OPERATIONAL AND TRAINING GUIDE

Mississippi River Valley
Critical Incident Stress Management Team

Sponsored by

Gundersen Lutheran℠

La Crosse, Wisconsin

Note: Credit to Lynn Kennedy-Ewing
CISM of Delaware County, Pennsylvania
for component contributions

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MISSION STATEMENT

The Mississippi River Valley CISM team will consist of a multifaceted approach for recognition and intervention of emergency service stress and critical incident stress.

The CISM program will consist of the following components:

1. Pre-incident educational programs will be available to emergency service organizations and community groups. Topics will include stress identification and management, critical incident stress, team services and function and other topics as appropriate.

2. The CISM team will be available for consult and intervention in events where critical incident stress has been identified. This may include scene support, debriefings, defusing or demobilization services. Follow-up services and mental health referrals may also be provided by the CISM team when appropriate.

REGION

As defined by CISM of Wisconsin, the Mississippi River Valley CISM Team (Region 10) serves emergency personnel in Buffalo, Jackson, La Crosse, Monroe, Trempealeau and Vernon Counties in Wisconsin. The team also is available to portions of Southeast Minnesota and Northeast Iowa. When requests for service are made from outside of the assigned area, it is recommended that the requesting agency be referred to the CISM team within their region. It is suggested the on-call team member contact the CISM team personally to assure that they are able to provide the necessary services.

CISM TEAM STRUCTURE

The Mississippi River Valley CISM Team is sponsored by Gundersen Lutheran Medical Center and is within the Department of Behavioral Health.

The organizational structure of the CISM team is as follows:

Leadership Committee

Consists of co-coordinators, various emergency service disciplines, Clinical Director of CISM, and secretarial support. Total membership ranges from 5-8. Three-year staggered terms are recommended for Leadership Committee representatives. The committee meets as needed, presently every other month, and is responsible for the overall operation and management of the team. Members of the Leadership Committee are assigned to the team's various operational committees and share the duties of membership, education, on-call, media requests, incident documentation, review of team activities, consultation for service requests, and representation at CISM of Wisconsin meetings. Leadership

Committee members may alternate facilitating the team meetings.

Membership Committee
Recruits new team members, when needed. Reviews applications for team membership, interviews and contacts the references of prospective members. A representative of the Membership Committee is assigned to the Leadership Committee. When there is concern or uncertainty regarding an applicant, the Leadership Committee will assist with the final decision for membership.

On-Call Committee
Consists of team members who rotate being on-call to coordinate requests for service, i.e. debriefings and defusings. This includes obtaining information from the Gundersen Lutheran Medical Center Trauma and Emergency Center social worker about the agency/individual requesting services. The on-call team member will then contact the requesting agency/individual, assess the type of service needed and the appropriateness of the request, and contact team members to respond to the request for intervention.

Prior to the end of each year one or more members of the On-call Committee takes responsibility for circulating a schedule or assigning weeks of on-call coverage for the next year. Requests for educational programs are referred to the Education Committee. Additional on-call considerations are on page 19.

Education Committee
Assumes responsibility for providing educational programs to emergency service organizations and community groups on topics related to the CISM team and critical incident stress. Also reviews literature, videos and other training materials for potential inclusion in the team library. Coordinates team education at the team meetings.

Mental Health Professionals
Should have a minimum of an undergraduate degree and four years of experience in either social services, counseling, pastoral counseling, psychiatric nursing, psychological services, or crisis intervention. It is recommended that the mental health team member act as the team leader or co-leader during debriefings and assists in assuring that follow-up is completed following team interventions. It is also the responsibility of the mental health team member to be available to assure that the debriefers are debriefed following team interventions when necessary. Mental health team members may also assist with education programs and team training.

Peer Support Personnel
Individuals drawn from emergency services, i.e. law enforcement, fire fighters, EMTs, paramedics, nurses, air medical, dispatchers, disaster response personnel, etc. Frequently, peers have the first contacts with emergency personnel at the scene of a critical incident and are able to assess the need for a defusing or debriefing. After consulting with the affected team, peers may contact the on-call team member to arrange for services. Peers collaborate and work together with the team mental health professional when providing intervention services. Peers may assist with team training and educational programs.

The average team membership ranges from 20-40 members.

ORIENTATION AND TRAINING

Training is the key to a successful CISM team. It will take several forms and may be presented by various team members and community representatives.

All team members must complete a minimum of the two-day Basic CISM Training sponsored by the International Critical Incident Stress Foundation (ICISF) or presented by trainers sanctioned by ICISF. The registration fee for the Basic Training is the responsibility of the individual team member or the team member's employer.

Mental health professionals who are not emergency service providers will be expected to "cross train" with the various emergency service groups. This will involve "riding along" and/or observing the operations of the emergency dispatch center, law enforcement, fire, ambulance, and trauma/emergency department. Mental health team members will be responsible for contacting the respective emergency service agencies to arrange "cross training" time. It is suggested that a shift be spent at each location. Agency contact information will be provided by the new member's mentor.

Team training will be provided at the team meetings and will be coordinated by the Education Committee. Topics may include a review of the material covered during Basic CISM Training, skill building/role play of the debriefing and defusing process, communication skills, grief, group process, emergency service protocols, line of duty death protocols, incident command, disaster response, and other topics felt to be appropriate to the team. Team members are also encouraged to participate in periodic drills and mock disaster situations.

New team members will be provided with a Team Operational and Training Guide. Orientation to the Mississippi River Valley CISM Team will include attendance at team meetings, becoming familiar with team members, and going along on team interventions as an "active observer" and not in the capacity as a "lead" team member. Generally new members will participate in 1-2 interventions as an "active observer" prior to assuming a "lead" role in an intervention.

A mentor will be assigned to each new CISM Team member. Current Team members will volunteer or be requested to provide mentorship to a new member by the CISM Team Membership or Leadership Committee.

Mentors will be responsible for, but not limited to, the following:

1. Meet with the new member, preferably speaking in person or by phone.

2. Provide new Team member with information on upcoming required Basic Training opportunities.

3. Assist new Team member with getting a CISM Team I.D. Badge by taking them to the Gundersen Lutheran Medical Media Department in the basement of the Clinic to have their photograph taken. (Note: Medical Media's phone number is 608-775-3950 if you wish to call ahead, however, walk-ins are accepted.) Indicate to Medical Media that the photo is for CISM

and should be sent to Human Resources for creation of the badge. Human Resources will send the new badge to Sally Armstrong, who will put it in the mail to the new member.

