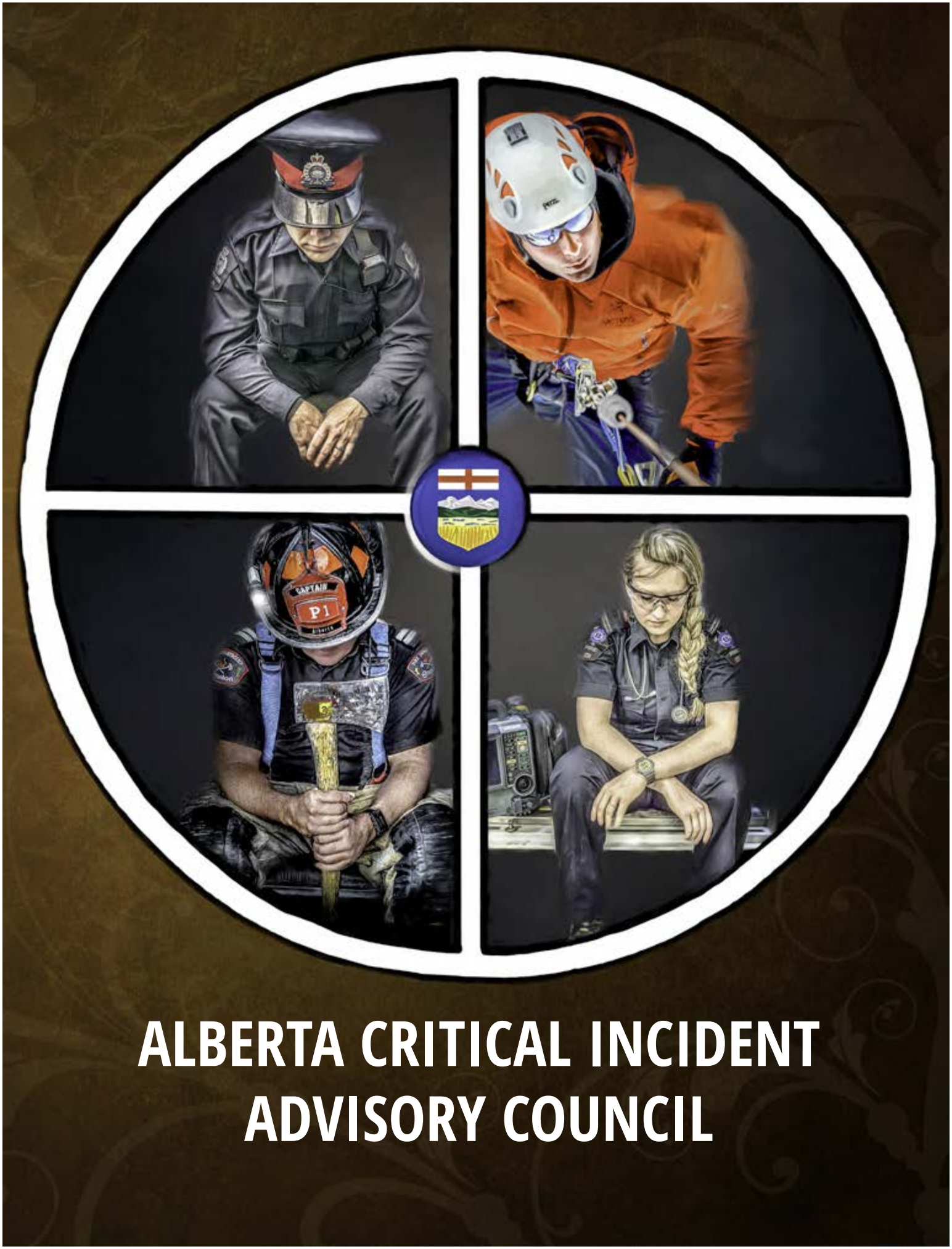

ALBERTA CRITICAL INCIDENT ADVISORY COUNCIL

THE ALBERTA CRITICAL INCIDENT ADVISORY COUNCIL

CISM BEST PRACTICES AND PROCEDURES FOR TRAINING, DEVELOPING CISM TEAMS AND NETWORKS, CISM RESPONSE TO CRITICAL INCIDENTS AND DISASTERS WITHIN THE PROVINCE OF ALBERTA

Table of Contents

DISCLAIMER

This document has been developed based on the collective expertise of the membership of the Alberta Critical Incident Advisory Committee (ACIAC).

The Executive Committee members provided direction and a critical eye on the development, implementation, and maintenance of a peer-support team program specific to this target population, relying upon recommendations from other groups specific to the peer-support model adopted by the ACIAC working group.

This document supports the development of a comprehensive, consistent program for a provincial network of peer-support with evaluation and contribution to research and adherence to best practices, rather than endorsing any one peer support model.

Back to Table of Contents

SECTION 1
ACIAC OVERVIEW

1.1 – Mandate and Purpose of the ACIAC

THIS SECTION HAS BEEN BORROWED AND ADAPTED FROM THE ONTARIO CRITICAL INCIDENT ADVISORY COUNCIL (OCIAC) PEER SUPPORT CISM MANUAL, WITH THE PERMISSION OF CCISF AND OCIAC-

Mandate of The Alberta Critical Incident Advisory Council (ACIAC):

The ACIAC provides advice on the development, training, maintenance, and sustainability of a peer-support model specific to first responders in the province of Alberta.

The ACIAC's purpose is to provide consultation, education, resources, and support to Provincial first responder personnel, and to develop, support, and advise on a standardized province-wide approach to best practices for critical incident response.

Statement of Purpose:

The ACIAC shall be open by way of membership to a steering committee with representation from stakeholders in the provision of Peer Support to first responders in the province of Alberta and may include members from other jurisdictions where equitable mutual aid and service agreements may exist or be developed. The expressed purpose of this steering committee is to provide a network of Critical Incident Stress Management - Peer Support teams, service providers, trainers, and resources utilizing the ICISF CISM Model to enhance crisis response within the Province of Alberta to first responders.

ACIAC membership will meet at least two times a year to review current issues and to provide recommendations to its members.

Leadership:

The ACIAC will be run on a volunteer basis.

The ACIAC executive shall be comprised of a Chair, Co-Chair, and Secretary selected from its membership by nomination and simple majority vote at the first meeting in the calendar year.

All positions shall be two-year terms.

Nominations and selection of the executive will be held at the first regular scheduled meeting of the calendar year. The meeting host will facilitate the election for each position which will be determined by a secret ballot majority vote of members present at the meeting.

A member may not hold more than one executive position at a time.

There is only one vote per membership.

Back to Table of Contents

OUTLINE OF EXECUTIVE ROLES AND RESPONSIBILITIES:

Role of the Chairperson/Co-Chair

- Take a leadership role in the uptake that all agreed upon items moved forward as recommended by the membership.
- Make decisions in a fair and unbiased manner based on the best interests of the ACIAC.
- Encourage and foster open respectful dialogue of group participants.

The Co-Chairperson shall assist the Chair with executive committee duties. They shall also assume the duties of the Chairperson during any absence or by request.

Role of the Secretary:

- Coordinate and communicate important dates, decisions, meetings, and policies amongst the committee members.
- Record, and disseminate minutes from meetings to all committee members.
- Record, store and maintain (update) any important documents.

Role of the Past Chair/Co-Chair

- Serve as part of the Executive Committee and the general committee membership.
- Continue to see that the ACIAC develops a common view of its purposes and shared responsibility for leadership.
- Serve as an ex efficio (voting) member of the Executive Council and general committee membership.
- Maintain current knowledge of the group's concerns, goals, committee functions and outcomes of past matters.
- Advise the current Chair/Co-Chair, executive and general committee
- membership on any past issues or current issues that have come before the Council.
- Other duties as delegated by the current Chair/Co-Chair.

Back to Table of Contents

ACIAC TERMS OF REFERENCE

Executive Committee

Established in June 2017 to promote and appoint working group members to the Alberta Critical Incident Advisory Committee (ACIAC) who shall create a document with guidelines and resources. The Executive Committee will meet a maximum of three times:

1. To review and adopt the terms of reference and formally appoint the Working Group.
2. The second meeting will occur after a review of the finished product of the Working Group. This meeting will serve to provide direction to and acceptance of the Alberta Critical Incident Advisory Committee Working Group.
3. For the release and launch of the finished document.

Executive committee membership:

Chris McIntosh, MA., ACP
Senior Advisor
Office of the Chief Paramedic
Alberta Health Services

Randy Schroeder
Vice President
Alberta Fire Chiefs Association (AFCA)

Debra Smith, B.COM
Director of Human Resources
Strathcona County

R. Nicholas Carleton, Ph.D., R.D. Psych
Department of Psychology
University of Regina

Spence Sample
Fire Commissioner
Office of the Fire Commissioner
Public Safety Division
Municipal Affairs
Government of Alberta

Sgt. Michael Elliott
Director, Edmonton Police Association
President, Alberta Federation of Police Associations

Andy McGorgan, MA.
Chief of Police
Medicine Hat, AB

Back to Table of Contents

Working Group

The Working Group comprises acknowledged professional champions and key individuals working in the field of ICISF CISM, Disaster Management, and/or Work Place Health. The group members are appointed to the Working Group by the Executive Committee, and agree to be the conduit sharing the group's progress along with soliciting feedback for consideration by the working group in the development of the document. The final document will then go to the Executive Committee for final review and approval.

The Working Group have created a document which informs and establishes Provincial best practices for the effective operation of CISM Peer Support teams within first responder groups (i.e., EMR, EMT, & Paramedics), with a focus on rural fire departments (i.e., paid on call and full-time professionals working in rural areas as well as emergency medical services in rural areas).

