staff (upon assurance that efforts made to personally notify all personnel). Objective: assuring all are accurately informed, encouraged to seek help, and equipped.

Construct Letter with the following key elements (using the *Sample Letter in Appendix D*, as desired) Note: send copies to your superiors, HR, EAP Program.

Acknowledge the event and how difficult this has been for all

Affirm efforts made by all personnel to support each other and operations

Explain that a Leadership Support Team (joined by the Peer Support Team, if exists) is working to assure ongoing support now and in the weeks and months to come

Provide names, emails and phone numbers of those on your Peer Support Team (if exists, and if not, your Leadership Support Team)

Urge acceptance of personal responsibility for seeking out help available from the Team, from the EAP Program, and therapists specializing in traumatic stress (include names and contact information)

Remind and welcome use of your Open Door Policy as their leader(s), including deputy director

Attach the “Signs to Look For” resource in Appendix C or comparable information sheet.

PHASE 2: Leadership Steps: Day 3 through End of Week 1

Note: your actual timeline for implementation of these activities may vary significantly from the timeline suggested here, depending on nature of the HIE, readiness of personnel to engage in support efforts, staffing, available resources and other variables.

Optional Step 1: Identify and engage your community “LOSS Team” (if event was a suicide within the emergency response family).¹³ See map and listing of Loss Teams [here](#).

□ **Step 1: Reconvene Support Team**

1. Share peer support with your Support Team: invite venting; remind members of their agreement to seek personal support as needed

¹³ LOSS Teams are highly trained survivors of suicide who have been equipped to deploy after a suicide and provide specialized support to bring insight, comfort and support to your team members. The model was developed by suicidologist Frank Campbell. exist in many locations in the United States, so agencies and their communities may be able to liaison with existing teams for support while developing internal support systems.

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2. Remind team of your Open Door Policy (Director and Director's Designee) for their personal use; and encourage them to remind all agency personnel to use as needed
3. Pursue personnel participation in a CISM Debriefing¹
4. Inform them of role of LOSS Team (if applicable) and define any coordination needed with team members to assure follow through how you as a full team will provide support in the remainder of Week 1 and beyond (refer to all information below in Step 2 and beyond):
5. Introduce the PEPCP (Post Event Personal Care Planner, Appendix B) if adopted.¹⁴
 - Provide printed copies of this tool and describe its purpose
 - Walk through steps to complete an example PEPCP
 - Identify those who will assist employees in administering this tool (being your Peer Support Team if exists, or designees on each squad)
 - Provide the link to the recorded webinar *PEPCP Orientation and Training*

Step 2: Deploy your Peer Support Team (if exists, or other designated support team members) to meet and partner with each employee to create their PEPCPs

Day 2 and 3 for initial meetings and begin completing PEPCPs with those most affected (as defined earlier in Phase 1, Step 6) and activate referrals as needed for professional assistance

Days 4-7 Complete PEPCPs for remaining personnel and activate referrals as needed for professional assistance

Step 3 (by Day 4): Verify that EAP is fulfilling all agreed steps of support:

1. Has initiated visits on site as agreed
2. Has provided printed information on the EAP Program
3. Also request that EAP to conduct follow-up email with agency personnel (through you) encouraging use of the EAP Program

Step 4 (Day 6): Verify PEPCPs have been completed per above goals and referrals have been achieved when professional assistance was required

Step 5: Provide HIE Week 1 Report to Superiors (top management, governing body) informing of all steps above taken thus far, and plans for ongoing follow-up below

PHASE 3: Weeks 2 through 8 (actual number weeks will vary per specific event¹⁵):

- Reconvene Leadership Team on Weeks 3, 4, 6 & 8 (or more as needed)** (including Peer Support Team, if exists):
 - Share peer support with members of team; encourage venting to support wellbeing
 - Seek reports on overall status/well-being of personnel for all squads

¹⁴ Use of the PEPCP in your agency requires that agency leaders and those who will directly administer the tool have participated in the web-based *PEPCP Orientation and Training*, provided at no charge by the 911 Training Institute. Contact info@911Training.net for more information. If your agency has not yet adopted the PEPCP, strive nonetheless to assure each employee has been personally made aware of all available resources and is encouraged to use them as needed.

