SOUTHEAST REGIONAL CRITICAL INCIDENT STRESS MANAGEMENT TEAM

TEAM GUIDELINES

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I. OVERVIEW

Emergency service personnel by the nature of their profession are exposed to human suffering and tragedy sometimes on a daily basis. Case studies by Dr. Jeffery Mitchell and others reveal that exposures to major incidents where numerous injuries or fatalities have occurred result in a significant number of stress-related symptoms after the incident. Research indicates that more than eighty-six (86%) of emergency service personnel experience a reaction to traumatic stress whether emotional, behavioral, cognitive, or physical. Fifty percent (50%) of these people will continue to experience these reactions for three weeks post event and ten percent (10%) for one year post event without intervention. Even with proper intervention, 3-5% of those with reactions will require professional intervention.

Factors that cause stress to one individual may be non-stressful for another. Research has demonstrated very few emergency service personnel are not affected by stressors inherent to their professions. Research has also indicated the majority of those who demonstrate symptoms related to stress cannot resolve these issues on their own and continue to be affected.

Responses to stress may be immediate and incident specific; they may be delayed for a period of time after an incident; or they may be cumulative, building up over a long period of time and can include many incidents. Multiple factors affect an individual's response to stress and include factors specific to the stressor, such as the individual's personal qualities and past experiences and the resources available to them.

According to Dr. Jeffery Mitchell, a critical incident can be defined as any situation faced by emergency personnel that caused them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later. A situation does not have to be at the magnitude of a major disaster to be classified as a critical incident. The only requirement is that it generates unusually strong feelings in the emergency workers that overwhelm the person's ability to cope.

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The following are examples of incidents that may have significant emotional impact among emergency service personnel:

- The death or serious injury of an emergency services worker in the line of duty, including during the incident, en route to or following the scene, or during a training exercise
- Mass Casualty Incidents
- Suicide of a crew member or other unexpected death
- Serious injury or death of a civilian resulting from emergency services operations, i.e. auto accident, etc.
- Events that seriously threaten the lives of responders
- Death of a child or violence to a child
- Loss of life of a patient following extraordinary and prolonged expenditure of physical and emotional energy during rescue efforts by emergency services personnel
- Incidents that attract excessive media coverage
- Personal identification with the victim or the circumstances. Events where the victims are relatives or friends of emergency personnel.
- Any incident that is charged with profound emotion
- Any incident in which the circumstances were so unusual or the sights and sounds so distressing as to produce a high level of immediate or delayed emotional reaction.

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II. MISSION STATEMENT

The primary mission of the Southeast Regional Critical Incident Management Program will be to provide a multi-component stress management plan to help mitigate the impact of traumatic stress on the emergency service provider. The team will provide services to all emergency service organizations in the geographic area of the Tri-State Mutual Aid Association and the Southeast Tennessee EMS region. All other requests for service will be considered on an individual basis. ~~The Southeast Regional Critical Incident Stress Management Team is a non-profit (501-C3) corporation.~~ Services of the team are free of charge, however the requesting agency may be asked, as they are able, to assist with operational expenses incurred.

The program will consist of the following elements:

- Stress education and prevention training concerning duty-related stress arousal, stress identification and management, critical incident stress and post incident interventions.
- To provide interventions such as debriefing (CISD), defusing, demobilization, and on the scene support to diminish the impact of major events on emergency service personnel.
- To provide critical incident stress education and support services to emergency services family members.
- To provide references and referral network for emergency personnel requiring additional intervention beyond the scope of the team.
- A plan for the incorporation of mental health professionals and team members during times of large-scale crisis or disaster will be made available to county and state emergency planning officials.

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III. TEAM MAKEUP

A. TEAM COORDINATOR

The Team Coordinator shall be responsible for the overall management of the CISM program. The Team Coordinator shall also have the following responsibilities:

- Oversee the operation of the CISM program
- Recruits volunteers for the program
- Represents the CISM program before service and community organizations
- Assists in the CISM Team selection process
- Assists in the training of the team, the providers, administration, and the public
- Answers requests for CISM assistance or training
- Evaluates requests for CISM interventions
- Dispatch the CISM team
- Provide debriefing of the debriefers when necessary or requested
- Solicit support from appropriate agencies
- Establish a Peer Review Board
- Hold periodic team meetings
- Maintains record of team activity
- Keeps updated lists for referrals
- Sets up training, seminars, and in-services
- Acts as liaison with Emergency Services Administrators

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B. ASSISTANT TEAM COORDINATOR

The Assistant Team Coordinator shall be responsible for assisting the team coordinator in the overall management of the CISM program. The Assistant Team Coordinator shall also have the following responsibilities:

- Assist with the operation of the CISM program
- Recruits volunteers for the program
- Represents the CISM program before service and community organizations
- Assists in the CISM Team selection process
- Assists in the training of the team, the providers, administration, and the public
- Answers requests for CISM interventions
- Evaluates requests for CISM interventions
- Dispatch the CISM team
- Provide debriefing of the debriefers when necessary or requested
- Solicit support from appropriate agencies
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C. CLINICAL COORDINATOR

The Clinical Coordinator shall be a Mental Health Professional responsible for overseeing the delivery and quality of the support services. The Clinical Coordinator shall also have the following responsibilities:

- Offer quality assurance for Professional CISM team members.
- Represent CISM programs before the public, professional, and governmental agencies.
- Monitor the debriefing process.
- Assist in establishing cross-training programs.
- Assists the Team Coordinator in establishing protocols for debriefings, defusings, peer support programs, and spouse programs.
- Reviews reports and records of the team activity.
- Assist in the selection of the Peer Review Board.
- Maintain lists of referrals.
- Make follow-up contacts of debriefings.
- Offers clinical support and guidance to Program Coordinator and team members.
- Maintains professional liability insurance.

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D. MENTAL HEALTH PERSONNEL

Mental Health Professionals who assist the CISM team will be volunteers who assist primarily in the debriefing process and program development. Mental Health Professionals are persons with advanced degrees in a mental health field and work as a mental health services provider in setting such as hospitals, crisis centers, community mental health centers, or in private practice.

Qualifications of Mental Health Personnel include the following:

- A Master's Degrees or above in mental health or related field.
- Completion of a 2 day Basic Critical Incident Stress Management Course approved by the International Critical Incident Stress Foundation.
- Exposure to Public Safety disciplines is mandatory.
- Participation in cross-training with EMS, Fire, etc.
- Willingness to work as a team member.

Responsibilities of the Mental Health Professional include

- Provide psychological leadership and assistance during the intervention.
- Assist with training.
- Make recommendations for the program.
- Assist in CISM program development.
- Assist in developing referral resources.
- Represent the CISM program.
- Complete all necessary paperwork.
- Make post intervention contacts and suggest further counseling as necessary.
- Complete cross training requirements consisting of 24 hours of exposure to Emergency Services domains to include but not limited to "ride along" with EMS and fire departments, Incident Command and others.
- Become familiar with various emergency service operations.
- Serve as a member of the Peer Review Board as assigned.
- Attend team meetings and in-services.
- Consultation with the Clinical Coordinator when necessary.
- Must have professional liability insurance.

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E. PEER SUPPORT PERSONNEL

A peer support person is defined as an emergency service worker who has been specially selected and trained to provide a first line of assistance and basic crisis intervention to other emergency service personnel. Peer support personnel work collaboratively and under the direct supervision of the mental health clinicians. In the Critical Incident Stress Management model the process is described as peer driven, but clinically guided by mental health professionals.

Qualifications of Peer Support Personnel include the following:

- At least five (5) years continuous experience in emergency services.
- Well respected by fellow peers.
- Emotional maturity.
- Perceived as a confidante.
- Sensitive to the needs of other people.
- Willingness to work as a team member.
- Willingness to receive and seek out additional training in human behavior, crisis intervention, traumatic stress, etc.
- Agreement to work within their own limitations and seek guidance and assistance when needed.
- Completion of a 2 day Basic Critical Incident Stress Management Course approved by the International Critical Incident Stress Foundation.

Duties of the Peer Support Personnel include:

- Initiate contact with emergency service personnel who have responded to a critical incident.
- Assessing the need for intervention by the CISM team.
- Contact the Team Coordinator to set up the process for intervention.
- Attend team meetings and training. Members are required to attend a minimum of four (4) training sessions per year.
- Make post intervention contacts as assigned.
- Assist Program Coordinator as required.
- Serve as a member of the Peer Review Board as needed.
- Assist in the development of CISM programming

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IV. SERVICES PROVIDED

A. Pre-Incident Education and Training

Pre-incident education regarding stress, stress recognition and stress reduction strategies are essential parts of the CISM process. Educational programs for line and command staff include the preceding and information on critical incident stress interventions, how to contact a team, on-scene considerations, etc. Programs for spouses and significant others may also include stress recognition and management.

B. On-Scene Support Services

Four types of services may be provided:

1. One-on-one support with rescuers who show obvious signs of distress.
2. Consultation to the Incident Commander or command officers.
3. Assistance to victims of the incident when necessary and appropriate until other victim's services can be activated.
4. Demobilization of personnel being disengaged from the scene.

C. Defusing

The defusing is a small group process instituted usually within several hours of the incident. It is a shortened version of the debriefing utilized for rapid reduction of the intense reactions to a traumatic event, allowing personnel to "normalize" the experience and return to routine duties as quickly as possible. A defusing also assists in the assessment of the need for a full debriefing.