The Scope of the Working Group document includes topics such as:

- CISM best practice call-out procedure specific to first responder groups:
    - *In mutual aid between departments.*
    - *To aid departments and services who do not have CISM trained staff.*
    - *In mutual aid between services.*
    - *In disasters.*
- Current CISM best practices for initial training.
- Recommendations on standards and team make-up for the maintenance and operation of CISM teams.
    - *Recommendations for team structure and role descriptions, including;*
        - Team Coordinator,
        - Clinical Director,
        - Mental Health Professionals,
        - Chaplaincy, and,
        - Any other agreed upon support entity.
- Program evaluation and documentation guidelines.
- Program reporting and quality improvement review guidelines.
- Research contributing to increased knowledge and effectiveness of Provincial ICISF CISM Peer Support programs.
- Recommendations for the development of a Provincial Network of first responder groups.
- Determine Provincial supports and resources required to foster and support the network.
- Establish an ACIAC CISM Approved Trainer list specific to first responders, with:
    - *Recommended minimum ICISF CISM Approved Trainer qualifications*
    - *Recommended training requirements as part of the provincial CISM network*

Back to Table of Contents

- Identify mental health experts in different parts of the Province to formally support CISM teams.
- Address resources required to formally engage mental health experts.
- Provide suggestions for the sustainability of a Provincial CISM Network including:
    - *Identify sources of support.*
    - *Identify funding models.*
    - *Identify a Provincial Network Models of CISM Peer Service delivery.*

Working Group Committee Membership:

Jeff Sych, M.Sc., R. Psych
Registered Psychologist Contracted to Office of the Fire Commissioner
OSI Working Group & Clinical Director CISM Strategy for
Fort McMurray Wildfire First Responders
Public Safety Division Municipal Affairs Government of Alberta
Representing: Office of the Fire Commissioner

Careen Condrotte, B.A., RSW
Provincial Coordinator CISM & Peer Support
Alberta Health Services
Emergency Medical Services
Representing: Office of the Chief Paramedic Alberta Health Services

Malcolm McNeill, B.Sc. Psych.
CISM Coordinator
Representing: Alberta Fire Chiefs Association CISM Project

Denise Annicchiarico, B.Sc. OT
Disability Supervisor
Human Resources Strathcona County
Representing: Strathcona County Human Resources.

Jason Greidanus, CD, MADEM
Assistant Chief & Deputy Director
Emergency Management Strathcona County Emergency Services
Representing: Strathcona County Emergency Management

Dr. Gail Eastman, Ph.D., R. Psych
Consulting Psychologist
Medicine Hat Police Services South Zone
EMS Peer Support
Representing: Medicine Hat Police Services

Curtis Hoople
Edmonton Police Association
Representing: Alberta Federation of Police Associations

Back to Table of Contents

1.4 – Membership

There are no costs associated with ACIAC membership.

Membership in the network is limited to sworn or civilian emergency service staff directly involved in providing Peer Support or CISM within their organization.

To optimize joint CISM response during a major event, and to ensure quality control, and a standardized approach is upheld, the ACIAC requires that all members be trained according to, and adhere to recommended best practices of the ICISF CISM model.

Back to Table of Contents

SECTION 2
INTRODUCTION

2.1 – Synopsis

SCOPE

The Alberta Critical Incident Advisory Council (ACIAC), provides recommendations for the development, operation, and maintenance of Peer Support best practices for Alberta's first responders (FRs). The document provides information and guidance on the development, maintenance, day-to-day operations, mutual aid, and disaster preparedness and response in Peer Support and critical incident stress management (CISM).

The ACIAC recognizes the inherent difficulties for FR groups assessing and evaluating Peer Support, and CISM strategies. The Government of Alberta has adopted a comprehensive model and a provincial network to provide resources and supports for all FR groups.

This document accepts that the International Critical Incident Stress Foundation (ICISF) model of CISM is robust and qualified to meet the needs of such a provincial network, and advises on best practices specific to the ICISF CISM model.

The Committee accepts that some FR groups may adopt different Peer Support programs. This document should inform those groups who choose to participate in a provincial network of ACIAC CISM approved teams, including training in the ICISF CISM model as a minimum standard.

The ICISF CISM model is an evidence-informed, adaptive, short-term psychological helping process. The model utilizes trained peers to monitor, assess, and address pre- and -post incident psychological responses to stress in individuals and groups. The model is based on the principles of psychological resiliency, resistance, and recovery.

The provincial network and its partners, with the informed consent of peers, develops and maintains centralized databases including current information on trained peers, resource locations, contact information, experience, and regional capacity to deploy trained FR Peer Support team members.

The network is supported by provincial ACIAC CISM coordinator(s) and clinical director(s), as well as local and regional representatives. The network assists FRs and enhances established structures, supports, programs, and resources. The network ensures a reporting structure, confidentiality, guidelines, quality assurance and research, ensuring best outcomes.

A confidential reporting system allows for early identification of trends in psychological responses, resources, and required follow-up for an individual or group. This strategy assists FRs to maintain their mental well-being, and targets those FRs who do not have access to a Peer Support structure, or are reluctant to access other local supports and services. The network has the added benefit of accessing the pre-incident education plan in support of building a program for resiliency best-practices to reduce the impact of stigma related to psychological stress and injury.

Back to Table of Contents

OUT OF SCOPE

This document is not intended to provide information regarding the dissemination of formal mental health services, and is limited to the development and support of ICISF CISM, resiliency, and resistance programs.

Support for recovery from any psychological effects should be referred out to the most timely, appropriate, and culturally competent healthcare provider.

Back to Table of Contents

PEER SUPPORT

Peer Support is a broad construct which can involve, but is not limited to, the support of friends in conversation, children at school, and colleagues at work[1]. The specific type of Peer Support referenced in the current CISM document is that of workplace colleagues. Further, the ICISF CISM model specifically refers to colleagues that are FRs in the field of emergency services. For the purposes of the current document, the term peer(s) refers specifically to FR group members of an emergency service agency.

The nature of FR operational duties involves exposure to high frequencies of potentially traumatic events, including "critical Incidents" defined by the ICISF as overwhelming, threatening, terrifying, disgusting, or unusually challenging events that disrupt usual coping abilities and have the potential to create positive growth or significant psychological distress[2]. Psychological distress in response to a critical incident is called a Psychological Crisis[2]. Psychological Crisis is an acute response to trauma, disaster, or other critical incidents wherein:

- Mental wellbeing is disrupted, increasing stress;
- A person is unable to benefit from their normal coping mechanisms due to the impact of the critical incident, and;
- There is evidence of significant distress, impairment and dysfunction[3]

Critical Incident Stress (CIS) is an intensified arousal that indicates a state of crisis, and is characterized by strong cognitive, physical, emotional, behavioural, and spiritual symptoms that occur as a result of exposure to a critical incident[4]. Evidence suggests that by providing comfort, information and support, as well as meeting practical and emotional needs, immediate coping can improve[5]. Providing acute psychological support as soon as possible after exposure to a critical incident event has the potential to mitigate the impact of such psychological injuries. Recent recommendations in critical incident mental health interventions include the use of diverse interventions matched to the needs of the situation, and the recipient population[6].

Crisis Intervention (CI) is a formalized systematic set of techniques designed to intervene before the effects of a potentially traumatic event can become entrenched causing distress, dysfunction, and impairment[7].

CI has four main goals:

1. Stabilize the individual in crisis (i.e., provide a safe and comfortable environment and meet their basic needs);
2. Reduce symptoms of distress;
3. Return the individual back to their own adaptive functioning;
4. Provide access as necessary to continued care for psychological assessment and/or access to community supports.

Back to Table of Contents

CI can involve Peer Support or community support. Peer Support is strictly for the use within defined primary groups such as families, teams, work groups, social groups and FRs. These primary groups are homogenous and involve members with a shared history who have worked together or shared experiences over a period of time, and have a relationship such that they consider themselves a cohesive unit.

Community support services support secondary groups, defined as being larger, more diverse groups than primary groups, sharing less interpersonal bonds or relationships and having a greater heterogeneity. Local/rural communities, schools, large corporations, armies, and professional associations are some examples of secondary groups.

Community Support focuses on establishing and maintaining basic needs of the individual(s), a brief exchange of information, and facilitating access to resources. It differs from Peer Support in that Community Support is not based on peer relations and therefore requires supporters to avoid making assumptions regarding the individual's condition, experiences, perspective or culture.

The most common well-established form of CI used in emergency services is Critical Incident Stress Management (CISM). The International Critical Incident Stress Foundation has established a specific model of Critical Incident Stress Management referred to as the ICISF CISM model. This model adheres to Best Practices as follows:

- Early Psychological intervention is valued.
- Specialized crisis intervention training is necessary.
- An integrated, multi-component intervention system is required.
- FR programs rely heavily on "Peer Support"[2].

CISM falls within a continuum of support services focused on providing support to a primary group; in this case, FRs.

Back to Table of Contents

2.2 – Foundations of CISM Peer Support

CISM OVERVIEW

CISM refers to a comprehensive strategic planning system with a multitude of crisis intervention tactics. Such a wide array of crisis interventions assures that the continuum of supports meets the needs of most first responders, and limits opportunities for "falling through the cracks." A CISM system can be tailored to provide acute crisis intervention for individuals, small groups of those directly affected, or large groups of those indirectly affected. Effective CISM systems require:

1. Surveillance, assessment, and triage.
2. Ongoing strategic planning.
3. Proficiency in using various interventions.

The benefit of using the ICISF CISM Peer Support model is that FRs possess a unique culture and extend minimal trust to those outside their demographic[7]. FRs affiliate in socially exclusive groups that can differ from the general population owing to exposure to events arising from operational roles. They perceive themselves as being little understood or even misunderstood by the general public and healthcare system[7,] and are less likely to seek help or disclose the impact of their exposures to non-FRs, including healthcare professionals. Thus, Peer Support programs may be an effective conduit for connecting at-risk FRs with continued care from culturally-competent health care providers.