4. Provide the list of Team Meetings (dates/time/location) to the new member, accompany the new member to Team meetings, if possible, and introduce the new member to the rest of the Team.

5. Review the Mississippi River Valley CISM Team Operations Manual with the new member. Discuss the opportunities to join the various Team Committees.

6. Make certain that the On-Call Coordinators, responsible for setting up debriefings, are notified that the new member needs to be contacted to be an "active observer" of at least 1 or 2 debriefings initially and that you, as the new member's mentor, would also like to be contacted to accompany the new member, whenever possible. Review the observations with the new member following the debriefing and answer any questions or comments he or she might have regarding the experience. If you are unable to accompany the new member, have him/her contact you to process the experience following the debriefing. Follow-up again with the new member, as necessary.

7. Provide information on all ride-along opportunities and assist with the paperwork required to apply for ride-alongs. Return the documentation to the Team Coordinator upon completion of ride-along experiences.

8. Explain appropriate attire for debriefings, assist with the debriefing paperwork and with returning all necessary documentation to the proper location following debriefings.

9. Other assistance as needed.

REVOCATION/SUSPENSION OF MEMBERSHLP

Team membership is revocable at the discretion of the Leadership Committee. Action is appropriate for, but not limited to, the following:

1. Failure to maintain confidentiality regarding CISM interventions, including topics discussed and personnel involved. Any breech in confidentiality will result in immediate dismissal from the team.

2. Failure to follow protocols and directives regarding team activity.

3. Organizing or in any way attempting to organize any type of team intervention without following proper team protocol.

4. Going to the scene or place of an incident to act on behalf of the team without prior knowledge or consent of the on-call coordinator or a member of the Leadership Committee.

5. Obstructing or impeding incident command.

6. Failure to be present at an assigned intervention when the member has made a commitment to do so.

7. Continued absenteeism from monthly team meetings.

8. Any misrepresentation of the activities or operations of the team.

9. Failure to complete required paperwork following team interventions.

The Leadership Committee will meet and discuss the problem with the team member within 72 hours of notification.

The Leadership Committee will submit a written report and recommendation to the Clinical Director of CISM or Coordinator within 48 hours of meeting with the team member.

The Clinical Director of CISM or Coordinator will review the written report and either accept the recommendation of the Leadership Committee or suggest an alternative action to the Leadership Committee within 48 hours of receiving the written report and recommendations of the Leadership Committee.

TEAM ACTIVATION

It is important that all requests for team utilization be coordinated in an orderly fashion. Generally requests will be for educational programs, debriefings or defusings. Occasionally there may be a request for scene support or for demobilization in the case of a large-scale event or disaster.

Requests for team utilization will be directed to the social worker in the Trauma and Emergency Center (TEC) at Gundersen Lutheran Medical Center. The social worker will have the team on-call schedule and will contact the team member on-call for the week. The on-call member will contact the requesting agency and determine the type of incident, the appropriateness of the request, and the date, time and location of the intervention. The on-call coordinator will then contact appropriate team members based on the type of incident and emergency providers to be served. It is recommended that activated teams should include a mental health member and peers appropriate to the request.

Team members are encouraged to meet at a central location so that they can travel together to the site of service. Materials for the intervention are located in a blue canvas bag in the TEC social workers' office (handouts, feedback forms, business cards). Team members who are Gundersen Lutheran employees may reserve a hospital car for travel. Other team members should submit their mileage to the Leadership Committee for reimbursement.

Team members are to wear their I.D. badge to all interventions.

Following the intervention, the activated team leader is responsible for completing the Outreach Request form and sending it to the appropriate Leadership Committee member. At the completion of follow-up, it is the responsibility of the member doing follow-up to send the Follow-up form to the Leadership Committee member responsible for team statistics.

SCENE SUPPORT SERVICES

On-scene support services are most often provided by peer support personnel who usually arrive at the scene with the primary goal of performing their usual emergency job. Any actions on behalf of their co-workers must be approved by command staff so that operations in the field are not disrupted. Most often the on-scene support services offered by peer personnel are limited and brief and may occur at or near the scene of operations. The peer support personnel are expected to conclude their assistance as soon as possible and return to usual duties. Mental health team members may be requested to provide further assistance if the situation warrants or an extended critical incident event is expected.

On-scene support services may include any of the following:

1. Brief assistance to obviously distressed co-workers through one-on-one contact. Peer support personnel should assess the need of moving the distressed co-worker from the immediacy of the event to reduce auditory or visual stimuli that could be exacerbating symptoms.

2. Peer support personnel may give advice to command staff as the situation warrants on topics of stress management or issues related to specific critical incident.

3. Peer support personnel may provide brief assistance to the victims or their family members to reduce interference with operations.

Peer support personnel need to keep in mind that peer support dispatched to an incident need to operate within the confines of their organization or unit. Peer support personnel may be of significant value to command personnel, department safety officers or incident command staff. During the course of routine operations peer support personnel may have an opportunity to recognize obvious signs of distress in fellow workers. We would encourage peers to contact command staff in the event any co-worker appears distressed or if scene activity suggests that the potential is unusually high for development of critical incident stress. Peer support may encourage command to activate a Critical Incident Stress Management Team but are reminded that the ultimate decision about team activation is at the discretion of command.

While command personnel may initially request that the peer support personnel already at the scene continue to monitor co-workers, it is our position that team activation should be considered for the following reasons:

1. Allows the Team Leadership/on-call member to be apprised of site activity, ensure continuity and consider options for additional backup.

2. Further assessment can occur to determine the appropriateness of the peer support personnel

providing service to his own unit.

3. Peer support personnel may be needed by command to focus on site activities and performance of usual duties.

4. The critical incident may be of significant magnitude that one or two peer support personnel are insufficient to meet site or staff needs.

5. It may not be in the best interest of the peer support personnel to continue to provide services if he or she has already been closely involved in the critical incident as well.

Dispatching Team Members for On-Scene Support

Either peer support team members or mental health team members dispatched to an incident should rendezvous at a designated site so as to proceed to the scene as a unit. Efforts will be made to provide an estimated time of arrival to incident command staff so as to assist in team access to the incident scene. We encourage those team members dispatched to the scene to take a minimum number of vehicles so as to minimize scene congestion. Any off site team members dispatched to the scene should be done so after consultation with the on-call Coordinator or Team Leadership.