D. Formal Debriefing

Ideally conducted within 24 to 72 hours of the incident. The debriefing is a confidential, non-evaluative discussion of the involvement, thoughts and feelings resulting from the incident. The process also provides discussion and education regarding the possible stress-related symptoms.

E. Demobilization

Utilized during or following a large scale incident as units are released from the scene primarily for stress prevention and intervention before personnel return to normal duties.

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F. Follow-up Services

Conducted in the days or weeks following an incident. May include an informal defusing session, phone, or personal follow-up. Primary focus is delayed or prolonged stress syndrome and evaluation of intervention services offered.

G. Spousal / Family Support Services

Spousal and family support is provided as needed or upon request following a traumatic event, to include but not limited to spousal debriefings and educational training.

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V. TEAM MEMBERSHIP

A. LENGTH OF SERVICE

Team members serve for a minimum period of one (1) year.

Any member wishing to resign from the team for any reason will discuss the matter with the Team Coordinator or the Clinical Director and submit their resignation in writing.

At the conclusion of the membership year, current membership will be evaluated. Members must express their desire to remain active for another year and remain on with the approval of the Team Coordinator and the Board and/or membership Committee.

Vacancies will be discussed by the team and recommendations made to the Team Coordinator regarding replacing members on the basis of:

- Number of vacancies
- Type of vacancy
- Current membership
- Time interval to end of term
- Availability of training funds / opportunities

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B. REVOCATION / SUSPENSION OF MEMBERSHIP

Membership is revocable at the discretion of the Clinical Coordinator and Team Coordinator. An appeal of this action may be instituted and will be acted upon by the Membership Committee. Action that may result in revocation includes, but is not limited to the following:

- Failure to maintain strict confidentiality regarding interventions held, including topics discussed and personnel involved. Any breach in confidentiality will result in the immediate removal from the team and the program.
- Failure to follow all protocols and directives regarding team or programs activity.
- Organizing or attempting to organize any CISM activity or program without the prior knowledge or consent of the Team Coordinator.
- Going to an incident on behalf of the CISM program without prior knowledge or consent of the Team Coordinator.
- Failure to be present at an assigned intervention when the member has made the commitment to do so.
- Continued absenteeism at meetings or training. Members are required to attend a minimum of four (4) training sessions per year.
- Acting contrary to the expressed direction of the CISM team, Team Coordinator, or Clinical Coordinator.

The suspended team member will immediately surrender any Team identification. The suspended team member will not be allowed to participate in any team activities while under suspension.

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VI. PEER REVIEW BOARD PROCEDURES

A Peer Review Board will be established to evaluate any criteria of membership revocation or suspension. The Peer Review Board will be composed of the Clinical Coordinator, Team Coordinator, and other team members. The Peer Review Board will consist of a mental health team member and two other team members if the incident involves a clinical matter. For non-clinical problems, any three members may be selected.

For clinical issues the following procedures apply:

- Peer Review Board will meet and discuss the problems with the member within seventy-two (72) hours of notification.
- The Peer Review Board will file a written report and recommendation within forty-eight (48) hours to the Clinical Coordinator and Team Coordinator.
- The Team Coordinator will review the recommendations of the Peer Review Board and shall either initiate any disciplinary action recommended or resubmit the report to the Board for further review.

For non-clinical issues the following procedures apply:

- Peer Review Board will meet and discuss the problems with the member within one week of notification.
- The Peer Review Board will file a written report and recommendation within one week to the Clinical Coordinator and Team Coordinator.
- The Team Coordinator will review the recommendations of the Peer Review Board and shall either initiate any disciplinary action recommended or resubmit the report to the Board for further review.

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VII. THE INTERVENTION PROCESS

A. ACTIVATION OF THE CISM TEAM

1. Public Safety Service, command officers, and critical care authorities are responsible for identifying and recognizing significant incidents that may require certain types of CISM intervention. When an occurrence is identified as a "critical Incident", a request for a CISM intervention should be made as soon as possible.

2. The CISM Team is activated by a call to the Hamilton County Emergency Operations Center. The phone number is (423) 622-7777. All CISM interventions are coordinated by the Team Coordinator to guarantee the quality of the intervention and to ensure appropriate procedures are followed. Team coordinators are available by pager 24 hours per day / 7 days per week.

3. The Team Coordinator contacts the requesting party to:
   A. Assess the need for the type of CISM intervention.
   B. Determine the nature of the incident
      1. Magnitude or scope of the event
      2. Agencies involved
      3. Types of personnel involved (i.e., firefighters, EMS, hospital personnel, police, dispatchers, etc.)