Peer Support has been reported to be more helpful than psychotherapy in the immediate aftermath of traumatic events[10]. The peer-to-peer aspect of the intervention process is crucial for establishing a positive psychological climate through empathic communication; listening to another person with the intention of understanding what that other person is expressing in reference to their own value system. Within a positive psychological climate, conflicts between words and feelings may be resolved and when people feel safe in expressing themselves openly, and honestly, they may also become open to support and more likely to accept help.

People can make more informed and effective decisions when they do not anticipate shame or blame, and when they feel safe in being open and honest[9]. When interacting with peers, FRs are less likely to be confronted with the psychological threats likely present when dealing with management, or those who hold roles that may be perceived to have aspects of superiority or authority, including medical or mental health professionals. It is important to eliminate perceived psychological threats such as fear of operational critiquing, being judged, or possibility of breach of trust. Appropriately trained peers can help to minimize fear and foster the trust necessary to facilitate effective support.

Peer Support offers empathy and validation which can guide the individual to regain stability and develop a greater sense of wellness and, in turn, manifest hope and a positive expectancy for the individual; both key factors for recovery[8].

Back to Table of Contents

2.2 – Foundations of CISM Peer Support

Established Peer Support guidelines are based on the principle of self-determination; specifically, the idea that everyone has the knowledge of what is best for themselves, coupled with a strong desire for improving their own personal well-being[8]. Peer Support for FRs has been effective in reconnecting individuals and cohesive groups with their adaptive coping strategies after disruption by exposure to a traumatic event or a critical incident.

Accepted models involve supporting peers as they identify their own coping strategies through simple tasks, short contacts, innovative techniques, practical suggestions, comfortable environments, immediacy, and expectations of reasonable positive outcomes[2].

A Peer Support program incorporating the full continuum of care, and linked to other supports and services ensures that needs are met over multiple access points. ICISF CISM is well-positioned to complement other forms of support and can be a conduit for facilitating referrals to continued care for individuals who otherwise would never accept treatment. Peer Support can address social isolation and break down stigma that interferes with the recovery process[8].

Peer Support for FRs can increase resistance to the psychological effects of trauma, and improve resiliency by equipping FRs with the skills to rebound from these effects and return to adaptive functioning. This means that more FRs will remain healthy, resulting in a reduction in associated lost time. Case examples of established CISM programs with a Peer Support program demonstrate the cost savings in the first year[11].

Back to Table of Contents

2.3 - The Use of Community Supports

FRs care for others as a function of their work. As such, utilizing supporters who are not FRs can shift the focus away from the affected FR, impeding their engagement and willingness to discuss challenges. The peer relationship recognizes that FRs possess a unique culture, extend minimal trust to outside groups, and see themselves as not being understood outside their own group, thus demonstrating the importance of peer to peer interaction. FRs are less likely to engage in peer support interventions when the principles of a peer relationship are compromised. Further, CIPSRT and the University of Regina publications suggest that a uniformed model of crisis management will benefit FRs in consistency of programming regardless of locale, thereby further reducing the effects of exposures to traumatic experiences in the workplace[13].

FRs require access to a full continuum of support professionals (e.g., clergy, mental health professionals), however, the unique nature of their work suggests caution in selecting specific professionals. Ideally, professionals working with FRs in the context of mental health will also have dedicated experience that reflects the specific needs of the individual or affected group.

Using civilians or community members operating in support capacities as peers for FRs violates Peer Support principles set out by the Mental Health Commission of Canada, the ICISF CISM model, and the mandate and scope of practice of many community-funded groups. Community supports often have inadequate access to the necessary levels of supervision, a peer code of conduct, established peer confidentiality agreements, their own support resources and also often lack the resources to provide timely referrals to culturally-competent providers when escalations of care are needed. These factors may all increase the risk of injury due to vicarious trauma and produce ineffective, or even detrimental, outcomes for FRs.

Back to Table of Contents

2.4 – Dual Roles

Dual or multiple role-relationships in Peer Support programs exist when an individual assumes one or more supporting roles at the same time. Even the perceived existence of dual or multiple roles may be detrimental to the affected FR, with potential for significant negative impact. It is essential for peers to take a primary responsibility and clearly declare their role in providing support.

The basic principles of Peer Support include clearly defined roles, boundaries, and explicit adherence to a code of conduct or scope of support. Dual or multiple role relationships in Peer Support, when necessary, need to be identified and addressed through proper processes and adherence to guidelines. Only peers who have the proper training and supervision shall attempt to manage dual roles in providing support to an individual or group. This support must be consistent with standards of practice, guidelines, and accountability to the individual and peer team. It often falls to the clinical director of the peer team to undertake these dual or multiple roles.

Examples of common dual or multiple roles:

Example A
A member of the Peer Support team is a FR and a chaplain. They should operate as only one or the other. If they initially respond as a peer and subsequently identify the need for support through chaplaincy, a referral should be made to another chaplain.

Example B
A community member (e.g., victim services) takes on a Peer Support role for a FR. This "community based peer" might also work with primary victims; for example, being involved in a death notification with the family. This dual role has the potential to cause harm to both parties, requiring that another supporter be accessed for the FR.

Example C
A peer responsible for operational management within an employment setting (i.e., supervisor or manager) takes on a dual role if they provide Peer Support to frontline staff. This dual role puts the peer in conflict with their professional role and responsibilities, as information obtained through the Peer Support process may influence an operational critique, review, or investigation.

Example D
A Peer Support team member is asked for support by their best friend; a co-worker within the same FR group. The peer must refer the friend for other Peer Support, and provide only informal support as a friend.

Back to Table of Contents

COMPENSATION

The well-being of the FR is the responsibility of the employer, and organizations have a responsibility to address the health effects associated with work place hazards. Return on investment in an effective Peer Support program has been demonstrated at $6.00-$17.00 for every $1.00 invested[11,12], through the reduction of total lost time, WCB claims, and the general costs associated with work place injuries.

Programs and teams can be completely volunteer, involve a combination of paid, and volunteer members, or may be comprised completely of paid members. Examples exist where peers are compensated for all their peer work, from planning to delivery of support, to being compensated for a portion of the work excluding the delivery of direct Peer Support (i.e., one-to-one, or groups).

Some feedback from FRs indicates that compensating peer supporters can lead to the perception that their support is financially motivated, rather than by any sense of empathy, creating a potential barrier to accessing Peer Support. To avoid this perception, it is critical that positive outcome expectations be established through fostering rapport, building trust, and maintaining a spirit of altruism. A thorough assessment of barriers related to compensation needs to be conducted to avoid negative perceptions attached to compensation for peer supporters.

There are no set standards or expectations related to compensation in the ICISF model. Compensation strategies vary widely, ranging from volunteer and partially paid to fully paid, depending on factors such as size of organization or community, access to external resources, and Collective Agreements. Compensation guidelines are typically developed through partnerships between management, union representatives and the other stakeholders. Compensation for other specialized teams within an organization can serve as a benchmark when determining compensation rates for CISM team members.

Peer supporter compensation may be resourced by multiple agencies, including Provincial and Municipal sources. It is the responsibility of the operating agency to explore their financial options and to cover costs and expenses associated with Peer Support. Different levels and types of resourcing have been deemed necessary for program efficiency and continuity. Variability in operational procedures, quality of services, contractual agreements, and other factors, such as the cultural nature of the agency, may influence resourcing and how it is applied.

Back to Table of Contents

Budgeting

FRs who are receiving the Peer Support should never be expected to pay out of pocket for any fees for services rendered, or to cover any costs or expenses whatsoever, according to ICISF Best Practices[14].

In developing a budget and planning for resources, the agency/organization should consider:

- Program Management: Coordinating Committees may operate on a voluntary basis or be covered under employment contract. The Positions of Peer Coordinator and Clinical Director typically incur a cost to the organization. Clinical Directors are usually financed at a rate appropriate to their profession. Installing a full-time Peer Coordinator can increase efficiencies and reduce the costs for a Clinical Director. Hourly rates or consultancy contracts may be negotiated separately.
- Training of Peers: Initial peer training programs are essential for creating fully trained and qualified personnel to provide CISM Peer Support Services. Costs may include release of staff to attend, conference venue and catering, audio visual support, payment for Instructors, production of training manuals, and certification of participation, as well as costs to interview and select prospective trainees.
- Mental Health Professionals (MHP): MHPs are required for psychological assessment, and treatment and may be funded through agreements with EAP, third party insurance, or extended health benefits.
- Operating Equipment and Resources: Every agency and organization must assemble the necessary assets to effectively support the team in their unique circumstances.
- Administration: Costs for printing, stationery, postage, promotional material, team ID cards, and secretarial assistance.
- Research and Quality Improvement: Creation of a database on health and stress in the organization to accurately assess the efficiency of Peer Support services, and to contribute to scientific knowledge regarding Peer Support.
- Travel and Accommodation Expenses: Team members may be required to travel to deliver Peer Support Services, acquire field education, and continue their related education.
- Production of Educational and Promotional Material: Policies, protocols, and informational fliers need to be printed and distributed throughout the organization. Regular newsletters and an annual report should be produced.
- Disasters and Large-Scale Emergencies: Coordinate and establish a funding policy, appropriate to available funding avenues and consistent with the provincial disaster protocol.
- Training and Attendance at Conferences and Workshops: Funding to provide high quality training of peers and ongoing learning and skill development.

Back to Table of Contents

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Back to Table of Contents

i) Compensation Examples to be Considered for use for Fire Services

For the purpose of compensation, deployments of Peer Support teams will be divided into three (3) types:

1. Local Deployment – These are considered "In-House Deployments", where the Peer Support team is asked to provide assistance within, and will be compensated by, their own department or agency.

   For a local deployment expenses to be compensated are:

   i. Maximum of up to 2 hours at the double time rate for the member who co-ordinates the team response.
   ii. All operational expensed incurred during interventions (e.g., food, refreshments, charges for meeting rooms/venue bookings, etc.)
   iii. Team members agree that the direct provision of support to members during an "In-House Deployment" will be done on a voluntary basis (e.g., individual interventions or group Peer Support interventions).
   iv. All expenses incurred will be borne by the "In-House" department or agency.