Leadership Protocol/On-Scene Support

When selecting on-scene support team members the on-call Coordinator or Leadership member will select an individual to act as "team leader" who will be responsible to coordinate team activities at the scene. The team leader will have responsibilities of initially reporting to the command post as well as engaging peer support personnel who may have initiated activities prior to the team's arrival. The team leader will advise command of the team's presence, numbers of personnel available and will request direction from the officer for initiating team activities. The team leader will serve as the linkage between the commanding officer and the team throughout the course of the incident. Participating team members should make any observations or recommendations known to the team leader who can in turn report to the commander.

Additional Scene Support Protocols

- Members of the Critical Incident Stress Management Team involved in on-scene support should wear proper identification at all times while on site, going to the site or during the course of any activities under the auspices of the Critical Incident Stress Management Team.
- No team member should enter the internal parameter unless requested to do so by commanding officer.
- Team members should make every effort to be appropriately dressed in representing the team as well as take every safety precaution; utilizing protective clothing as deemed appropriate by command.
- The team leader is responsible for tracking all activities of team members during the course of the incident.
- Any task assigned to team members should be approved or reviewed by the team leader for the incident.
- Generally team members involved in scene activity should retain a "low profile" so as not to distract from incident operations.

GUIDELINES FOR ON-SCENE SUPPORT SERVICES AND INTERVENTIONS

I. **One-on-One Interventions**

A. One-on-one interventions or assistance should be provided to workers displaying obvious signs of distress and who are receptive to assistance. Signs of obvious distress include:
   1. Crying
   2. Shock-like state
   3. Unusual behavior (may include a change in cognitive skill ability)
   4. Acting out behavior (punching, screaming, other violent conduct)

B. Never interrupt an operational procedure to provide assistance. The intervention should take place when personnel are not actively engaged in service.

C. Generally on-scene support services last 5-15 minutes in length.

D. Support services should take place in as neutral an atmosphere as possible that is out of view, sight or sound of ongoing operation.

E. The general focus should be on the immediate concerns of the individual. Sample questions include the following:
   1. Ask content questions such as, "What happened?" or ask the individual what is happening with him or her at that moment.
   2. General discussion with the emergency provider is important to build rapport. Avoid questions such as "Are you okay?" On-scene support personnel should listen and reassure individuals that they are in contact with that their feelings are normal and make efforts to dispel the "myth of uniqueness."
   3. Indicate to the emergency personnel that your goal is to get him or her in service as soon as possible. Allow the emergency worker some input in terms of when they feel ready to return to scene activity.
   4. Ask the emergency provider, "What is the worst part for you right now?"
   5. Ask the emergency provider, "What will help you right now?" Be ready to provide the need if at all possible.
   6. Good listening skills are imperative. Display attention, make supportive comments and generally inquire if the individual has ever had an experience like this before.

F. Group interventions in the field are not appropriate.

G. Generally encourage individuals to take a 15-30 minute rest period if impacted from a critical incident.

H. Also consider giving the distressed individuals some "breathing space" so as not to be seemingly pressuring them to receive service of any kind. Re-check with them in follow-up personally.

I. If at all possible, restore the individual to service or alternative duty. If the individual is in need of discontinuation of provision of services, provide assistance in calling their home and make sure the individual is not home alone. If an emergency provider continues distressed and on-scene support seems ineffective, consideration should be given to immediate removal from the site.

J. If the worker is displaying psychotic behavior immediate removal is indicated.

K. If an emergency provider is in any way injured, removal to a hospital or medical area is indicated.

L. If a provider who has received services from the on-scene support staff returns to work and then redevelops stress symptoms, removal from the site is most likely indicated.

II. Advice to Command Staff From On-Scene Support Staff

On-scene support staff has no command authority. All decisions are the responsibility of the incident commanders or officers. Team members should not take or presume any position of command or authority for the incident management.

There are several considerations that can help minimize stress reactions and effects and maximize the performance of the emergency services staff performers. They include:

A. Rest/Rotation

1. Prolonged responses require proficient use of resources. Rest periods enable response teams to function for a much longer total period of time. Responses greater than two hours in duration should alert command for the potential need of change in operational procedures. The general rule of thumb is that two hours on (working) then 30 minutes of down time. This type of schedule can be followed for 12 hours at the scene. Twelve hour maximum time limits at the scene are the goal. This type of rotation will decrease the possibility of injury, decrease fatigue and will decrease the emotional drain-of the incident.
2. Crew rotation, mutual aid or drawing in of non-scene personnel should be considered. If any rotation of crews occurs it should be suggested that part of the old crew be replaced with part of the new crew so that continuity of scene care can be maintained.
3. There may be incidents where the scene stress is so intense that some emergency personnel may not be able to work two full hours before they are given a break. Special accommodations should be made for individuals hit with extraordinary stress. One of the first considerations is to cut down their exposure to sites, sounds, and smells of the immediate scene. Remove them to a short distance away and have peer support personnel stay with them until their vital signs can be monitored and assurances given that their stress reaction will not become life threatening.
4. Caution should be exercised in rotation of staff. Be careful in terms of separating supervisors from crews as well as team members that normally work together.
5. Caffeine products should be avoided. If they are to be used at all they should not be offered to crews until after four hours of operation. Water and juices should be served throughout. Salt tablets may irritate an individual's stomach and hence should be avoided as well. If Gatorade is used, dilute with ¼ to ½ of water to cut excessive sugar intake.
6. Alcohol is absolutely inappropriate for a considerable period of time after the emergency. Alcohol directly increases stress reactions and can cause other problems with judgment, decision-making and behavior. Alcohol can also directly enhance dehydration in those who utilize it.

B. Field Observations

1. On-scene support members may have an objective eye or better vantage point for observing intricacies of the operations and tasks. If a team member notices anything out of the ordinary or anything that might present a situation of concern later you should bring it to the attention of the team leader who in turn can inform command or safety officers. Examples include:

- Inappropriately dressed providers
- Clothes not conducive to weather
- Providers improper utilization of protective gear
- Need for water or rest breaks
- Need for food
- Need for toilet facilities
- Need to establish a demobilization site
- Need to establish a victim/survivor staging area
- Need to call victim support organizations
- Need to send someone with a provider being removed from the scene
- Need to remove provider from operations
- Need to restore provider to lighter or alternative duty
- Any substantial reason for providing insight to command when it can be determined that command is unaware of a potentially harmful situation.