4. Intervention process considerations include:
   A. A location will be selected for the intervention that is free of distractions and represents a neutral environment, (i.e., school, church or other meeting facility).
   B. All intercoms, paging systems (personal and emergency), and/or alarms <u>will</u> be inactivated during the process.
   C. All personnel involved in the incident will be invited to the intervention and encouraged to attend.
   D. Arrange a time and location for CISM intervention. Obtain directions and a contact telephone number. This name and number will be given to the peers in case of an emergency.
   E. The Team Coordinator selects a team from available appropriate members. The team is peer driven consisting of at least two (2) peers with a mental health worker. The number of peers is directly proportional to the size and the professions represented within the group.
   F. Team members should coordinate a time and location to meet prior to the intervention to discuss the incident, any available resource information and the

approach to be used during the process.

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Guidelines for Intervention:

1. Strict confidentiality will be maintained. All information regarding agencies involved, situations, and issues discussed will not be divulged before or after a CISM intervention except with team members or as part of the team continuing education process.

2. No recordings or written notes will be allowed during an intervention. It is the responsibility of the team to enforce this during the process.

3. **Absolutely** no news media (TV, radio, or newspaper, etc.) personnel will be permitted to attend, video, or record an intervention. In the event that these individuals are present without the team's knowledge, phrases such as "Everything said here is off the record" may be helpful. This does not guarantee, however, that information will not be reported. Participants in the intervention may speak to the media either before or after the process. It is important to explain that individuals speak only for themselves and NOT for anyone else in the intervention process.

Debriefers may speak to the media, but only to educate about the process of CISM and to discuss the effects of stress. All other inquiries are to be referred to the Program or Clinical Coordinator.

4. CISM interventions are not a critique of the incident. The team has no evaluation function of tactical procedures. The process provides a format in which personnel can discuss their feelings and reactions and thus reduce the stress resulting from exposure to critical incidents. The goal of the CISM is to encourage expression of emotions, provide support for the individual, and in coping more effectively.

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B. ON SCENE ACTIVITIES

Support services and intervention may be utilized during a critical incident. These may occur at or near the scene of operation. On scene support will consist of, but not limited to the following types of services:

1. One-on-one contacts with those emergency service workers showing obvious signs of distress as a result of the incident or their participation.
2. Advice and consultation to incident commanders on topics of stress management specifically issues related to the critical incident.
3. Demobilization of personnel being disengaged from the scene.

GENERAL INFORMATION AND GUIDELINES FOR ON SCENE ACTIVITIES OF CISM PEER SUPPORT PERSONNEL ENGAGED AT THE SCENE

Any Peer Support Member who is dispatched to a critical incident as a member of an emergency services organization is primarily responsible for operating with that organization. For example, Peer Support/Firefighter who accompanies their units to the scene will serve in the capacity designated by their fire commander. This hold equally true for all emergency service personnel/CISM involved at an incident.

While performing assigned duties, it may be possible for the CISM Peer Support/Emergency Service Providers to observe the scene for situations that may increase the potential for stress affect. It may also be possible, while performing one's duties, to observe personnel for signs of obvious distress. While these are not the primary functions of these persons at this time, appropriate disclosure of their observations may provide insight to command officers. If the need to make recommendations to command becomes obvious of if the CISM suspects that the potential is unusually high for the development of affect, the CISM may suggest to the commander that he/she consider calling the CISM team. Even if the commander designates the function as CISM On Scene Support, the CISM shall request additional CISM dispatched to the scene. The rationale for this action would be:

1. To keep the Program Director and/or on duty Team Coordinator advised of the activity and ensure continuity.
2. It is inappropriate for the CISM Peer Support to provide services to their own unit.
3. It proves to be too "draining" for the CISM who is or has been engaged in service to carry out the functions on On-Scene Support activities.
4. It is in the emotional best interest of the CISM Peer Support member to provide the service in this situation.
5. The task may be too involved for one or two to handle effectively.

6. The unit may be disengaged before On Scene Support activities are completed.

CISM PEER SUPPORT DISPATCHED TO THE SCENE

CISM Peer Support Team Members dispatched to the incident scene by the Team Coordinator will rendezvous so they may go to the scene as a unit. Every attempt will be made to have the Team escorted to the scene by an Emergency Service Agency to permit easy access to the incident scene. If this is not possible, the team members will take the minimum number of vehicles required to transport the team to the scene.

ON SCENE TEAM LEADERSHIP

Once on the scene, one member will act as Team Leader (the senior CISM Peer Support or Mental Health member) and will report to the Command Post. This member will advise the commanding officer. The Team Leader will advise the officer of where the team will be located and what they will be doing. The Team Leader will act as liaison between the command and the team throughout the incident when possible. Therefore, any recommendations and observation of any team members should be made to the Team Leader who will in turn report to the commander. It will be ideal if team members can arrange "report times" to offer information to the Team Leader and so that the Team Leader will not be interrupting the command operation any more than necessary to make a report.