¹⁵ Be flexible in your efforts outlined here to fit how your team is reacting to your intervention steps. They may feel you have "done enough", so you may approach them more informally and less frequently for check ins. However, also remember, your employees' "push back" to check-ins doesn't automatically mean you should cease offering them. Most responders are still quite awkward with acknowledging their struggles, per the traditional "Suck it Up" Emotional Code (*The Resilient 9-1-1 Professional*, Chapter 5). The objective as a leader and supporter is to do your best to assure "no one is left behind" while also respecting personal privacy and individual differences in how folks cope with trauma and loss.

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- Assess support efforts thus far (Phases 1 & 2); strategize to optimize ongoing efforts
- Identify and make plans/identify additional resources needed to succeed at ongoing support to personnel and to address any serious fallout (e.g., increased sick leave/staffing, morale, performance)

- Peer Supporters (or Director's designees) continue weekly check-ins** with personnel
 - Formal Check-ins with those most affected personnel (following PEPCP) to offer real-time support and assure their follow-through with other supports and pursuit of professional mental health assistance to assess and treat traumatic impacts
 - Informal Check-ins with all other personnel

- Verify how EAP will continue support and weekly on-site visits:** determine (with EAP rep.) number of consecutive weekly visits prior to tapering off in-house support; request EAP to provide printed/email correspondence reminding and encouraging use of services
- Continue Weekly Leader's Email** to personnel reminding of supports available from peer support team, EAP, clinicians, and your own Open Door policy
- Continue weekly Leader's Post-Tragedy Update** to superiors

Phase 4: Month 3 through Year 1 Anniversary of Event¹⁶: Continue oversight:

Lead monthly meetings of your Leadership Support Team (including Peer Support Team, if exists)

Share peer support among members to assure well-being and encourage seeking of professional care (since leaders often defer care until after employees are covered)
Verify that PEPCPs are being implemented with those identified as most-affected by the HIE (while maintaining confidentiality) to assure needed supports are delivered
Verify (by contact if needed) that the EAP Program continues to provide services required to support agency recovery from HIE:

1. Monthly visits on site (at minimum)
2. In-services on topics supporting recovery of your personnel,¹⁷
3. Printed/email correspondence reminding and encouraging use of EAP services
4. Other services as deemed necessary
5. If the above services are not forthcoming, seek alternative clinical source for same

Assure Functioning of Peer Support Team (if exists; or, if not, Leadership Support Team)

Meeting regularly as defined in PEPCPs with those identified as most impacted by HIE to foster follow through participation with all needed supports (all confidentiality upheld)
Regularly re-inviting employees to participate in PS (via newsletter, email blasts and personal invitations during work to their squads)
Referring those in need of professional help as needed

¹⁶ Each employee may have different "triggers" or touch points to the original event. Some triggers are predictable, (e.g., event anniversary, birthdays of the deceased). Consider brainstorming such possible triggers. Also, as time passes through the first several months consider ways in which your team might benefit from memorializing the deceased. Such shared experiences often are a powerful part of the healing process.

¹⁷ The role of an *effective* EAP could include delivery of in-service presentations to agency personnel on topics such as: grief recovery after catastrophic losses; coping after mass-casualty events; recovery from exposure to traumatic events, etc. If your EAP provider does not offer such in-services, seek assistance for same from the local clinicians recognized as qualified and trusted by first responder agencies to assess and treat traumatic stress.

- **Continue sending monthly Leader's Email to all personnel:**
 1. Acknowledge that healing after such a HIE can take months or longer
 2. Affirm your belief as their leader that professionalism means seeking needed help
 3. Encourage personnel to use all available supports (in accord with PEPCPs when used)
 4. Remind them of the availability and key role of the Peer Support Team (if exists)
 5. Remind them of your Open Door policy, and encourage use

- **1-2 Weeks Prior to 1st Anniversary of the HIE¹⁸**
 - a. Write a letter to all personnel acknowledging the anniversary of the event recognizing that folks may struggle more during the period of this anniversary and reiterating the points in the above monthly Leader's email.