III. **On-Scene Support -Victims, Survivors, Families**

The primary function of the team is to provide on-scene support for the emergency care workers. While that assignment is given it may be necessary to provide some assistance to victims, survivors or family members on an interim basis. Team members may maintain a list of victim resources during on-scene operations or consider contacting agencies such as Great Rivers 2-1-1 to provide other back up information. The team may initially need to provide a staging area for families to meet away from the operation site and out of the way of the emergency services workers.

DEMOBILIZATION SERVICES

Demobilization services are typically reserved for a large scale or unusual event that lasts longer than eight hours. Demobilizations typically take place away from the scene and last approximately 30 minutes. The objectives of demobilization include:

1. An opportunity to provide stress information.

2. Rest and fluid options in a comfortable atmosphere before returning to quarters or home.

3. Providing command officers an opportunity to make announcements or updates regarding the event.

4. Providing an opportunity for initial ventilation of feelings about the event.

Guidelines for Demobilization Services

Demobilization services will be implemented by several mental health team members and peer support members not required in on-scene support or in incident activities. It is best to offer it at a location that has a large room away from the incident site. Personnel are ordered to the center when their work at the scene is completed. The entire process lasts a total of 30 minutes. Ten minutes are

used in giving stress information and 20 minutes are allocated to feeding and resting the crews. The process will be as follows:

1. Command determines the appropriateness of demobilization and a site is established.

2. Units or personnel disengaged from all scene activities will be processed through the demobilization center.

3. As units leave the scene they will stop at the center if at all possible.

4. When units arrive at the demobilization site a team member will greet each arriving unit and usher them to a specific site in the room. Units will be kept together and combination of units will be discouraged.

5. As indicated, the demobilization lecture takes approximately 15 minutes. It consists of the following information:

    - Recognition of the workers' efforts and their fatigue.
    - Indicate your objective and desire to give the workers a chance to rest, eat and unwind before the end of their duty.
    - Provide information on how they would be informed as to site, time, etc. if a debriefing is planned.
    - Provide general information to workers consistent with CISM literature. Indicate that some individuals will have no reaction to the event and that is common, but that some others may have a delayed reaction. Others may already be experiencing uncomfortable feelings as a result of the event as well. Offer a brief list of signs and symptoms of stress. Allow the workers an opportunity to stick around and ask questions or talk about anything. Dismiss the worker to a location in the same building where they could eat and get fluid rejuvenation.

6. All information provided to participants should be consistent to all groups. It may be necessary for a demobilization team to meet and develop an outline or script to ensure consistency and continuity.

7. One mental health team member should remain in reserve to meet with the next incoming group.

8. If any unit officers or command officers arrive after the initial demobilization has occurred ask them to consider the following:

    - Give praise to their group for a job well done.
    - Ask them to be specific in terms of what their expectations are for the unit in terms of equipment care or discharge.
    - Only officers or command staff should report any information of injury or death to co-workers. Team members should not offer any of this information as they are not a part of the unit, EMS care group or family.

DEFUSINGS

Defusings are much shorter, less formal and less structured versions than a Critical Stress Debriefing. They are performed after the incident and after the unit have returned to the station or original work site. The purpose is to offer information, support, allow initial ventilation of feelings, set up or establish the need for a formal debriefing and to stabilize crew members so they can go home or back in service.

Guidelines for Defusing Services

1. Ideally defusing should be done immediately after an event. They may be done within an eight-hour time frame of the incident. If it is not possible to hold a defusing within these guidelines, a formal debriefing should occur. The key point is that it is an immediate intervention.

2. Defusings are a group process and all persons of the unit involved in the incident should attend the defusing.

3. Defusings are brief and last 20 to 45 minutes.

4. Defusings may be provided by peer support personnel. The peer support personnel should be well aware of his or her personal limitations and should call for support from the mental health member or senior peer member if the situation warrants. Peers directly involved with the operation should not perform defusings for the group.

5. All parties should remain in the defusing until its conclusion. They are best held in a comfortable atmosphere that is free from distractions and interference.

6. Consider targeting the core group of individuals that worked the call.

Defusing Format

The components for the defusing include:

1. **Introduction** – Attempt to motivate the participant and establish the ground rules.

2. **Content** – Ask participants to talk about the facts of the events and their experiences, ask the group to tell you what happened and what the worst part of the event was for them. Allow freedom of discussion to take place on the worst part.

3. **Teaching** – Talk of survival strategies and offer information on possible signs and symptoms of stress that they may or may not experience and information on what they can do about it. Give informational handouts to each one and make sure they know how to get in touch with the CISM Team.

   It is important to acknowledge the feelings and reinforce the feelings described by participants. Do not probe or dwell on particular topics, as it is much too early after the critical incident for this tactic. Keep the session informal but to the point. Do not allow the

crew to lapse into critique of operations. The team member's primary function is to facilitate and direct the session.

FORMAL CRITICAL INCIDENT STRESS DEBRIEFING

Critical Incident Stress Debriefings are essentially discussions of the incident in confidential meetings. The goals are to reduce the impact of the critical event and accelerate the normal recovery of normal people. It is recommended that the critical incident stress debriefing be led by a mental health professional and several peer support personnel. It typically lasts 1½ to 2½ hours and is best offered after 24 hours and before 72 hours of the event. It is not psychotherapy nor is it a form of therapy or treatment. It will produce a therapeutic effect in that it will assist participants in understanding their stress affect and it will accelerate the recovery process. The debriefing process provides a chance to ventilate pent up feelings, provide opportunities for stress reduction education, emotional reassurance and forewarning personnel what signs and symptoms of distress might materialize later. Debriefings tend to reduce the fallacy of uniqueness and abnormality. It is hoped that CISM is a positive interaction between mental health professionals and personnel. Other positive experiences documented include restoring group cohesiveness, assist in interagency cooperation, helps facilitate prevention programs, provides screening for those not yet ready to return to service and allows an opportunity for referral of those individuals requiring additional services.

The on-call coordinator will evaluate the need for a debriefing when one has been requested. Criteria used in deciding to do a debriefing include:

- Many individuals within a group appear to be distressed after a call.
- Signals of distress appear to be quite severe.
- Personnel demonstrate numerous behavioral changes.
- Personnel make significant errors on call occurring after the critical incident.
- Personnel request help.
- The event is extraordinary.
- Various agencies are showing the same reactions.
- Signals of distress continue beyond three weeks.