2. Short term out of jurisdiction deployments – Also called, "Mutual Aid" deployments. The Peer Support team is asked to provide short term assistance at the request from another department or agency. Short term assistance is defined as a deployment where a Peer Support team responds outside their own "In House" department or agency and the deployment is organized and completed in 24 hours or less.

   Mutual Aid deployments compensations:

   i. Up to 2 hours of at the double time rate for the member who is coordinating the team response.
   ii. Up to 2 hours prep time at the double time rate for responding team members.
   iii. All operational expensed incurred during interventions (refreshments, charges for meeting rooms/venue location, etc.).
   iv. Travel expenses for all responding team members will be compensated by the inter-agency or department requesting mutual aid and CISM services from the given CISM Peer Support Team deployed to render those services.
   v. Team members will be given a department vehicle for the deployment. If a department vehicle is not available, members will be compensated mileage wherever possible.
   vi. If travel requires the member to stay overnight, accommodations will be booked by the CISM Peer Support Team's "In House" department's or agency's administrative staff where accommodation expenses adhere to their "In House" department's or agency's Employee Business Expenses Policy.
   vii. Team members will be compensated for travel time at the members' double time rate.

Back to Table of Contents

viii. Team members agree that the direct provision of support during "Mutual Aid" responses will be done on a voluntary basis, based on previous agreements for compensation, or agreement that regular salary will be covered.
ix. All expenses incurred will be charged back to the requesting department. The proper level of financial approval needs to be obtained before deployment of the Peer Support team members.

3. Long term, out of jurisdiction deployments – These are known as Large Scale Emergencies or "Disasters" such as a flood, earth quake, or forest fire. These deployments involve assistance from the Peer Support team during protracted incidents where team involvement will be greater than 24 hours. This category is further subdivided into (a.) Response during the mitigation phase of an incident; and (b.) Response during the recovery phase of an incident.

   For "Disaster (a.)" deployments, members will be compensated:

   i. At minimum, the member will receive the same compensation as "Mutual Aid" deployments;
   ii. Additional compensation will be discussed and an agreement will be in place between the Chief of the "In House" department or agency and the governing body of the corresponding Agency requesting assistance.
   iii. All expenses incurred will be charged back to the requesting department or to the governing body of the corresponding agency.

For "Disaster (b.)" deployments, members will be compensated:

i. At a minimum, the member will receive the same compensation as "Mutual Aid" deployments.
ii. Additional compensation will be discussed and an agreement will be in place between the Chief of the Peer Support Team's "In House" department or agency and the governing body of the corresponding agency requesting assistance prior to deployment. These agreements will differ from "Disaster (a.)" agreements as it will allow more flexibility of time for the deployment and will not involve responses of an urgent nature.
iii. All expenses incurred will be charged back to the requesting department or to the governing body of the corresponding agency.

The compensation may be funded by multiple agencies including the Provincial and Municipal level. In the end, it is the responsibility of the operating agency to explore their financial options. Again, the FRs who are receiving the Peer Support should never be confronted or expected to pay out of pocket for any fees for services rendered, or to cover any costs or expenses whatsoever, according to ICISF Best Practices (Mitchell, 2017)

Back to Table of Contents

ii) Compensation Scenarios

Scenarios to Consider:

(a) At Work Scenario: A colleague asks another colleague trained in CISM to talk and do a SAFER-R during regular paid work hours. This service is considered an additional work duty and the peer provider should be given leave from his/her regular duties and paid regular wage or salary to provide Peer Support. This scenario can apply to individual Peer Support and group Peer Support.

(b) Off-Duty Scenario: A colleague approaches another colleague trained in CISM to provide Peer Support outside the regular work hours. Best practice supports that this would be done on a voluntary basis.

In all scenarios, team members have the right to refuse participation, for any reason, in order to preserve their own health and well-being.

Back to Table of Contents

CODE OF CONDUCT FOR CRISIS INTERVENTION RESPONDERS:

The Code of Conduct was adopted by the ACIAC steering committee, along with the Canadian Critical Incident Stress Foundation, in developing ethical standards for peer teams involved in Crisis Response, as set out by the International Critical Incident Stress Foundation.

The crisis responder:

1. First and foremost resolves to do no harm.
2. Is competent, and has met and continues to maintain training standards.
3. Has a primary responsibility to meet the needs of the individuals in crisis.
4. Adheres to the confidentiality agreement.
5. Recognizes his or her own limitations in meeting individual needs and has valuable adequate consultation and referral resources.
6. Continues to learn and expand their knowledge of crisis intervention theory, and techniques.
7. Is culturally aware and respectful of other cultures, religions, ethnic groups, and other diverse populations.
8. Is aware of their personal values, beliefs, and attitudes that could impact their interactions with others and avoid imposing those views on others.
9. Respects the individual's rights not to talk and/or share their personal trauma experience.
10. Accurately represents their credentials.
11. Avoids where possible, or manages where necessary, dual or multiple roles.
12. Maintains a professional appearance and demeanor.
13. Practices self-care.
14. Recognizes their own stress or life situations that may prevent them from performing Peer Support.

The code of conduct does not replace peer agreements, but serves to inform others of a voluntary code of conduct that is managed by each of the ACIAC CISM Teams.

Back to Table of Contents

SECTION 3
ICISF-APPROVED TRAINING

TRAINING REQUIREMENTS

Basic ICISF training requirement is to be an active peer on a CISM team, with successful completion of both basic courses: Assisting Individuals in Crisis and Group Crisis Intervention.

Upon successful completion of basic course requirements, individuals may choose to pursue further training in the Advanced Crisis Intervention course.

Assisting Individuals in Crisis develops skills that are essential to establishing the basic communication strategies for working with a single person or a group, and is a pre-requisite for the Group Crisis Intervention course.

The Advanced Group Crisis Intervention course is recommended for the most experienced members of the current team, with a minimum of one year of actively engaging the skills from the basic training. (Full course descriptions can be found in the next section.)

Training must extend beyond the successful completion of the two basic courses. Effective CISM Peer Support teams engage in continuous training, ongoing maintenance of skills through regular training, and supervision by qualified personnel such as a clinical coordinator. The model suggests teams meet every four to six weeks, with the majority of the meeting being dedicated to clinical supervision and skills re-refreshers, which have been shown to increase peer effectiveness, team cohesion, and peer retention.

The refresher training also serves to inform CISM peers of new and emerging trends and practices, and assists them in modifying current practices in keeping with new best practices. It is the primary responsibility of the Clinical Coordinator to ensure the Peer Support Team Members are up to date on current information and training.

Where possible, training should be organized and conducted by the Clinical Director with the assistance of the Peer Coordinator. In established peer teams, peers themselves can contribute to the training. The content should incorporate informational input, experiential skill practice, and discussion of peer program operations. Courses can be accessed through your local CISM Coordinator. The ICISF offers many internationally accredited courses, including: Assisting Individuals in Crisis; Group Crisis Intervention; Advanced Group Crisis Intervention; CCISM from UMBC Training Centers; and many other Continuing Education Workshops in CISM. Outside experts can be incorporated, as can key people from similar work environments.

Back to Table of Contents

CORE COURSES

Assisting Individuals in Crisis – Course Description

Crisis Intervention is NOT psychotherapy. It is a specialized acute emergency mental health intervention which requires specialized training. Crisis intervention is sometimes called "emotional first aid". The course teaches participants the fundamentals of, and a specific protocol for, individual crisis intervention. It is designed for anyone who desires to increase their knowledge of individual (one-on-one) crisis intervention techniques in the fields of Business and Industry, Crisis Intervention, Disaster Response, Education, Emergency Services, Employee Assistance, Healthcare, Homeland Security, Mental Health, Military, Spiritual Care, and Traumatic Stress. This course is a pre-requisite for Group Crisis Intervention training.

Program Highlights
- Psychological crisis and psychological crisis intervention
- Resistance, resiliency, and recovery continuum
- Critical incident stress management
- Evidence-based practice
- Basic crisis communication techniques
- Common psychological and behavioural crisis reactions
- Putative and empirically-derived mechanisms
- SAFER-Revised Model
- Suicide Intervention
- Risks of iatrogenic "harm"

Group Crisis Intervention - Course Description

Designed to present the core elements of a comprehensive, systematic, and multi-component crisis intervention curriculum, the Group Crisis Intervention course helps participants to understand a wide range of crisis intervention services. Fundamentals of Critical Incident Stress Management (CISM) are outlined, and participants gain the knowledge and tools to provide group crisis interventions, especially RITS, defusing's and the Critical Incident Stress Debriefing (CISD). The need for appropriate follow-up services and referrals is also explored.

This course is designed for anyone in the fields of Business & Industry Crisis Intervention, Disaster Response, Education, Emergency Services, Employee Assistance, Healthcare, Homeland Security, Mental Health, Military, Spiritual Care, and Traumatic Stress. Successful completion of Assisting Individuals in Crisis is a pre-requisite.

Program Highlights
- Relevant research findings
- Relevant recommendations for practice
- Incident assessment
- Strategic intervention planning
- "Resistance, resilience, and recovery" continuum
- Large group crisis interventions

Back to Table of Contents

- Small group crisis interventions
- Adverse outcome associated with crisis intervention
- Reducing risks
- Critical Incident Stress Debriefing (CISD)

Advanced Group Crisis Intervention – Course Description

Advanced Group Crisis Intervention is designed to provide participants with the latest information on CISM techniques, and post-trauma syndromes and builds on the knowledge obtained through the Group Crisis Intervention course and/or in publications. Participants will be exposed to specific strategies for intervening with those suffering post-trauma effects. Emphasis will be on advanced defusings and debriefings in complex situations. The course is designed for EAP, human resources and public safety personnel, mental health professionals, chaplains, emergency medical services providers, firefighters, physicians, police officers, nurses, dispatchers, airline personnel, and disaster workers who are already trained in the critical incident stress debriefing. The course will benefit those working extensively with traumatized victims, and requires previous training and experience. ICISF's "Group Crisis Intervention" should be a prerequisite.