PHASE 5: Year 2 and Beyond¹⁹

- **Reconvene your Leadership Team** (including Peer Support Team, if exists)
 1. Invite members to share their impressions of the status of personnel (overall) relating to the HIE
 2. Together review Phase 4 Activities and determine which, if any, should be sustained to assure full support needed to foster ongoing healing
 3. Encourage Peer Support Team (if exists) and Leadership Support Team to continue monitoring well-being of squads and urging use of supports and services as needed

¹⁸ Traditionally, military, paramilitary and emergency response agencies have sought to "get past" tragedies suffered by their personnel by avoiding recall of the event (construed as "staying strong") and pressing on with business as usual. However, experts in recovery from traumatic stress and grief concur that healing is fostered by openly sharing recollection of a major loss or traumatic event among those impacted. It is especially powerful when leaders of these agencies set the "standard of care" by declaring their belief in, and commitment to remembering, feeling, and healing together. Accordingly, leaders should strive to officially, and by their own conduct, communicate this message to their personnel.

¹⁹ The psychological fallout of a High Impact Event may extend for years beyond the incident, making it vitally important to review and consider re-implementation of the activities recommended in Phase 5. Messaging to staff can be abbreviated over time, but always including assurance that agency leaders will assure support when needed no matter how many years have passed since the HIE.

Leader's Care Checklist Background and Rationale

There are many among our nation's emergency response leaders who have expressed the urgent need for such a resource as this. It is far from perfect and is considered a perpetual draft. It is to be freely shared in accordance with the copyright allowances and restrictions on page 1. 911 Training Institute welcomes comments and suggestions for improvement. Please contact Info@911Training.net.²⁰

9-1-1 directors have increasingly found themselves facing High Impact Events (HIE) as defined with examples given on page one, including the suicide of 9-1-1 Professionals and field responders, and man-made mass casualty events to which our agencies have responded. 9-1-1 leaders report sharing a strong concern for attending to the psychological fallout among their personnel associated with these HIEs; yet also a sense of helplessness and lack of confidence in how to proceed. They describe feeling quite unprepared to provide optimal guidance through the aftermath of such tragedies amidst concern about the immediate, and longer-term impacts on the personal well-being of their surviving personnel, their families, and the stability of the work force to sustain performance amidst unrelenting demand for service. This leadership struggle is expressed well by statements and questions I recall and will paraphrase here:

- "We checked on those most involved but not much else for the rest...not sure what that would be..."
- "We just jumped into action, checked on people, but didn't really know what we *should* be doing."
- "What do we do next? How long do we check...when do we refer them to professional help?"
- "It's been a few weeks now. Hard to really know how people are doing...not sure how to ask or how often to ask."

Reliable answers to such questions can be gained from mental health experts, such as Suicidologist Frank Campbell. Dr. Campbell emphasizes the importance of providing "postvention", a model he pioneered and which he defines humbly as "...those kind acts that are extended after a suicide...to those bereaved by suicide..."²¹

Such postvention acts of kindness need to be well-organized and guided. Most 9-1-1 centers have (through their governing agencies) Employee Assistance Programs (EAP) which are contracted to provide mental health assistance to all employees. If well prepared, such EAPs can be of great help in postvention and support after other HIEs. Yet too often the EAP organizations upon which 9-1-1 centers depend are not available 24/7/365, are not knowledgeable about the specific psychological demands of first responder work and have not developed ongoing relationships with agency personnel to earn their trust and confidence. Most EAPs are also not equipped specifically to provide postvention. In lieu of such support, 9-1-1 leaders through the years have sought help from the 911 Training Institute (911TI). But dependence on an organization external to the community like the Institute is not an optimal or sustainable solution. 911TI recognizes that 9-1-1 leaders must be locally empowered with a

²⁰ Those at risk of suicide or struggling with other acute mental health crises should seek the guidance of a licensed mental health professional."

²¹ Campbell, F. Postvention is Prevention: Overview of the circular model of suicide reduction. <http://www.lossteam.com/postventionisprevention.php>. Last accessed 7.31.19.

hands-on resource tool they can use to guide their steps after tragedy and assisted by capable local clinicians wherever possible. For this purpose, the 911 Training Institute has prepared the Leader's Post-Tragedy Care Checklist to guide you step-by-step as you lead your personnel in the moments, days, weeks, and months after such a death. It was designed on the premise that adequate support to personnel after HIEs is not a week-long endeavor after which we proceed with "business as usual"; it is a calculated, coordinated long-term effort encompassing preventive education, intervention, and ongoing support.