Debriefings may be recommended for the following events:

- Death to a fellow worker in the line of duty.
- Serious injury to an emergency provider in the line of duty.
- Care provision for a relative or close friend.
- Suicide involving fellow emergency worker.
- Disaster/serious multiple casualty incident.
- Violence or personal threat to the emergency worker.
- Any case with excessive media interest.
- Traumatic death of children.
- Serious injuries to children.
- Death to civilian caused by emergency operations.
- Prolonged incident especially with loss of life.

Who Will Be Debriefed

Any person directly involved in the operation of the event or persons for whom the event has elicited an unusually strong reaction should be debriefed. It may be necessary to perform several debriefings for one incident depending on the nature of the event, the number for debriefing, the types of units or the nature and extent of their involvement in the event. Persons not directly involved in the event will not be debriefed in most cases. Exceptions to this will be the serious injury or death of a unit member. Children, members of the family (participants or survivors), victims or members of the press should not attend the debriefing. If services are needed for these persons, referrals or alternative services may be provided.

Where Will The Debriefing Take Place

It is important that the site for the debriefing be free from distraction and interruption. It needs to be a place large enough to accommodate the numbers present, be fairly comfortable and hopefully be available to place participants in a circular seating arrangement without visual interference. It hopefully is a neutral site as well.

Debriefing Timing

Debriefings are best offered 24 to 72 hours after the event or as soon after this time that it is possible to get the parties together. Most debriefings lose their effectiveness after 8 to 12 weeks. There is a gradual decline in effectiveness as time goes by. The bigger the event, however, the bigger the window to enter for a debriefing. It is not recommended that debriefings occur after 12 weeks post incident. After 16 weeks Dr. Jeffrey Mitchell suggests that additional harm might be done. In most cases if the debriefing is done before 24 hours post event it may be too early to reap all the benefits of a potential debriefing. There may be too much cognitive blocking for maximum gain. Line-of-duty death or traumatic multi-casualty incidents may be exceptions. If you do need to do a debriefing within 24 hours it is best to do a second debriefing in follow-up. A second debriefing also may be necessary post disaster or line-of-duty death. If multiple debriefings are needed the same team should be utilized if possible. A second debriefing should occur within one week. In arranging for a debriefing it is best to reserve the debriefing for a truly awful event.

Debriefing Time Commitments

There are a number of variables involved in estimating the time needed for a debriefing process. They include travel time, pre-debriefing activities, site evaluation, debriefing process, post debriefing activities, etc. The pre-debriefing activities or meetings should last approximately 15–30 minutes. The debriefing process averages approximately 1½ to 2½ hours. Post debriefing activities length would depend upon the team members and the debriefing participants. It is impossible to accurately gage the length of the debriefing process. It is advisable that no member commit themselves to attend a debriefing when they are limited in time or must report to work within 8 hours of a scheduled debriefing start time.

PRE-DEBRIEFING ACTIVITIES

Prior to a debriefing all the coordination elements must be in place. The room must be selected, the time set, refreshments arranged for the end of the debriefing and proper announcements made to

participants and team members.

The debriefing team will generally arrive about 15 to 30 minutes early. Team members have three important tasks to accomplish in the time before the debriefing. They may review the photographs, newspaper articles, videotapes and incident reports. Next they will want to meet casually with some of the personnel who are gathering at the debriefing center. Finally CISM members will want to have a brief strategy meeting before the beginning of the debriefing. Generally a formal debriefing will not be held for less than three persons. When there are less than three, one-on-one consults or mini-group sessions will be used. Ideal debriefing group is between 3 and 40 participants. Maximum group size should be approximately 60 participants. In groups of over 40 participants procedures for the debriefing process may be adapted.

Team members responding to a debriefing should, if at all possible, travel to the debriefing site together. They may wish to visit the incident site if necessary. Team members should develop a strategy for the debriefing to determine who is the leader, develop any signs or signals that may be needed during the debriefing and establish team member roles. Seating arrangements should be discussed and confirmation made that participants will not be drawn out of the debriefing for call or service. Arrangements should be made so that chairs are in a circle fashion. Generally team members are divided equally within the circle. Arrangements should be made so that doors may be closed for the debriefing area and that one peer is available at least to negotiate a return for any participants leaving early or ask inappropriate participants to leave the area.

DEBRIEFING PHASES

Introductory Phase

In this phase the team leader introduces the process, encourages participation by the group and sets the ground rules by which the debriefing will work. Participants are told:

1. The entire process is confidential.

2. Participants do not have to speak if they chose not to but, they are encouraged to discuss the incident.

3. There will not be any breaks. Participants are asked to return to the debriefing area after attending to personal needs. Participants should not leave prior to the end of their session as this might endanger their recovery.

4. Participants will speak only for themselves.

5. It is not necessary to go into details that could jeopardize an investigation or cause job difficulties.

6. Pagers should be left off, if at all possible, or only one pager left on.

7. All personnel are equal during the debriefing and rank does not exist.

8. The Critical Incident Stress Debriefing is not an operations critique of the incident.

9. A Critical Incident Stress Management team member will be available after the debriefing for anyone wanting to talk individually.

10. Generally only people involved in the incident are allowed in the debriefing.

11. This is a preventative program, not a therapy program.

Fact Phase

During this phase the group is asked to describe briefly their job during the incident and from their own perspective some facts regarding what happened. Things participants might include are: where were they, what they heard, saw or smelled. This phase recreates the event. By talking about the incident participants feel a sense of power in being able to overcome the situation. If this proves to be especially difficult for a participant, acknowledge and validate their feelings and move on to the next person.

When the circle gets to the peer support personnel or co-leader they will introduce themselves and identify their level of emergency service involvement and offer a sense of identity and reassurance to the participants.

Thought Phase

This phase requires the participants to conceptualize what they have heard and seen. Each participant is asked to discuss their first thoughts during the event; this taps into the more personal aspects of the situation.

Reaction Phase

The leader will ask the participants to share their reactions to the incident. This phase moves participants from the cognitive to the emotional level by asking, "What was the worst thing about this incident for you?" The leader will not probe except to get clarification on specific issues.

Symptom Phase

In the symptom phase, the participants are asked to describe their cognitive, physical, emotional and behavioral signs and symptoms or signals of distress which appeared:

- At the scene or within a 24-hour period.
- A few days after the event.
- Are still being experienced at the time of the debriefing.

An important question might be as in terms of how participants knew that this event was different from others for them.