ADDITIONAL FIELD SERVICE PROTOCOLS

1. All CISM members acting on behalf of the program will wear CISM photo ID at all times while on site, going to the site, etc.
2. Team Members will be appropriately dressed with appropriate clothing to be on the site.
3. No CISM Team Member will go inside the internal perimeter unless requested to do so by a commanding officer.
4. The Team Leader will keep track and know where all team members are during the operation.
5. Except in extreme circumstances, the Team Leader will be the liaison between command and the team.
6. The Team Leader will assign tasks to team members as required.
7. All members will retain a "low profile".

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ASSISTING VICTIMS, SURVIVORS, FAMILIES

While assisting victims, survivors, and families is not the primary function of the Team, it may be necessary to provide interim support services to these individuals so that the emergency service crews may perform their duties without being hampered. The Team will maintain a listing of victim resources during on scene operations and will call these services if warranted and approved by command. 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 emergency service workers. Once on the scene, management of these persons should be turned over to the appropriate victim support agency.

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C. DEFUSINGS

Defusings are performed after the incident and after the unit has returned to the station. The purpose is to offer information, support allow initial ventilation of feelings, to set up or establish a need for a formal debriefing, and to stabilize crew members so they can go home or back in service. It is similar to a "mini debriefing" but is not as detailed or as long.

Guidelines for Defusing Services are as follows:

1. Defusings should be done immediately after the event. The ideal time frame is three to four (3-4) hours post incident to the end of the same day. If it is not possible to hold the defusing within these guidelines, a Formal Debriefing will have to be performed. The key is immediate intervention.
2. Defusings are a "group" process (as opposed to one-on-one) and all persons of the unit involved in the incident should attend the Defusing.
3. Defusing should last approximately forty-five (45) minutes.
4. Defusings can be performed by Peer Support Persons but the CISM Peer Support Personnel should be well aware of his/her personal limitations and should call for support from a Mental Health Member or another Peer if the situation warrants. Peers directly involved with the operations should not perform defusings for this group.
5. Defusings should be held in a comfortable atmosphere, free from distractions and interference. All parties should remain in the Defusing until its conclusion.
6. The format for the Defusing shall be as follows:
    A. Introduction - ask the group to tell you what happened
    B. Ask the group - "What was the worst part?"
    C. Allow freedom of discussion to take on the "worst part".

After the discussion subsides, offer information on possible signs and symptoms of stress they may or may not experience and information on what they can do about it. Give the Informational Handout to each one and make sure they know how to get in touch with the Program Director, yourself, the Clinical Director, or the On Duty Team Commander.

D. Allow initial ventilation of feelings. Acknowledge the feelings, validate the feelings, and move on. **DO NOT** probe or dwell, it is much too early after the critical incident for this tactic.

E. Keep the session informal but to the point. Do not allow the crew to lapse into a critique of operations. The Team Member's primary function is to facilitate and direct the session.

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D. DEBRIEFINGS

Debriefings are specially structured group meetings between the persons directly involved with the Critical Incident and CISM Team Members. It is a confidential non-evaluative discussion of the involvement, thoughts, reactions, and feelings resulting from the incident. It has psychological and educational components. It serves to mitigate the stress impacts resulting from exposure to a Critical Incident through ventilation of feelings, along with educational informational components. 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 normal affects after an encounter with an abnormal situation".

The goals are to:

- Provide stress education
- provide a mechanism for ventilation of feelings before they can do harm.
- provide reassurance that what they are experiencing is normal and that they will probably recover.
- Forewarn those who have not yet been impacted that they MAY be impacted later and inform them on ways to deal with it.
- Reduce the fallacy of "uniqueness".
- Reduce the fallacy of "abnormality".
- Provide positive interaction with mental health services and providers.
- Add or restore group cohesiveness.
- Assist inter-agency cooperation.
- Help set up a prevention program.
- Screen those that may not yet be ready to return to service.
- Refer those requesting or requiring additional service.