Yet, there is more to prevention than what we may think. In accord with Dr. Campbell's model, we need to recognize that leaders' involvement in postvention will also serve as suicide *prevention* in the first responder professions. By more effectively coming alongside those in the aftermath of suicide, we can help restore hope, lessen helplessness while fueling empowerment, and begin the individual corporate healing process. This shared experience enables members of the impacted community to stop the cascade of despair and decrease the risk of more suicides among those most profoundly impacted.²²

Two of the most common HIEs impacting our 9-1-1 centers in recent years and on the increase are *suicides among emergency responders* and man-made *mass casualty events*.

Understanding Suicide

Suicide in the United States (General Population)

The number of suicides in the U.S. increased significantly between 2007 (34,598) and 2017 (47,173)²³, an increase of 30.5% during this period. The rate among men in 2007 was 27,269, and in 2017 it was 36,782, an increase of 34.8%, whereas the rate among women in 2007 was 7,329 and in 2017 it was 10,391, for a 41.7% increase during this period. While these rates are alarming for both genders, it is also significant to note that between 2001 and 2016, the suicide rate increased more dramatically among women (50%) compared to men (21%) between 2001 and 2016, with the greatest rate of increase in the latter ten year stretch.^{24 25}

Suicide Among 9-1-1 Professionals

Some of the suicides embedded among those statistics are deaths of our 9-1-1 professionals. Even in the three weeks preceding writing of this introduction, three more dispatchers suicided, leaving a wake of devastation among our 9-1-1 family members. While the 9-1-1 Training Institute is unaware of any official data specifying the rate of suicide among emergency telecommunicators, we can reasonably assume that the rate among 9-1-1 Professionals and other first responders has at least been on par with the increases cited above for the general public. Many 9-1-1 leaders in the U.S. (including members our Institute team) have been personally impacted by several telecommunicator suicides in the

²² Ibid, Campbell, F.

²³ Drapeau, C. W., & McIntosh, J. L. (for the American Association of Suicidology). (2018). U.S.A. suicide 2017: Official final data. Washington, DC: American Association of Suicidology, dated December 10, 2018, downloaded from <http://www.suicidology.org>. Note: these data are updated/republished annually. For current data, see website here.

²⁴ NCHS Data Brief, No. 309, June 2018. <https://www.cdc.gov/nchs/data/databriefs/db309.pdf>

²⁵ Drapeau, C. W., & McIntosh, J. L. (for the American Association of Suicidology). (2018). U.S.A. suicide 2017: Official final data. Washington, DC: American Association of Suicidology, dated December 10, 2018, downloaded from <http://www.suicidology.org>. See Appendix A for additional details.

past three years alone. The statistics above indicating increases in female suicide are cause for alarm within the 9-1-1 community since our workforce is still predominantly female.

Further concern for anticipated increases in suicide rates among 9-1-1 professionals is supported by the finding that for each woman who completes suicide, 3.5 men will suicide.²⁶ More men each year are joining the 9-1-1 ranks, including military veterans--a population with a suicide rate higher than the general population.

In the general population women attempt suicide 3.5 times more often than men.²⁷ Yet, there is some support from current understanding in suicidology that would suggest that *a higher percentage of females in 9-1-1 and other emergency response roles may complete suicide compared to females in the general public.* (These factors include lessened fear of death and increased “courage and competence” to take one’s own life, due to extensive exposure on the job to violence and death in many forms.²⁸ (See footnote below for more thorough explanation about these factors.²⁹)

A final factor driving concern about suicide among 9-1-1 ranks is that suicide risk is known to be significantly higher among those with untreated Post-traumatic Stress Disorder (PTSD) and clinical depression; the rates of PTSD in the 9-1-1 industry is believed to be four to five times higher than the general public³⁰, while the rate of depression in this population is double the rate among the general public.³¹

²⁶ Drapeau, C. W., & McIntosh, J. L., *ibid.*

²⁷ *Ibid.*

²⁸ Joiner, T. *Why people kill themselves.* Kindle ed. Harvard University Press, 2007.