Teaching Phase

This is an opportunity for an explanation to the group that the signals of distress they have encountered are normal and will subside in time. Information regarding stress reactions and recovery are shared with the group. The mental health professionals and peer support personnel may teach

additional signs and symptoms that may not have been expressed for additional reference. It is during this phase that information will be offered on positive coping methods and general information on stress management. It is an opportunity for the leader to invite the participants to ask any specific questions about the management of stress which they may have

Re-entry Phase

This is the wrap up phase in which additional statements or questions can be presented by the group. Anything that the participants have not said or any repetition of previously stated material is encouraged.

Sometimes members of the group decide to formulate some sort of supportive contract with one another during this phase. At other times they decide to do something as a group to assist others. During the later stages of this segment the CISM team members are required to make a summary statement to the group. No one else has to speak if they do not wish to do so. The invitation is made but no one is forced to speak. Handouts with phone numbers of the CISM team members should be distributed at each debriefing. Writing phone numbers on a board is not a good idea. People are often too embarrassed to copy these down.

A copy of the CISM Information Sheet, Post-Incident Survey, and a postage-paid envelope is given to each participant.

Post Debriefing Activities/Meeting

Immediately after the debriefing concludes, the CISM team members will make themselves available to the group for individual contacts, additional questions, requests for referrals, personal reassurance and so on. It is an opportunity for team members to seek out those that may be having the most difficulties and attempt to give them reassurance, instructions, advice, referrals, etc.

After the formal debriefing and post debriefing, the team members shall meet and discuss the debriefing strategy used, any concerns, topics and issues. Recommendations for follow-up services will be noted and the debriefing report will be completed by the team leader. The report is to be left in the CISM bag or mailed in the postage-paid envelope immediately after the debriefing.

DEBRIEFING THE DEBRIEFERS

Voluntarily subjecting oneself to an outpouring of emotion for a period of several hours is very draining for the debriefing team members. The extent of this drain has often resulted in the manifestation of stress related symptoms for some team members. In order that the CISM Program may not fall victim to those it serves, the team members will be debriefed on a regular basis.

Regardless of the magnitude of the disaster or the numbers to be debriefed, it will be policy that at no time will all of the team members be summoned to respond to a debriefing request. Thus, some team members will remain uninvolved at all times. This will enable them to act as a debriefing team for the debriefers. It would be erroneous for us not to make provisions to take care of ourselves.

These debriefings will be accomplished in several ways:

1. The debriefing team may request that a debriefing take place immediately or shortly after an incident debriefing. This decision will rest solely upon the discretion of the team leader of that team. The request will be facilitated via normal channels and procedures through contact with the on-call coordinator.

2. Debriefings may take place after regularly scheduled team meetings. It will be understood that such may occur and shall be automatically incorporated into the agenda for each team meeting.

3. Any debriefing team member may contact the Leadership Committee directly if the team leader has elected not to request a debriefing. A member of the Leadership Committee will contact an appropriate member to meet with the debriefer.

FOLLOW-UP

Follow-up services are very important in the CISM process. Follow-up post incident intervention may include phone calls, visits to stations or agencies, mailing of printed material, coordination of additional counseling for individuals or groups or general advice to command. Additional debriefings, or specialty debriefings, hot lines, counseling, spouse support or community education programs may be requested/needed. Guidelines for confidentiality must be maintained.

Team initiated follow-up will be at the direction of the mental health team member or lead team member. Peers wishing to establish follow-up contact with an individual or organization should first discuss the matter with the other incident debriefers. This will enable continuity of care, insure privacy and confidentiality, and make sure appropriately trained members provide required service

MUTUAL AID REQUEST

Occasionally events occur that may necessitate a request for assistance from teams outside our service area. Examples include the International Critical Incident Stress Foundation, the CISM of Wisconsin Network or teams from Iowa or Minnesota that might require assistance if a local disaster or mass casualty incident occurred that committed peers in scene activity. Mutual aid requests will be reviewed on a per incident basis by the on-call Coordinator/Leadership Committee.

Clarity of expense reimbursement should occur before a commitment for mutual aid is given.

QUALITY ASSURANCE

Methods for determining quality assurance have been established. These will take several forms:

1. A survey or questionnaire will be offered to solicit comments from the audience attending any training or educational program.

2. Quality assurance will be evaluated during follow-up procedures after incident debriefings.

3. Overall effectiveness of the program may take several years to evaluate as attrition rates, substance abuse rates, referral rates, etc. are monitored through the counties.

4. Quality assurance of team activity and membership will be an ongoing process.

5. Written debriefings reports will be completed by the lead debriefer following every debriefing.

KEY REMINDERS FOR TEAM MEMBERS TAKING CALL

The continued credibility and value of our CISM Team is directly linked to how effectively we manage the on-call process. Below are some key reminders to assist you when you are scheduled to take call:

1. It will be our on-call **standard of care** that you must **respond** to the page from TEC Social Service within **30-35 minutes**. It is also important at that time to make an initial call to the requesting agency or department. It will be important during this initial contact to get a sense of the urgency of the request, i.e., immediate response defusing. If, at that time, you are not able to take all of the information necessary to begin facilitating team services, it would be important to schedule a time within the next three hours in which you can call that individual in the community back to obtain all necessary information for scheduling services. Therefore, in your initial phone call to the community agency or department requesting services, it would be important to get appropriate name, position, telephone numbers and locations of where they can be reached when you do make arrangements to call them back.

2. Call runs from 8:00 a.m. on Monday mornings through 8:00 a.m. the following Monday morning.

3. If needed, it is your responsibility to pick up the CISM pager from the Gundersen Lutheran Trauma and Emergency Center (TEC) Social Services Office (located in the TEC Department) as your week begins, and return it promptly at the end of your week of call. If the person having call the week before you uses their own pager or cell phone (see schedule for that information), this means you could pick up the pager earlier. Several of the on-call volunteers have their own pagers or cell phones, so be sure to consult the schedule.

4. It is fine to trade a day, evening, weekend or entire week with another on-call member. However, **it is your responsibility to inform the TEC Social Worker of that trade**. This is a critical step, as TEC Social Services must have the correct name/pager or cell phone number at all times.

5. Feel free to contact any of the Leadership Committee Members if you need help or

consultation with a Team request.

To Contact TEC Social Services call 608-775-3652 or 800-362-9567.