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The Formal Debriefing Process will adhere to the guidelines developed by the International Critical Incident Stress Foundation. No alternate forms of group process, group dynamics, therapy, or counseling will be employed during these sessions. The Program Director and/or Clinical Director, On Duty Team Coordinator will evaluate the need for a debriefing when one has been requested. Some of the considerations will include:

1. The number of individuals affected. If less than three (3), individuals or Small Group Consults will be arranged and lead by a Mental Health Team Member.
2. The symptoms that are being reported by the participants in the event. Continuation of symptoms of acute or delayed stress is an indication that a Debriefing is probably necessary.
3. Any noted or reported change in behavior of the participants in the event.
4. Any regression of behavior in the participants in the event.
5. Of the symptomatic persons, do they need a Formal Debriefing, or just the opportunity to "talk it out" with peers or administration?
6. Do the circumstances warrant a debriefing, are the symptoms pronounced, or is the group seeking information on stress management?
7. Other factors and considerations pertinent to the event, the persons involved, and the signs and symptoms expressed.
8. Debriefings will be recommended for the following events:

    - Death of an Emergency Service Provider in the line of duty.
    - Serious injury to an Emergency Service Provider in the line of duty.
    - Mass/Multi casualty incidents with serious injury/death.
    - Suicide of an Emergency Service Worker.
    - Civilian killed as a result of Emergency Services or Police operations.
    - Serious injury or death of a child.

    The Formal Debriefing Process will consist of the following components:

    1. Pre-Debriefing Activities Meeting
    2. Introduction Phase
    3. Fact Phase
    4. Thought Phase
    5. Reaction Phase
    6. Symptom Phase
    7. Teaching Phase
    8. Re-Entry Phase
    9. Post Debriefing Activities Meeting

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Pre-Debriefing Activities Meeting

1. Team members responding to a Debriefing should, when possible, travel to the debriefing together.
2. The goals and objectives of the Pre-Debriefing Activities/Meeting are:
    - To permit the Team members the opportunity to go over all facts, rumors, and data concerning the incident.
    - To visit the incident site if necessary.
    - To review any videos, newspaper articles, reports, etc., about the incident.
    - To talk to the participants to become aware of any other facts about the incident not previously known (TO CUT THE CHANCE FOR "SURPRISE" DURING THE DEBRIEFING PROCESS).
    - To develop a strategy for the Debriefing:
        - Determine who the leader is
        - Develop any signs or signals that may be needed during the debriefing
        - Establish Team Member roles
    - To set up the seating (circle arrangement).
    - To make sure the unit is out of service and/or that the participants will not be called to service during the Debriefing.
    - Doors to the Debriefing area should be closed but not locked.
    - The senior peer shall act as the "door person". According to Dr. Mitchell, it will be this person's responsibility to "identify the appropriate people into the Debriefing, and guide the inappropriate out". The ideal placement of the "door person" will be the peer positioned nearest the door of primary entrance and egress. It will also be the responsibility of the "door person" to check on persons who have left the Debriefing. They will not force or attempt to force the return of any individual not wishing to return. In this circumstance, the senior peer may find they are in a position to offer some one-on-one counseling and should offer names and phone numbers to referral services to this person. After the encounter, the senior peer should return to the Debriefing.

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Introduction Phase

During the Introductory Phase, the mental health leader will set the rules for the debriefing, introduce themselves and give a brief description of what will take place during the debriefing process. The Leader will state the purpose of the Debriefing and the Team's involvement i.e.: "To try and help you deal with some thoughts and reactions you may be experiencing and to give you information on how you can help yourself deal with these issues. You may be able work through this alone, but we have found that people who go through the debriefing process sleep, eat, perform their job, and home responsibilities better, and that's what we want for you".

NOTE: Before beginning the debriefing rules, information specific to the incident may need to be discussed or pictures, videos, etc. may need to be reviewed to refresh memories if the incident happened while ago.

Rules for the Debriefing:

1. You do not have to talk during the debriefing, but if you choose to, what you may say may help reassure and support your colleagues.
2. This meeting is strictly confidential. No notes will be taken and no records will be made. It is important that we make a pact of trust among everyone here that no one will disclose any information about anyone or anything said during the debriefing.
3. No breaks are taken during the debriefing process. If you need to use the facilities, please attend to your personal needs but then return to the group. A CISM team member may escort you.
4. No one talks for another. You may only comment about your own thoughts, feelings, or reactions.
5. You do not need to say anything that may legally incriminate you, or offer information that may be necessary for any investigation or litigation.
6. No pagers are to be on and the company (or at least those participating) are to be out of service.
7. No one has rank during the debriefing process. Everyone is equal.
8. This is NOT a critique of operations. We are not here to place blame.
9. The CISM Team is NOT part of any investigating agency. We are only interested in your welfare.
10. Look around the room. If someone is here that should not be here, please let us know before we begin. This includes press and any others not directly involved in the incident (This will need to be tailored to each debriefing).
11. Feel free to ask questions.

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Fact Phase

During this phase the leader will ask the members of the group to go around the circle and state their name, what their role was, and what happened. This will serve to recreate the event and present the pertinent facts surrounding the incident.

If this proves to be especially difficult for a participant, acknowledge and validate their feelings then move on to the next person.