Program Highlights

- Relevant research findings
- Managing complex group-oriented crisis interventions
- Nature and importance of incident assessment
- Strategic intervention planning
- Comprehensive, integrated, systematic and multi-component CISM
- Concepts of enhanced group processes
- Significantly delayed interventions
- "Multiple incident CISD"
- Suicide of a colleague
- Small group crisis support sessions after a disaster

Back to Table of Contents

[1] Mitchell, J., Personal Correspondence, 2017.

[2] Everly, G. (2017). Assisting Individuals in Crisis. 5th Ed., Revised. International Critical Incident Stress Foundation, Inc.

[3] Mitchell, J. (2017). Group Crisis Intervention. 5th Ed., Revised. International Critical Incident Stress Foundation.

Back to Table of Contents

SECTION 4
ICISF-APPROVED INSTRUCTORS_

4.1 - Selecting an ICISF Approved Instructor

NOTE: ACIAC will consult and advise on accessing ICISF Approved Instructors and will, construct an online database of instructors who ascribe to the ACIAC principles.

Selecting the best ICISF Approved Instructor and the recommended CISM training courses for your organization requires some insights into the nature of instructor training. ICISF Approved Instructors have completed a screening and training program to teach specific courses.

4.2 - Screening

- Completion ICISF courses in:
    - *Assisting Individuals in Crisis*
    - *Group Crisis Intervention*
    - *Advanced Group Crisis Intervention*
- A minimum of three years critical incident/traumatic stress experience.
- A letter of recommendation/endorsement from a local, provincial or regional CISM team or agency, dated within three months of application due date.
- A letter of recommendation from a local, provincial or regional CISM coordinator or clinical director, dated within three months of application due date.
    - *At least one letter of recommendation must attest to the instructor candidate's teaching ability.*
- Active membership on a crisis intervention team.
- Certification in Critical Incident Stress Management from UMBC Training Centers (CCISM).
- Current ICISF membership.

4.3 - Training

All applications are reviewed by ICISF, which selects candidates for training.

An ICISF Faculty member leads the course, providing important information on instruction, setting up roll-play scenarios, and hi-lighting key areas. Trainees are also required to attend a one-day course on Best Training Practices for the CISM Instructor. This course helps instructors develop an engaging presentation style and introduces them to the adult learning/education model.

Back to Table of Contents

4.4 - Suggestions for Selecting an Approved Instructor

It is recommended that organizations establish a screening or interview process which includes questions addressing the instructor's ability to adapt to specific learning needs, cultural components, and local conditions or circumstances.

1. Recommendations
    - Contact ACIAC for a list of known instructors
    - Inquire with similar organizations as to who they found was a good fit for their group and team purpose.
    - Check with organizations who have used the instructor to determine how the instructor and their courses were received.

2. Questions to ask a potential ICISF-approved Instructor:
    - Have you applied to the ACIAC to be included on the ACIAC Instructor List?
    - Are you currently working with a CISM team? If so, what is your role?
    - Can you provide current references who can comment on your abilities in working with CISM teams?
    - How long have you been an instructor?
    - When is the last time you taught a course?
    - What is your experience in working with our FR group (i.e. Fire, EMS, Search and Rescue, Police)?
    - Do you co-instruct and, if so, is the other person an ICISF Approved Instructor? (Note - Non-ICISF-approved co-instructors can only present 10% of the course material.)

3. Cost considerations:
    - Be sure to consider all costs when making your instructor selection, including instruction fees, material costs, and venue costs
    - ICISF Approved Instructors will order material through ICISF, including course workbook and certificate.

4. Be creative when developing pricing/cost scenarios:
    - All-inclusive cost – covering all expenses including materials for the number of participants, travel, meals etc. Price for "per person" instruction may be negotiated.
    - Specific costs: cost per person to cover materials, cost of ICISF Approved Instruction, mileage, other travel, meals etc.
    - Other Considerations:
        - *Quality of instruction*
        - *Trainers experience and background*
        - *Trainers preparation time*
        - *Trainer investment in self-funded training and continuing education*

Back to Table of Contents

4.5 - Instructor Evaluation and Feedback

- ACIAC Instructors share participant feedback to monitor quality of training and instruction.
- ICISF has an established process for receiving feedback evaluations and concerns and addressing them to improve quality of approved instructor training.
- Any concerns about the instructor or their courses should be addressed with the instructor first, with follow-up contact with ICISF and feedback to the ACIAC.

4.6 - ACIAC Approved Instructor Network

To support effective development of a CISM program and team, and find the best fitting instructor for the peer team, the Alberta Critical Incident Advisory Council (ACIAC) has developed a network of Approved Instructors to provide instructor referrals and to directly benefit instructors through:

- Opportunities to instruct through referral from ACIAC.
- Opportunities to network and consult with other ACIAC Approved instructors.
- Opportunities for instructor mentorship and coaching by more experienced instructors
- Opportunities to learn about emerging trends in CISM training, courses, and best practice requirements.
- Opportunities for additional and/or specialized training.

To be part of the approved ACIAC Instructor Network, instructors must adhere and agree to the terms and values of this document as standard in Alberta. In addition, ACIAC Approved Instructors agree to:

- Follow the principles and values of the ICISF.
- Provide up to date, high quality instruction.
- Ensure that essential course materials, lesson plans, and suggested training schedules are adhered to as outlined by ICISF Instructor Guidelines.
- Share their course evaluations with the ACIAC committee.

Back to Table of Contents

4.7 - Guiding Principles for Approved Instructors

VALUES FOR CRISIS RESPONDERS

Values are personal and determined by individuals according to their own experience and world views, however, some values are identified as key for the crisis practitioner responder and/or instructor. Key values include, in no particular rank or order:

- Integrity
- Respect
- Accountability
- Responsibility
- Competency

The ACIAC has developed guiding principles for ICISF CISM Approved Instructors in Alberta. These adult educators must act within the context and be cognizant of their roles as educators within the field of crisis intervention and the ICISF model.

Approved Instructors must preserve the credibility to the ICISF model and integrity in the field of crisis intervention by operating in a manner consistent with the values and principles of the ICISF model:

1. Approved Instructors must avoid doing any harm to learners.

2. Approved Instructors must respect the ethno-socio-cultural heritage, special circumstances, and dignity of all adult learners.

3. Approved Instructors should use the best available professional knowledge and follow ICISF best practices in serving all learners.

4. Approved Instructors must respect the unique and diverse learning needs of adult learners.

5. CISM Course descriptions must conform to the ICISF standards as set forth in ICISF published material.

6. Approved instructors shall represent their credentials, experience, and knowledge areas in accurate terms, with documented references and claims accessible to interested parties.

7. Approved Instructors must role-model ICISF best practices to empower learners in participating actively and effectively in training.

8. Approved Instructors must be cognizant of, sensitive to, and communicate the potential negative impact of content and training activities on the learners.

9. Approved Instructors must create a safe and trusting learning environment.

10. Approved Instructors must avoid conflicts of interest and/or the appearance of conflict of interests in all aspects of their work.

11. Approved Instructors SHALL NOT use training materials not authorized by the ICISF (i.e., videos, photos). Any adjunct materials shall be given careful consideration for the potential for negative impact on learners.

Back to Table of Contents

Sources: "Toward Developing a Universal Code of Ethics for Adult Educators", PAACE Journal of Lifelong Learning, Vol 9, 2000, 39-64; "Ethical Practice in Adult Education", ERIC Digest No. 116, 1991.

Tritt, P. (2017). The Successful Team: Impacting Communities through Crisis Intervention. ICISF 14th World Congress on Stress, Trauma & Coping. May 1-6, 2017. Baltimore, MD USA. Keynote Speaker: P. Tritt, Director of Instruction Envision Healthcare. **www.icisfworldcongress.org**

Back to Table of Contents

i) Instructor Application Form

Alberta ICISF Approved Instructor Information

Name: _____

Agency/Business Name: _____

Position/Title: _____

Address: _____

Phone: _____

Email: _____

Website: _____

Approved Instructor for (list courses):

☐ Assisting Individuals in Crisis ☐ Group Crisis Intervention ☐ Pastoral Crisis Intervention ☐ Advanced Assisting Individuals in Crisis ☐ Advanced Group Crisis Intervention	☐ Other, please describe:

I am active in the following team(s):

Team	Role in Team	References

Describe your experience with specific groups:

Any other information:

Are you willing to travel? ☐ Yes ☐ No ☐ Depends

Additional information in relation to travel

Back to Table of Contents

SECTION 5
CISM TEAM

5.1 - Agency/Organization

A team requires a clear description of how they fit in the organization within which they operate. The most effective Peer Support teams operate best when structure is well-defined, transparent, and accepted within the organization[1].

Primary responsibility for the Peer Support program is typically undertaken by a Coordinating Committee managed by two key roles; the Peer Coordinator and the Clinical Director.

The lead agency (i.e. police department, fire service, EMS agency; etc.), regardless of structure[2], typically assumes responsibility for:

- Provision of or arrangements for the funding of initial team development.
- Development of a steering committee or board of directors for the team.
- Provision of necessary personnel for the developmental stages.
- Establishment of a team membership committee.
- Assistance in locating appropriate team leadership.
- Assistance in recruiting team members.
- Coordination of initial/basic team training.
- Provision of general support for the team.
- Assistance in developing research and evaluation methods and quality assurance processes.
- Allowing for release time for staff to manage the team.
- Arranging for continuing education of team members
- Adoption and implementation of operational policies and procedures.
- Maintenance of an up-to-date call out list of team members.

5.2 - Team Member Selection and Recruitment[3]

A Membership Committee shall determine the best methods to identify and recruit members, and may also be trained in CISM so that they have the skills and background necessary to select members effectively.