MISSISSIPPI RIVER VALLEY CISM TEAM
OUTREACH REQUEST

Date: _____ Time: _____

TEC Social Worker: _____

Referred To (On-Call Team Member): _____

Agency/Group Requesting Service: _____

Contact Person: _____

Telephone: (H) _____ (W) _____ (C) _____

Brief Description of Event: _____
_____
_____
_____
_____

Anticipated Number Of Participants And Their Role: _____

Service Requested: Scene Support ____ Defusing ____ Family/Significant Other
Debriefing (24-72 hrs) ____ Education ____ Support ____
Request Referred to Another Agency _____ Contact: _____

How Soon Are Services Needed? (Suggest 24-72 hours) _____
To Reserve Gundersen Lutheran Car, Call Malcom Clark at 775-1462

Team Members Dispatched: _____

_____

Team Leader: _____

Date of Service: _____ Time: _____

Location of Debriefing: _____

Address: _____
Directions – See Other Side

Total Attendance: _____

____First Responders ____ EMT ____ Paramedic ____ Nurse
____Fire Fighter ____ Dispatch ____ Law Enforcement
____Other (specify) _____

Total Time: _____ Travel Time: _____

Follow-Up Contact With Requesting Agency By: _____ Date: _____

This form is started by the person on-call and given to the Team members providing services. At the completion of service, please fill in the necessary data and return to Sally Armstrong at Mailstop H04-004 as soon as possible.

F:/share/TEC/CISM/Outreach Request 10/14/08 dk

MISSISSIPPI RIVER VALLEY CISM TEAM

Post Incident Survey

Your cooperation in completing this form will be greatly appreciated. The purpose of this survey is to help our team continually improve services. The information received in this survey is confidential and will only be used for our internal quality improvement program or to respond to your request for follow-up. Thank you in advance for your response.

***Please mail your completed survey in the pre-stamped envelope to Mississippi River Valley CISM Team, Gundersen Lutheran Medical Center, 1900 South Ave., La Crosse, WI 54601 (Attn: Sally Armstrong, Mailstop H04-004).

1. Date of form completion _____
2. Date CISM Team utilized _____
3. Name of your department: (optional) _____
4. I felt the utilization of the CISM Team was beneficial: yes no
   Comments? _____
5. I felt comfortable with the group leader: yes no
   Comments? _____
6. I felt comfortable with the team members: yes no
   Comments? _____
7. I wish that the team would have: _____
   _____
8. The most beneficial thing about having contact with the CISM Team was: _____
   _____
9. My suggestion(s) for improvement of services provided by the team include: _____
   _____
10. I was experiencing stress symptoms related to the incident: yes no (please refer to handouts to indicate what kind): _____
    _____
11. These symptoms are better/worse since contact with the CISM Team.
12. I am experiencing stress symptoms at this time: yes no (please refer to handouts (as a guide): _____

Optional: If you would like someone to call you about this incident or related concerns, please include your name, phone number and best time for one of our personnel to contact you.

_____

_____

Or, you may contact the **Mississippi River Valley CISM Team** at 608-775-3652 or 1-800-362-8255 (WI) or 1-800-356-9588 (Minnesota and Iowa). Again, this information will be kept confidential.

A service of
Gundersen Lutheran Medical Center
1900 South Avenue
La Crosse, WI 54601

MISSISSIPPI RIVER VALLEY CISM TEAM

Follow-Up Form

Date: _____

Member Doing Follow-up: _____

Follow-up To: Name: _____

Phone Number: _____

Incident: _____

Problem Areas/Symptoms Identified

_____
_____
_____
_____
_____

Coping Strategies

_____
_____
_____
_____
_____

Referrals/ Recommendations

_____
_____
_____
_____
_____

Total Time: _____

MISSISSIPPI RIVER VALLEY
CRITICAL INCIDENT STRESS MANAGEMENT

Information Sheet

A critical incident is defined as any event that may cause individuals to experience strong emotional reactions which could potentially interfere with their ability to perform routine duties or activities. Even though the event is over, you may still be experiencing, or may experience at a later time, some strong emotional or physical reactions. It is very NORMAL for people to experience these types of reactions following exposure to an extraordinary event.

Often the emotional aftershocks (or stress reactions) appear immediately after the traumatic event. Sometimes, they may appear a few hours or days later. In some cases, weeks or months may pass before the stress reactions appear. With understanding and the support of co-workers, friends and family, the stress reactions usually pass more quickly.

Occasionally, the traumatic event is so painful that professional assistance from a counselor may be necessary. This does not imply "craziness" or weakness. It simply indicates that the event was just too powerful for the person to manage without assistance.

Here are some very common signs and signals of a stress reaction:

PHYSICAL	COGNITIVE	EMOTIONAL	BEHAVIORAL	SPIRITUAL
diarrhea	confusion	anticipatory anxiety	change in activity	How do I make sense of this?
vision problems	calculation difficulties	denial	suspiciousness	questioning your basic beliefs
chills	poor concentration	fear	increased smoking	loss of meaning and purpose
shakes	disruption in logical thinking	survivor guilt	excessive humor	withdrawal from spiritual
upset stomach	repeatedly visualizing event	uncertainty of feelings	unusual behavior	inability to connect with
muscle aches	lowered attention	feeling abandoned	hyper-alert	uncharacteristic spiritual practice
tremors	memory problems	anger	withdrawal	
rapid heart rate	distressing dreams	identify with victim	communication changes	
fatigue	blaming someone	depression	increased alcohol use	
profuse sweating		grief	excessive silence	
dry mouth		feeling hopeless	eating habit changes	
poor coordination		feeling overwhelmed		
sleep disturbance		feeling loss		
nausea		worried		
chest pain *		feeling numb		
difficulty breathing				
shock, symptoms *				

*Note: Symptom(s) indicate a definite need for medical evaluation.

For any additional **Mississippi River Valley CISM Team** questions or services, call 608-775-3652. Available 24 hours a day, seven (7) days a week.

A Service of Gundersen Lutheran Medical Center
1900 South Avenue
La Crosse, WI 54601

Suggested Post-Incident "Do's and Don'ts"

Depending on the critical incident and post-trauma consequences, these are examples of coping skills for debriefing participants.