When the circle gets to the CISM members and Co-leaders, they will introduce themselves and identify their level of emergency service involvement which will 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. The leader will ask the participants to share their first "thought" and when they first realized they were thinking about the event. During this phase the participants will be taking the information supplied during the Fact Phase from the general state and applying it to a more personal state of thinking.

The leader will acknowledge, offer reassurance, and move on to the next participant. No probing will take place.

Reaction Phase

After the process of taking the incident from the outer environment and into the cognitive, the leader will ask the participants to share their reactions to the incident. They may ask them to describe what each sees as the worst part of this incident. The leader will not probe except to get clarification on a specific issue. During this phase the CISM members will not talk, offer any reassurance, suggestions, experiences, etc. The Leader will facilitate this phase solely unless they signal or request assistance.

Symptom Phase

After the participants have been able to bring the impact of the event to a personal level and have been able to identify some personal reactions to it, the leader will then ask the group to share information on any physical, emotional, cognitive, or behavioral signs or symptoms the may be experiencing, i.e., "How did you know this event was different? I know when something really gets to me, I don't sleep well and my stomach gets upset."

The Leader will want the participants to share items that happened during or shortly after the event, a few days later, in the present.

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Teaching Phase

After the signs and symptoms have been expressed, the leader (with support from other team members) will offer reassurance that these are normal reactions and may teach additional signs and symptoms that may not have been expressed. It is during this phase that information will be offered on positive coping methods, on issues specifically raised and general information on stress management. The leader will also invite the participants to ask any specific questions about the management of stress that they may have.

Re-Entry Phase

This is the time to "wrap up any loose ends", offer additional reassurances, answer any outstanding questions, offer the opportunity for participants to say anything they did not get a chance to say, and give the participants the opportunity to restate anything they may have said before. It is also during this phase that the leader may wish to bring out an emotion they feel is present but as yet, has not been expressed.

During this phase, the participants may wish to develop a "plan of action". They may wish to develop a preventative program, determine what they would like to do to make things better, or investigate information and educational resources to receive it.

Post Debriefing Activities Meeting

After the Formal Debriefing and Post Debriefing Activities, 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.

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Additional Debriefing Considerations

1. If the event is the death of an emergency service provider, two Formal Debriefings are probably indicated. The first should be performed eight (8) to twelve (12) hours after the death and the second should be performed three (3) to five (5) days after the funeral.
2. If the event involves a prolonged event with or without the death of a child, a defusing should be performed and possibly a debriefing.
3. If the group size is large than forty (40), the procedure for the Fact Phase may change. Each participant may not be asked to state who he is, what his role was, and tell what happened. The request for this information may be opened to the group for the participants to respond in a random group form fashion. The remaining procedures will remain intact.
4. It is permissible for the Team Leader to have a 3x5 card during the debriefing with information key to each phase listed. If they elect to bring this card to the debriefing, the reason for the card's presence shall be explained to the participants so they are not alarmed and so they are further reassured that no notes are being taken.
5. Team size will be two (2) to six (6) members per debriefing. The size of the team will be dependent upon the size of the group. The rule of thumb of one (1) to ten (10) will be generally employed for each event. In the event that the Team Member arrives and fins that there are few participants and several Team Members, the Leader will request extra Team Members to leave the Debriefing and return at the end. It should be understood by all members that such may occur at the last moment.
6. Debriefings may need to be postponed for the following reasons:
    - A child is present at the debriefing
    - Press will not leave
    - Spouses/family of Emergency Service providers are present
    - Survivors, victims, family are present
    - More than sixty (60) participants attend when not expected and there are not enough Team Members to handle the additional participants.
7. In situations where the participants are very resistant, more education and teaching will need to be employed.
8. If a participant is obstructive to the point that the debriefing process is jeopardized, sabotaged or otherwise irrevocably interrupted and disrupted, it will be the responsibility of the Team Leader to attempt to successfully "join" this individual or negotiate a discontinuance of this behavior. If this is not possible and the debriefing process is still salvageable, the senior peer or co-leader may attempt to enjoin this person in one-on-one contact while permitting the leader to continue the debriefing. Decision for a postponement or any alternative will rest with the Team Leader.

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Frequently Asked Questions

Who will be debriefed?

Any persons directly involved in the operation of the event, or any person for whom the event has elicited an unusually strong reaction should be debriefed. It may be necessary to perform several debriefings for one incident dependent upon the nature and extent, the numbers to be debriefed, the type of units, or the nature and extent of their involvement in the event. Persons not directly involved in the event will (in most cases) not be debriefed. The exception 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.

When will the debriefing take place?

Debriefings should take place twenty-four (24) to seventy-two (72) hours after the event or as soon after this time as it is possible to get the parties together.