²⁹ Suicidologist Thomas Joiner (2015) explains that lethality of suicide increases on par with the degree to which the individual experiences three of the suicide components, being suicide Desire, Capability *and* Intent. Desire is understood in accord with the Suicide Standard established by the National Suicide Prevention Life Line (NSPL) as the combination of one or more sub-components including ideas of suicide, hopelessness, helplessness (to change life circumstances), feeling like a burden to others, feeling intolerably alone, unresolved psychological pain, and feeling psychologically trapped (Joiner, et al. 2007); Per the NSPL Standard, Suicide Capability includes history of suicide attempts, history of violence, exposure to someone else’s suicide, alcohol intoxication, substance abuse, suicide means, recent dramatic mood changes, out of touch with reality, and extreme agitation; and Suicide Intent includes: attempt in progress, expressed intent to die, plan to kill self and/or others, preparatory behaviors. In accord with Joiner’s model (2015) it may be that emergency responders (irrespective of gender), due to their repeated exposures to work-related deaths in many tragic forms including suicide among co-workers, may become more “competent” to complete suicide; i.e., they “get used to” death and thus lose their fear of death while boosting “courage” to complete the act. As Palmer has found: “Acquired capability or the learned ability to overcome one’s natural fear of death—makes suicide possible...” (C. Palmer, C., *Monitor on Psychology*, November 2018). Lethality escalates further when such competence is combined with anger which can dissolve ambivalence about suicide (Joiner, 2015).

³⁰ Lilly, M., in *The Resilient 9-1-1 Professional*, 2019, p. 42.

³¹ Lilly, M., *ibid.*, p. 44.

APPENDIX A: Preparing Your Agency for Postvention Support after Employee Suicides

The following information supplements the Post-Tragedy Care Checklist and is offered to help you as a leader assure that your personnel receive the best possible support in the aftermath of a suicide. Such care after a suicide is called Postvention.³²

Preparatory Activities for 9-1-1 Leaders (pursued, as able, before deploying the Care Plan):

Participate in Training to use the Post-Tragedy Care Checklist (as presented in main document here)

Participate (or appoint a delegate to participate in) Suicide Postvention Training. 911 Training Institute recommends the LOSS training model (*Local Outreach to Suicide Survivors Team*) developed by Frank Campbell³³ to achieve the following objectives:

- Define the Purpose and Goal of Postvention: Reduce impacts, join those affected in the beginning of a healing process
- Describe Postvention within the full cycle of care (Postvention is also Prevention: see <http://www.lossteam.com/postventionisprevention.php> Define and establish core competency to come alongside others doing
- postvention
- Note: if you seek out Postvention training from sources other than Dr. Campbell strive to assure that the Training approach is consistent with his LOSS Team model.

Define The role of a 9-1-1 Peer Support Team in your agency (if in place)

- Purpose of the team

Activities of the team to fulfill this purpose (including the Team's role in activity "d." below.

How to proceed as an agency with Postvention if you do *not* have a PS Team

1. Identify limitations due to lack of such a team in the ability of agency personnel to fulfill the activities above
2. Define a plan to achieve those activities to greatest extent possible
3. Identify and establish relationship with area mental health providers

Employee Assistance Programs (EAP, if not already achieved)³⁴

1. Assess their ability and knowledge to serve 9-1-1
2. I.D. their clinical limitations (are they experts in PTSD and use Evidence Based Treatments for same; if not, define role with clear limits

³² Note that an instructional video on Postvention Care Planning is being prepared to help you and your leadership team prepare in these efforts. Email Jim@911training.com for more information.

³³ Dr. Campbell defines *survivors* as "those impacted by a suicide death". (See <http://www.lossteam.com/index.php>)

³⁴ For guidance, see Chapter 17, *The Resilient 9-1-1 Professional*.

3. Define terms by which EAP will assure 24/7 availability, including names of dedicated EAP personnel, specific contact procedures, and means of contact/communication e.g., dedicated cell phone numbers for use by agency.
4. Selection of clinician and assigned as dedicated to comm center
Beyond EAP: Select a community clinician with expertise in PTSD using Evidence Based Treatments (EBT)
 1. Define terms by which these clinicians will assure 24/7 availability, including clinician names contact procedures, and specific means of contact/communication e.g., dedicated cell phone numbers for use by agency.