The Membership Committee or Team Coordinator will invite nominations and communicate the process through appropriate channels within the department.

The required qualities of a team member, include;

- Maturity;
- The respect of their peers;
- An ability to maintain confidentiality;
- Sensitivity to people's needs;
- Willingness to function as a team player and;
- A desire to undertake and maintain the necessary education/training.

The Team Coordinator or a designated Team Member, as well as the Clinical Director, will conduct interviews with nominated candidates and send selected individuals for the required training.

Back to Table of Contents

5.3 - Team Size

There is no exact formula for determining the size of a CISM team. A team of 10 team members might support a small organization of 60 staff/volunteers if activation is low. More team members may be required if activation is higher.

A team that is too large may lead to members feeling underutilized and disengaged. A team that is too small may lead to burnout among members. Either circumstance can lead to high attrition.

Finding the right team size for your organization can depend upon several factors:

- Severity and frequency of calls: Teams with high levels of activation, i.e., weekly, will require more members. Lower levels of activation, i.e., a few times a year, require fewer team members.
- Coverage: A team needs enough members to ensure coverage even when people are on holidays or involved in calls.
- Location: Providing service to one location will require fewer team members than providing services across the province. When serving a larger area, team members should be dispersed across the service region.
- Service population: Larger organizations, with larger populations, will need more team members than small organizations.

5.4 - Team Roles and Structure

It is important to remember that CISM is a comprehensive, integrative, systematic and multi component approach to managing traumatic stress, and interventions are only a fraction of the services a team can offer.

Others may include:

- Mental health awareness and continuing education programs.
- Family support programs.
- Development of Standard Operating Procedures (SOP's) to ensure a systematic approach
- Referral to outside providers.

Ongoing Team development and recruitment is necessary for a properly functioning team. In the early development stages of a team, experienced personnel may not be available for some positions (e.g., coordinator, clinical director), nevertheless, all positions must be filled in order for the model to be effective. Teams with insufficient experience should seek mentorship from more experienced teams.

Teams should establish back-ups for coordination and other key roles to allow for succession planning, vacations or illnesses and other possible interruptions, minimizing the impact on team operations and preventing undue pressure on individuals. Team rostering sufficient to ensure 24-hour / 365 days a year coverage is required.

Back to Table of Contents

5.5 - Coordinating Committee

The functions of the Coordinating committee are to:

- Oversee the program.
- Develop and advise on policy.
- Constitute a line of accountability from the Clinical Director and CISM Coordinator to the agency.
- Assess surveys, feedback, utilization, and trend reports in relation to the program to guide any recommended changes to processes and operations.
- Ensure adequate funding and budgetary management for the program.
- Ensure adequate administrative support to the program.
- Assist in the solving of any major problems.
- Consider complaints and grievances related to program members or program function.

The Coordinating Committee must be comprised of representatives from parties vested in the general area of staff support, and be representative of the cross-section of board members and functions of the agency[3]. Committee members are often people who believe strongly in staff support and are prepared to put their personal time into helping the system to function effectively.

Back to Table of Contents

5.6 - Team Coordinator

One of the most important components of a team is a coordinator with an energetic personality and a fundamental belief in the CISM program[2].

This team coordinator is responsible for the overall management and operation of the team, and each team should have at least one coordinator who oversees day-to-day operations. Team coordinators will hold CISM certification and have extensive general knowledge of critical incident stress, plus specific insight into the emergency services field.

Team Coordinator qualifications include:

- Current, basic and advanced-level CISM training.
- Significant employment history within emergency response.
- Significant experience with the six core elements of ICISF CISM interventions, debriefings, and defusings.

Team Coordinator duties include:

- Overseeing general operation of the Peer Support team
- Ensuring that team members adhere to applicable policies, procedures and operating guidelines.
- Ensuring that requests for Peer Support/CISM services are received and responded to in accordance with the ICISF model.
- Participation in the development of policies and procedures.
- Soliciting membership interest.
- Leading the Peer Support team selection and evaluation processes.
- Coordinating training of the team, supervisors and staff.
- Planning and coordinating team meetings.
- Evaluating membership needs.
- Representing the Peer Support team to community organizations.
- Assisting in training the team, the providers and the administration.
- Evaluating requests for CISM interventions.
- Dispatching the CISM team or ensuring activation via an alternate process.
- Debriefing the debriefers, where appropriate.
- Establishing a Peer Review Board.
- Holding team meetings every 4-6 weeks.
- Maintaining records of team activity.
- Keeping updated lists for referrals, mental health providers, key contacts within the organization (e.g., Disability Management), Employee and Family Assistance Program, Clergy, etc.
- Acting as liaison with Emergency Services Administrators.

Back to Table of Contents

5.7 - Clinical Director

All Peer Support programs must have an appropriately qualified, registered, licensed Mental Health Professional (MHP) serving in the role of Clinical Director[3].

All professional support personnel must be registered with their regulatory body as set out in the Alberta Health Professions Act, be able to provide the services as defined within their professional scope of practice, and provide proof of professional liability insurance.

The Clinical Director supports the team by:

- Overseeing the delivery and quality of Peer Support services, which is vital to the team's health, growth, and ability to function effectively.
- Assessing Peer Support team members for role-related stress.
- Providing guidance with respect to ongoing program and organizational development.
- Being available to work with the team, including attendance at interventions when the strategic plan calls for formal mental health support (i.e., participation in CISDs).
- Being a recognized provider to both the WCB and Insurance Carrier (i.e. Long-Term Disability), completing assessments and health care provider's statements for applications for benefits as required to ensure immediate access to formal mental health support for Team Members.
- Removing barriers to essential health services by providing direct and timely services for staff requiring interventions beyond the scope of Peer Support.
- Maintaining culturally competencies, delivering evidence-based treatment approaches and being recognized by the staff/Peer Support team as a safe and reliable resource.
- Creating, supporting and delivering education and information to working groups, spouses, families and leadership on effective resiliency and recovery programs.

Qualifications:

In order for the team to be ICISF accredited, the Clinical Director must:

1. Be a registered and licensed MHP with a professional association.
2. Hold at least a Master's degree in one of the following areas:
    - Psychology
    - Social Work
    - Psychiatric nursing
    - Pastoral counseling
    - Mental health counseling
    - Training and certification as a physician who specializes in psychiatry
3. Demonstrate regular employment or service provision in one of the following areas:
    - Social services
    - Psychological or psychiatric services
    - Crisis intervention services
    - Pastoral counseling
    - Psychiatric nursing
    - Other counseling services

Back to Table of Contents

4. Maintain current training in CISM by the International Critical Incident Stress Foundation (ICISF)

Since the focus of the Clinical Director is on the magnitude of impact of a critical incident on an individual or group, a comprehensive orientation must be developed in order that they gain an understanding, of the organization, available supports and services, and the unique cultural environment of the working groups. "Ride-alongs" alone are not sufficient, necessary, or a supported means to achieve this.

Clinical Director duties include:

- Coordinating with national and/or international research organizations to maintain current knowledge of evidence-based best practices and information.
- Working closely with the Team Coordinator to assure proper team performance and quality assurance.
- Advising the Team Coordinator regarding the development of policies and procedures, appropriate continuing education, and protocols for debriefings and team selection.
- Providing clinical support and advice to the Team Coordinator and other team members as needed.
- Developing criteria for selection of team members and assisting in the selection process.
- Arranging for debriefing of staff and coordinating further services as appropriate.
- Monitoring and delivering debriefing program activities and offering suggestions regarding follow-up services.
- Conducting routine reviews of team records, reports, and services.
- Conducting annual reviews of individual team members regarding their fitness to continue in their roles, with responsibility for revising roles or remove members as necessary.
- Developing training and delivering seminars, following a recommended schedule of every six-weeks, for team members on topics relating to Peer Support.
- Recommending and/or leading cross-training programs for team members
- Representing the Peer Support program before the organization/agency, the public, and others as required.
- Participating in a peer review board to address team issues/concerns.

Back to Table of Contents

5.8 - Peer Support Team Members

NOTE: Team Members have a responsibility for their own self-care, and are therefore given responsibility and authority to decline giving support under any circumstances which they feel are inappropriate due to the situation, individual, or other factors.

Peer Support Team Members facilitate the intervention process and actively promote the program among their peers. The CISM process is peer-driven and clinically guided by MHPs. Peer Support Team Members include representatives who commit their time, energy and expertise from various divisions or branches within FR organizations in support of the Peer Support program.

Qualifications:

- Emergency Service experience or experience (preferably 3-5+ years) in the professions served by the program
- Completion of a four-day ICISF approved Basic CISM Training course.

Peer Support Team Member duties include:

- Serving as the "eyes and ears" of the team.
- Receiving requests for Peer Support.
- Assessing and developing intervention plans based on ICISF CISM principles, including assisting with assessment of the need for defusing, CISD, individual contacts, family support services, referrals, etc.
- Collaborating with the Team Coordinator and Clinical Director as required.
- Leading group interventions and providing individual consultations where appropriate.
- Maintaining confidentiality throughout the CISM/support process.
- Attending the mandatory training hours and the required minimum of team meetings per year.
- Reporting on services delivered using the Initial Contact Checklist and/or Peer Contact Support forms by providing completed forms to Team Coordinator.
- Attending team meetings and training as outlined in the Team Contract.
- Seeking assistance from the Clinical Director/MHP when the limits of their own training, capabilities, and/or resources are exceeded.

Back to Table of Contents

5.9 - Chaplaincy/Pastoral Care[4]

Chaplains provide valuable guidance through a non-denominational approach and by referring staff for more formalized support. A chaplain can provide support after events including serious injury to department members, line-of-duty deaths, notification of family members for serious injuries or fatalities, suicides involving department members and their families, and visitation to injured personnel.