DON'T	DO
drink alcohol excessively	get ample rest
use legal or illegal substances to numb consequences	maintain a good diet well-balanced and regular meals
withdraw from significant others	take time for leisure activities
stay away from work	recognize that these consequences are normal
reduce amount of leisure activities	talk about the incident with support peers and family
use off-duty time for training immediately after event	spend time with family and friends
have unrealistic expectations for recovery	get extra help from post-trauma counseling (if needed)
expect the incident not to bother you	remember that flashbacks, dreams and recurring thoughts are normal
	exercise within the first 24-48-hours to relieve stress

Suggestions to Help Yourself and Others Following a Critical Incident

1. Encourage discussion about thoughts and reactions to the incident.

2. Don't assume that men handle this kind of trauma better than women.

3. Tell the person how you feel, i.e., that you're sorry they are hurting.

4. Remind the person that confusing emotions are normal.

5. Do not attempt to reassure that everything will be okay. Everything is not okay.

6. Do not attempt to impose your explanation of why this has happened.

7. Do not tell the person that you know how she or he feels. You don't. Often such attempts are really aimed at relieving our own anxiety about what has happened.

8. Be willing to say nothing. Just being there is often all that can help.

9. Tell your friends and family how you are feeling. Even if you are not a direct victim of the trauma, remember that people who care about the survivors often become co-survivors emotionally.

10. Monitor any unusual physical symptoms that might be interfering with your daily routine.

11. Don't be afraid to encourage a person to ask for help, including counseling if necessary. Don't be afraid to ask for help yourself, even if you are not directly involved.

12. Try not to project your own feelings onto those around you. Each person experiences trauma and its consequences differently. Be understanding to the pace that coping and healing occur.

13. Don't be afraid to ask how someone is doing. Do not ask for details of the trauma. If the survivor wants to talk, listen. The best thing to do is to let the person know you are there and that you care.

MISSISSIPPI RIVER VALLEY CISM TEAM

Suggestions to Help Yourself and Others After a Critical Incident

- Encourage the person to talk to you about how he or she is feeling.
- Don't assume that men handle this kind of trauma better than women.
- Tell the person how you feel; that you are sorry that they have been hurt.
- Remind the person that their confusing emotions are normal.
- Do not attempt to reassure the person that everything will be okay. Everything is not okay.
- Do not attempt to impose your explanation of why this has happened to the survivor.
- Do not tell the person that you know how she or he feels. You don't. Often such attempts are really aimed at relieving your own anxiety about what has happened to the survivor.
- Be willing to say nothing. Just being there is often all that can help.
- Tell your friends and family how you are feeling. Even if you are not a direct victim of the trauma, remember that people who care about the survivors often become co-survivors emotionally.
- Monitor any unusual physical symptoms that might be interfering with your daily routine.
- Don't be afraid to encourage a person to ask for help, including counseling, if necessary. Don't be afraid to ask for help yourself even if you are not directly involved.
- Go to any court hearings, community meetings, meetings with insurance companies - any events which directly relate to the trauma. Offer to go for support.
- Try not to project your own feelings on those around you. Each person experiences trauma and its consequences differently. Be understanding to the pace that coping and healing occur.
- Don't be afraid to ask how someone is doing. Do not ask for details of the trauma. If the survivor wants to talk, listen. The best thing to do is to let the person know that you are there and that you care.

A Service of Gundersen Lutheran Medical Center
1900 South Avenue
La Crosse, WI 54601
608-775-3652

MISSISSIPPI RIVER VALLEY CISM TEAM

Helping Your Child After The Incident

Children may be especially upset and show feelings about the incident. These reactions are normal and usually will not last long. Listed below are some problems you may see in your children:

- Excessive fear of darkness, separation or being along.
- Clinging to parents; fear of strangers.
- Worry
- Increase in immature behaviors.
- Not wanting to go to school.
- Changes in eating/sleeping behaviors. Increase in either aggressive behavior or shyness.
- Bedwetting or thumb sucking.
- Persistent nightmares.
- Headaches or other physical complaints.

Some things that will help your child are:

- Talk with your child about his/her feelings about the event. Share your feelings too.
- Talk about what happened. Give your child information he/she can understand.
- Reassure your child that you are safe and together. You may need to repeat this reassurance often.
- Hold and touch your child often.
- Spend extra time with your child at bedtime.
- If you feel your child is having problems in school, talk to his/her teacher so you can work together to help your child.

For any additional **Mississippi River Valley CISM Team** questions or services call 608-775-3652, available 24 hours a day, seven days a week.

A Service of Gundersen Lutheran Medical Center
1900 South Avenue
La Crosse, WI 54601

MISSISSIPPI RIVER VALLEY CISM TEAM

Critical Incident Stress Management Information For Family/Significant Others

Your family member or friend has been involved in a powerful and potentially emotion-charged event, often referred to as a critical incident. He or she may be experiencing normal stress responses to such an event (critical incident stress). Research has shown that critical incident stress affects up to 87% of all emergency personnel exposed to powerful events. No one in emergency services is immune to critical incident stress, regardless of past experiences or years of service, and it is difficult to predict in advance which events will impact personnel. Your family member or friend may experience critical incident stress at any time during his/her career.

Important things to know about critical incident stress:

- The signs of critical incident stress may be physical, cognitive, emotional, and behavioral. We have provided a handout outlining the signs/symptoms he/she may experience.

- Critical incident stress responses can occur right at the scene, within hours, within days, or even within weeks. There are situations where the responses are delayed well after the incident is over.

- Your family or friend may experience a variety of signs/symptoms of a stress response or he/she may not feel any of the signs at this time.

- We often remind the emergency service personnel that "normal people have normal reactions to extraordinary events". Other emergency service personnel who participated in the event may be impacted as well as your family member or friend.

- The symptoms will normally subside and disappear in time.

- All phases of our lives overlap and influence each other: personal, professional, family, etc. The impact of critical incident stress can be intensified, influenced or mitigated by personal, family and current developmental issues.

- Talk is the best medicine. Encourage, but do NOT pressure your family member or friend to talk about the incident and his/her reaction to it. Your primary "job" though is to listen, reassure and try to understand. Remember that if an event is upsetting to you and those involved in the incident, your children may be affected also. They may need to talk, too.

- Offer your love, friendship and support as you may not understand what your family member or friend is going through at this time. Don't be afraid to ask what you can do that he/she would consider helpful.

- Accept the fact that life will go on: his/hers, yours and your children's. Maintain or return to normal routine as soon as possible.

- If the signs of stress your family member or friend is experiencing do not begin to subside within a few weeks, or if they intensify, consider seeking further assistance. The Critical Incident Stress Management Team can help you, your family member or friend find a professional who understands critical incident stress and how it has affected you.

- If you have any follow up questions or concerns, feel free to contact Mississippi River Valley Critical Incident Stress Management Team at (608) 775-3652, available 24 hours a day, seven days a week.

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1900 South Avenue
La Crosse, WI 54601