NOTE: Implement the 9-1-1 Director's Post-Tragedy Care Checklist according to the guidance set forth in that document. Director's Post-Tragedy Care Checklist Resource

Recognizing and Responding to Signs And Symptoms of Traumatic Stress

Common Reactions to Traumatic Stress

Physical Responses:

- Change in sleep patterns
- Change in appetite
- Shallow or rapid breathing
- Headaches
- Muscle tension & soreness
- Increased heart rate, palpitations
- Stomach upset

Emotional Responses:

- Shock or numbness
- Anger toward others involved
- Fear
- Depression or low mood
- Guilt/frustration
- Sadness/tearfulness
- Feeling unsafe or vulnerable
- Loneliness

Mental/Cognitive Responses:

- Confusion
- Difficulty concentrating
- Difficulty remembering details of event
- Feeling mentally 'foggy'
- Impulsivity
- Over focused on an activity

Behavioral Responses:

- Withdrawal from others
- Angry outbursts, irritability
- Crying
- Decreased energy/ambition
- Marital/relationship conflict
- Increased use of alcohol or medications
- Fear of being alone

Tips to Manage Stress

1. **Stick to the basics:** eat well, exercise consistently especially cardio workouts, rest & sleep.
2. **Avoid over use of** stimulants: caffeine, chocolate, nicotine. Avoid over use of depressants; alcohol, sleeping pills.
3. **Gravitate towards** what is comfortable: familiar surroundings, balance your time with others and alone time. Humor is good!
4. **Talking is good for the mind & body!** Tell your story, share your thoughts & feelings with those who are supportive. No need to block recollections. Feel free to set boundaries with those who are not helpful or who are draining.
5. **Don't be surprised by memories.** Thoughts of past experiences may emerge. This is normal.
6. **Give yourself time to recover.** Difficulties like the ones listed on the left are common but short-term. Seek help if reactions interfere with job responsibilities or last too long.
7. **Slow down!** Doing less is better for a short time. You aren't yourself right now. Your brain needs rest & time to heal and re-organize.
8. **Communicate your feelings clearly.** Others may not know how to respond so let them know what is helpful & what is not.
9. **Do not compare yourself with others.** Don't take responsibility for others. Each person's experience is unique & personal.

*NOTE: All these signs can be normal responses to abnormal circumstances. But be sure to seek professional help if they endure for over 30 days OR are seriously interfering with your ability to function now, AND OR you are struggling with suicide thoughts. In crisis, text reach out to Crisis Text Line: **741741** and message: **"Help"** (see <https://www.crisistextline.org/textline> for more info.) or contact 988. Both services are 24/7/365 support for you!

APPENDIX C

Agency Leader's Sample Letter Informing Staff of Tragedy

Note to leader: this is only an example of the type of communication that can be helpful for leaders to initiate after a High Impact Event. It is offered simply as a resource. Be sure to carefully read this and revise as desired to make it your own, replace bracketed instructions with your actual information, and, place document on your letterhead.

Dear Staff:

When tragedy strikes our comm center, it's important for us all to be informed so we can join together to give and receive the support we need. As you hopefully know, since our leadership team has worked to inform all personnel in-person, today we face such a situation.

Let me briefly summarize again what we know to be sure we all share the same accurate understanding of what has taken place. On

[...time/date of the event]

[name of involved personnel]

[briefly define the incident and outcome that occurred]

I know this event is very hard to hear about, and I want to assure you that we've already reached out to most personally affected, including **[indicate names]**. We want to be sure that they, and *you too*, have all the support needed because each of us will be impacted in some way.

I'm also asking for your help in sharing responsibility for your well-being and your peers' as we travel through this hardship in the days ahead, so that no one is left behind. Let's not obey the old "Suck it up" mentality. It IS okay to *not be okay* as long as we're in it together. So please carefully read the attached handout called *Recognizing and Responding to Signs and Symptoms of Traumatic Stress*. If you recognize you're having a hard time, please be sure to reach out as needed to a trusted leader, peer, or one of the professional providers available through or recommended by our EAP. A list of all these support folks is attached **[you can create and attach list to include those parties, with names, phone and email]**.

If you notice a peer struggling, please assist them in seeking help, and if you aren't sure what to do, be sure to let me **[or your designee]** and or members of our peer support team **[delete if no peer support team]**. And please remember, I will keep my office door open to welcome your visit in the days, weeks and months to come.

We can all come through this together! Be assured **[I/we]** will keep you updated as we learn more along the way.

[Your Name, Title]