Qualifications:

- Maintain current training in CISM by the International Critical Incident Stress Foundation (ICISF).
- Have familiarity with emergency response roles, typically gained through orientation and engagement with emergency personnel in their environments.
- Able to provide, or make recommendations for, grief support.

Chaplaincy duties include:

- Providing support to emergency personnel and their families in times of need.
- Recognizing signs and symptoms of stress and referring personnel to formal supports as appropriate.
- Serving as part of the professional support staff, i.e. working closely with Mental Health Providers.
- Serving as a Mental Health Provider only if they hold the appropriate training and experience. (See: Clinical Director Qualifications)
- Providing spiritual support **only** when the emergency responder is clearly seeking such support. Where indicated, a Chaplain can serve as a liaison with an individual's clergy in addressing job stresses.
- Taking care to avoid, declare, and manage all dual roles and relationships, in coordination with the Clinical Director.

Back to Table of Contents

5.10 - Administrative Support

Administrative Support duties include:

- Maintaining current knowledge of CISM training by the International Critical Incident Stress Foundation (ICISF).
- Liaising with team coordinators, mental health providers and other stakeholders (i.e. Communications) to develop educational tools (e.g., literature, videos) about Peer Support.
- Developing team resources and reference materials as directed by the Team Coordinator or Clinical Director.
- Managing administrative functions such as scheduling team meetings, writing meeting agendas and minutes.
- Maintaining a current list of referral resources as outlined by the Clinical Director.
- Maintaining an up-to-date team member contact list.

Back to Table of Contents

[1] Robinson, R., & Murdoch, P., (2003). Establishing and Maintaining Peer Support Programs in the Workplace. 3rd Ed. CHEVRON Publishing Corporation.

[2] Mitchell, J., (2013). The Care and Feeding of a Successful Critical Incident Stress Management Team. CHEVRON Publishing Corporation.

[3] Mississippi River Valley Critical Incident Stress Management Team (2014). Operational and Training Guide.

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[4] Reference For Chaplaincy Section:

The Fire Service Joint Labour Management Initiative Wellness-Fitness Initiative Third Edition.
International Association of Fire Fighters Division of Occupational Health, Safety, and Medicine 1750 New York Avenue, NW Washington, DC 20006
 International Standard Book Number: 0-942920-50-3

Back to Table of Contents

i) Sample Peer Nomination Form

CISM PEER NOMINATION FORM

Nominations are accepted until: _____

In a continued effort to ensure members receive mental health assistance, a Peer Support Team has been established. Team members nominated by their peers will be provided with Critical Incident Stress Management (CISM) training. The CISM trainer and team will establish the roles within the Peer Support Team.

A "Peer Support" is a member of the workplace who has been selected and trained to provide first line assistance and basic crisis intervention to fellow workers.

- ✓ Is there someone in your department that you and your colleagues are comfortable talking with, knowing that the conversation will be kept confidential?
- ✓ Is that person non-judgmental and a good listener?
- ✓ Does that person have the time and focus to assist as needed?

Consider putting their name forward as a potential Peer Support Team Member.

Nomination of _____ as a member of the Peer Support Team.

Please describe the nominees abilities in the following areas:

i. Listening Skills:

ii. Trustworthiness & Confidentiality:

iii. Non-judgmental & Accepting:

iv. Level of Maturity & Relatable Life Experience:

v. Approachable & Open:

In 50 words or less, describe why you think the nominee would be a good Peer Support Team Member:

Nominators Name: _____
Nominators E-Mail / Contact: _____
Date of Nomination: _____

Back to Table of Contents

ii) Sample Peer Selection Interview

Peer Team Member Initial Interview – Conducted after attending "Basic Training"

Date: _____ Nominee's Name:_____

Interviewer(s):

_____

1. Why do you want to be a member of the Team?
2. What did you learn in the CISM training that you feel is important in your role as a peer?
3. How do you see yourself using these skills as a Peer Team Member?
4. Did the course meet your expectations?
5. From the ICISF Model, taught in the courses, what do you think are its strengths and weaknesses in developing you as an effective Peer?
6. What assets can you bring to the crisis support process as a Peer Team member?
7. What personal limitations are you aware of that could prevent you from adhering to the crisis support process as a team member?
8. How much flexibility do you have to respond on 24-48 hours' notice?
9. What stress management techniques are effective for your stress?
10. Do you have any comments or additional information that you would like us to know about you that would assist is in the Team building process?
11. How do you feel about the Peer Support Team and your level of confidence and involvement right now?
12. Based on what you learned about skills, techniques and procedure of CISM and being a peer, how confident are you that you can be an effective member of the Peer Support Team?

Back to Table of Contents

iii) Sample Peer Contract

CISM / PEER SUPPORT TEAM
Membership Contract

I, _____, agree to serve as a volunteer with the Crisis Support Team for a minimum period of one year, and commit to:

1. Attendance at a mandatory four-day combined Assisting Individuals in Crisis and Group Crisis Intervention training session.
2. Participation in approximately _____ hours of interventions, meetings and education presentations per year.
3. Attendance at a minimum of 50% of monthly team meetings.
4. Completion of required records of activities.
5. Maintenance of strictest privacy regarding crisis support services conducted, including topics discussed and personnel involved. Any breech in confidentiality will result in my immediate removal from the team.
6. Adherence to established team protocols and operational guidelines.

The Crisis Support Team commits to:

1. Provision of a four-day combined Assisting Individuals in Crisis and Group Crisis Intervention training session.
2. Provide, if necessary, interventions for team members following a team response.
3. Re-evaluation of team operation and personnel, annually.
4. Maintenance of quality in performance standards

I have read and understand these commitments and agree to serve as a member of the CISM / Peer Support Team for a one-year period.

_____ _____
(Signature) (Date)

The CISM / Peer Support Team agrees to fully support the Peer Support Team Members over the course of their term.

_____ _____
(Signature) (Date)

Back to Table of Contents

iv) Sample Peer Confidentiality Agreement

CISM / Peer Support Team

CONFIDENTIALITY AGREEMENT

The undersigned hereby acknowledges his/her responsibility under applicable federal law, and the agreement between _____(Team Member Name)_____ and the _____(Department/Agency Name)_____ Crisis Support Team, to keep confidential any information obtained during a crisis support intervention as well as all confidential information of the CISM / Peer Support Team. The undersigned agrees, under penalty of law, not to reveal to any person or persons, except authorized CISM / Peer Support Team members, any specific information obtained during a crisis support intervention and further agrees not to reveal to any third party any confidential information of the CISM team except as required by law.

Dated this _____ day of _____ 201__.

_____
Team Member

_____
Team Coordinator

Back to Table of Contents

SECTION 6
MAINTENANCE

6.1 - Background

There are numerous considerations in keeping a CISM team healthy and running once established. Peer Support teams require on-going maintenance and training. The practice and development of skills is necessary, as is the regular review and adaptation of policies and procedures[1]. Failure to follow guidelines increases the risk of failure and reduces the effectiveness of Peer Support[2].

The Primary Guidelines for Team Health are:

- Team education.
- Cross-Training of CISM team members.
- Regular team meetings.
- Team record keeping.
- Written protocols and procedures.
- New member recruitment.
- In-Service education about CISM to target population.
- Community education programs.
- Spousal/family education and support services.

It takes careful consideration, planning, and a dedicated team to build and develop a CISM Peer Support program. Development requires effective leadership, dedicated committees, clearly defined goals and objectives, and a collective work ethic focused on delivering the highest level of service to one's fellow co-workers[2].

6.2 - Team Membership

- Team members serve for a minimum period of one year.
- Membership is evaluated annually.
- A member wishing to resign should discuss the matter with the Team Coordinator, and submit a resignation in writing.
- Team members may request a leave of absence for a limited period of time.
    - *A leave of absence will only be considered for members with a minimum six months' active participation on the team.*
    - *All requests for a leave of absence must be submitted in writing to the Team Coordinator via email or letter.*
    - *Requests must specify the desired length of leave.*
    - *A leave of up to four months may be granted with automatic return to previous status.*
    - *A leave of four to eight months may require refresher training as determined by previous experience with the Team.*
    - *Team members on leave of any length are to be placed on the LOA/inactive portion of the Team Roster.*
    - *All Team members on leave must review Team meeting minutes/activities upon their return to work.*

Back to Table of Contents

6.3 - Team Meeting and Training Expectations

Participants at regular meetings, scheduled every 6 weeks, shall:

- Respond to meeting invites to facilitate agenda planning (i.e. training activities).
- Submit any agenda items to the Peer Support Team Coordinator prior to the meeting and arrive on time.
- Be prepared for meetings, including review of pre-circulated materials.
- Attend the minimum 50% of team meetings per year as per the Peer Team Contract.
- Focus the conversation on stated objectives.
- Keep all intervention reports and meeting discussions strictly confidential.
- Ensure that the Team Coordinator has current contact information for the member, including phone numbers and email addresses.

6.4 - Revocation/Suspension of Membership

Membership is revocable at the discretion of the Team Coordinator and Clinical Director on the recommendation of a Peer Review Board. Reasons for revocation include, but are not limited to:

- Absence from an assigned intervention, after commitment to do so.
- Any misrepresentation of the Peer Support Team.
- Absenteeism at regular meetings, with attendance of less than 50%, as per the Peer Team Contract.
- Acting against the expressed direction of the Team Coordinator or Clinical Director.
- Violation of confidentiality; except in cases where a team member identifies risk of harm, in which case one must report to the team's Clinical Director, as per stated Team Member Duties and Responsibilities.
- Failure to follow protocols and directives regarding Team activity.
- Any behaviour determined by the Peer Review Board to be unethical.
- Any behaviour that has the potential to damage the reputation or credibility of the Team.

Back to Table of Contents

6.5 - Peer Review Board Procedures

A Peer Review Board shall be selected by the Team Coordinator and Clinical Director to evaluate any considered membership revocation or suspension. For incidents involving clinical matters, the Board will consist of the Clinical Director and two other active members of the Team. For non-clinical matters, any three Team Members may be selected.