It will be necessary to match the schedules of those participating in the debriefing with those of the team members involved in the debriefing. We do not want to place any undue hardship on any party, but priority for time will have to be given to the participants. Since our aim is to return them to a pre-crisis state it would not be advisable to expect them to make major adjustments in schedule to accommodate a time that may be convenient for team members. Every attempt will be made to accommodate the schedules of all parties involved.

How long will the Debriefing last?

Many things have to be taken into consideration in responding to this question. Travel time, Pre-Debriefing Activities/Meeting, Site Evaluation, Debriefing Process, Post Debriefing, Activities/meeting etc. The Pre-Debriefing Activities/Meeting should last approximately forty-five (45) minutes to one (1) hour. Activities/Meeting length will be dependent upon the Team Members and the debriefing participants. It is impossible to accurately gauge the length of the debriefing process. It is advisable that no member commit themselves to attend a debriefing when they are limited on time.

What about refreshments?

If the unit desires to serve refreshments, this is permissible. However, it is suggested that the most appropriate time to offer these is after the Formal Debriefing has taken place.

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Who will lead the debriefing?

Debriefings are lead (facilitated) by Mental Health team members. Co-leaders may be additional Mental Health team members and experienced Peer Support personnel (CISM). Peer Support members are valuable members of the Debriefing process as they are the ones the participants can and will identify with as the ones who most understand their plights, feelings, and concerns. The process is "Peer driven, Mental Health guided".

How many participants will there be in a Debriefing?

A Formal debriefing will not be held for less than three (3) persons. When there are less than three (3), on-on-one consults or a mini group session will be used. Ideal debriefing group size is between three (3) and forty (40) participants. In groups of over forty (40) participants, the procedures for the debriefing process must be adapted (See "Additional Debriefing Considerations").

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E. DEMOBILIZATION

Demobilization services will be reserved for large scale, highly intense or unusual events that last a minimum of eight (8) hours. The objectives of Demobilization are to:

- Provide a place for disengaged (not returning to service) units to rest, get something to eat and drink away from the site in a comfortable atmosphere before returning to quarters or home.
- Provide information and support on possible stress related effects.
- Provide a place to command officers to give closing remarks or incident updates.
- Provide a resource for initial ventilation of feelings, if necessary.

GUIDELINES FOR DEMOBILIZATION SERVICES

MAKE SURE THE UNIT WILL NOT RETURN TO SERVICE BEFORE INITIATING DEMOBILIZATION SERVICES FOR THAT UNIT!

The demobilization center can be located in any large room where it is possible to carry out the above activities.

Demobilization Services will be handled by several CISM Mental Health Team Members and Peer Support Members not needed or engaged in incident activities. The process will be as follows:

1. Command will determine if a demobilization site shall be established.
2. ALL disengaged units and personnel will be processed through the Demobilization Center.
3. As the units leave the scene they will stop at the Demobilization Center.
4. Upon arrival at the Demobilization Center a Team Member will meet each arriving unit and usher them to a corner of the room. Units will be kept together and the combining of different kinds of units will be discouraged.
5. The Demobilization Lecture will take no longer than fifteen (15) minutes and will consist of the following:
    - Recognition of the workers efforts and their fatigue.
    - State as your objectives a desire to give the workers a chance to rest, eat, and "unwind" before going home or back to quarters.
    - If it is probable or possible that a formal debriefing will take place tell them how they will be informed as to its location, time, etc.
    - Inform the workers:
        - Some of them may have no reaction to this event and that's good and not an abnormal reaction.
        - Some of them may have a delayed reaction and that's OK too.

- Some of them may already be experiencing some uncomfortable feelings as a result of the event and this too is normal.
- Some of the most commonly reported reactions to events such as this are ...(offer a brief list of signs and symptoms).
- Give them the prepared "Signs and Symptoms Sheet" content.
- If they want to stick around and ask any questions or talk about anything, we'll be here, or you can call us later at the numbers on the sheet.
- Dismiss them to get something to eat and tell them their officers will be meeting with them soon.

6. One Mental Health Team Member will remain in reserve to meet with the next incoming group
7. All Team Members should be giving the same information to all groups. Therefore it will be necessary for the Demobilization Team to meet and develop an outline/script to insure continuity.

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F. INDIVIDUAL CONSULT

Individual consult will take two (2) forms. Individual consults may take the form of a small group debriefing session in those instances when one to three (1-3) members of a unit have experienced or are impacted by a critical incident. As with all activities and services these will be dispatched through protocols.

The second type of individual consults will be in the form of referrals to mental health clinicians for those requiring this type of service.

CISM Peer Support involvement in these services will be to:

- Assist as a peer support person a small group debriefing process
- Provide names and numbers to participants requesting additional services.

SOUTHEAST REGIONAL CRITICAL INCIDENT STRESS MANAGEMENT TEAM

ORGANIZATIONAL CHART