For clinical issues:

- The Review Board shall meet or discuss the problem by phone with the member within 72 hours of notification.
- The Peer Review Board shall file a written report and recommendations to the Team Program Coordinator within 48 hours of their meeting.
- The Team Coordinator or Clinical Director will initiate any disciplinary action recommended by the Peer Review Board.

For non-clinical issues:

- The Peer Review Board shall meet with or discuss the problem by phone with the member within one-week following notification.
- The Peer Review Board shall file a written report with the Program Coordinator within one week of the meeting.
- The Team Coordinator or Clinical Director will initiate any disciplinary action recommended by the Peer Review Board.

6.6 - Documentation

Document types fall into either Administrative or Intervention. Administrative documents will include minutes for meetings, team rosters, copies of ICISF CISM certificates, records of attendance for meetings and interventions.

Intervention records do not include any details of information shared, but include type of intervention, length of intervention, names of CISM team present, number of participants and, wherever appropriate, next steps. Other information may include the nature of the incident, and the name of the party making the initial request (barring issues of confidentiality).

Back to Table of Contents

Section 6 – References

[1] Robinson, R., & Murdoch, M., (2003). Establishing and Maintaining Peer Support Programs in the Workplace. 3rd Ed. CHEVRON Publishing Corporation.

[2] Mitchell, J., (2013). The Care and Feeding of a Successful Critical Incident Stress Management Team. CHEVRON Publishing Corporation.

Back to Table of Contents

i) Team Evaluation Questions

1. Introductions
    a. Participants: getting to know you
        i. Team background/assessment:
        ii. Type
        iii. Size
        iv. History
        v. Mission/goals/target population
        vi. Challenges

    b. Assessment tools
        i. Team Self-Assessment (Appendix iii.)
        ii. SWOT Analysis

2. Team Recruitment
    a. Desired team member characteristics
    b. Sources
    c. Selection process
        i. Solicit and screen applications
        ii. Review applications with existing team members
        iii. Provide adequate information about team responsibilities and expectations
        iv. Interview
        v. Background/reference checks
        vi. Choose members for the right reasons

3. Selecting for success
    a. Activity: Selecting for Success
    b. Interview pearls
        i. It is about us and them
        ii. Approach as if this was an employment interview
        iii. Select the interview committee carefully
        iv. Use a consistent group to interview
        v. Consider a written scoring tool
        vi. Use open ended questions
        vii. Avoid questions that could be construed as biased or discriminatory
        viii. Allow for questions
        ix. Use behavioural interview questions
        x. Ask all applicants the same questions
        xi. Observe for interpersonal interactions

4. Building your team
    a. Activity
    b. Team training standards: what and when?
    c. Courses
        i. Assisting Individuals in Crisis
        ii. Group Crisis Intervention
        iii. Advanced Group Crisis Intervention
        iv. Strategic Response to Crisis
        v. Refreshers
        vi. Other??
    d. Team building experiences/activities

Back to Table of Contents

5. The art of maintenance
    a. Activity: Quality Improvement Process
    b. Team Questionnaire
    c. Motivation
    d. Reward
    e. Weeding

6. What are some of the more difficult team maintenance issues?
    a. Stable leadership
    b. Succession planning
    c. Communication: keeping members informed
    d. Motivation
        i. Make people feel they are important
        ii. Clarify goals
        iii. Identify progress
        iv. Acknowledge achievements
    e. Orienting and mentoring new members
        i. Identify mentors
        ii. Establish touch points
    f. Hold each other accountable
    g. Meetings
    h. Effective utilization of all team members
    i. Continued training or education for team members
    j. Rotation of responsibilities: opportunity to participate in leadership of the team
    k. Developing trust of team (especially for in-house teams)
    l. Inability to recruit new members
    m. Silence is consent
    n. Potential loss of credibility of team members
    o. Not observing appropriate boundaries
    p. Request for services from non-target population groups

7. Common team mistakes
    a. Failure to have an adequate dispatch system
    b. Failure to maintain confidentiality
    c. Failure to use mental health professionals
    d. Poor timing of interventions
    e. Using the wrong intervention (strategic planning)
    f. Applying debriefings too soon (disasters)
    g. Allowing interventions to be “exclusive” (other affected personnel not invited)
    h. Not providing handouts
    i. Expanding beyond your area of expertise
    j. Failure to follow-up
    k. Succumbing to the territorial trap
    l. Succumbing to false pride (We’re the best)

8. Handling conflict
    a. Conflict must be addressed!
    b. Conflict = issue + emotion
    c. Sources of conflict
        i. Challenge to dignity, authority, or territory
        ii. Perceive a threat
        iii. Reduce to me vs. you
    d. Resolution principles
        i. Respect

Back to Table of Contents

ii. Modelling (leadership role)
iii. Diplomacy
1. Create a bridge
2. Generate compatible goals
e. Conflict resolution styles
i. Competing (I win-You lose)
ii. Compromising (Meeting halfway)
iii. Avoiding (denial, withdrawal)
iv. Accommodating (smoothing over)
v. Collaborating (I win-You win)
f. Who owns the problem?
i. I own the problem
ii. You own the problem
iii. We own the problem
iv. There is no problem
g. Conflict is neither good or bad: it is what you do with it
9. Team rituals
a. Service award recognition
b. Social Functions

10. Team Stress
    a. Root causes: symptoms vs. cause
    b. Treatment depends on the cause
11. Values/Code of Conduct/Professional Boundaries
12. Pearls: What matters in crisis support services?
    a. Responding in a timely manner
    b. Responding with courtesy
    c. Keeping our commitments
    d. Meeting their needs
    e. Making their needs
    f. Making the interactions/intervention a positive difference
    g. Listening
    h. Teaching to the topic
    i. Using a consistent model
13. Final Pearl: The absence of proof of benefit does not equate to proof of an absence of benefit
14. Questions/Comments?

Back to Table of Contents

ii) CISM Team Coordinator's Evaluation Questionnaire

CRISIS SUPPORT TEAM
PROGRAM QUESTIONNAIRE
Team Coordinator's Evaluation

Establishing and maintaining a Peer Support team continues to present challenges.
What is your story?

1. How long has your team been in existence?
2. What population or target group does your team serve?
3. How many member serve on your team?
4. What is the mission/goal of your team?
5. What factor or factors have been the most important in developing your team?
6. What is the biggest/most important lesson you have learned from your team experience?
7. What advice would you give a newly developed team?
8. What has been your biggest challenge as a team coordinator?
9. What is currently the most significant team need?
10. What is your team's concern for the future?
11. Estimate the percentages of requests for services:
    a. Individual / one-on-one
    b. Same day group Defusing
    c. CISD
    d. RITS
    e. CMB
12. Other Comments:
    _____
    _____
    _____

Back to Table of Contents

iii) CISM Peer Self-Assessment Template

Crisis Support Team
Self-Assessment

Assessment	Yes	No	Not Sure
1. Does your team have a defined selection process for all new members?			
2. Does your team interview team candidates and check references?			
3. Is Individual and Group CISM training required for team members before deployment?			
4. Does your team require ride-along experiences for mental health professionals?			
5. Do more than 50% of your team members have ICISF course training in addition to Individual and Group training?			
6. Does your team require members to attend a minimum number of team meetings annually?			
7. Does your team enforce team member participation requirements?			
8. Does your team have a mechanism to update members on new concepts or information from the field of crisis intervention?			
9. Does your team require annual recommitment through signature of members?			
10. Does your team provide a mentor to new members?			
11. Is there a minimum number of your team members who are mental health professionals?			
12. How often does your team meet? a. Monthly b. Every other month c. Quarterly			
13. Does your team keep minutes of meetings and distribute them to members?			
14. Does your team provide at least 6 continued education sessions per year?			
15. Does your team use role plays to develop skills?			
16. Does your team review cases/activity at meetings?			
17. Does your team have a leadership succession plan?			
18. Does your team update member roster/ contact information on a regular basis (i.e., after each meeting)?			
19. Does your team have a well defined policy and operating protocol?			
20. Does your team have a mechanism to address breach of protocol by a team member?			
21. Does your team have a fail-safe mechanism for receiving calls for service and dispatching team members?			
22. Does your team recommend required attendance by personnel at defusings and debriefings?			

Continued

Back to Table of Contents

23. Does your team always require that a mental health professional be present for debriefings?			
24. Does your team routinely use metal health professionals at defusings?			
25. Does your team provide satisfaction/effectiveness surveys following interventions?			
26. Does your team provide critical incident stress reaction handouts at all interventions?			
27. Does your team provide follow-up on all interventions?			
28. Does your team routinely offer continuing education sessions to your target populations/organizations?			
29. Does your team participate in local disaster drills?			
30. Does your team maintain statistics/information on activities?			
31. Does your team hold a minimum of one social event or activity annually?			
32. Does at leas one person on your team maintain membership in an association dealing with trauma or disaster response? (in addition to ICISF)			
33. Does your team haven difficulty recruiting qualified team candidates?			
34. Does your team have mutual aid relationships with other teams?			

Used with permission of Patricia L. Tritt, RN MN

Back to Table of Contents

iv) Example of Peer Support Team Protocol and Operational Guidelines

Developed by, and used with permission of, Strathcona County Emergency Services, and provided herein for adaptation and use by participating CISM teams.

(Agency Name) Emergency Services
Peer Support Team Protocol and Operational Guidelines

Table of Contents

Content developed by Agency Name and may only be used with permission.

Back to Table of Contents

Addressing the mental health needs of first responders differs from the general population due to repeated exposure to traumatic events that can have a cumulative effect. Without an effective referral source (i.e., a mental health provider), staff seeking support for issues such as depression, anxiety, sleep disturbances and addictions through a general service are more likely to experience lengthy or permanent absences from work and significant impacts to overall quality of life.

Peer Support is an essential component of a mental health program, as fire/EMS personnel are less likely to seek formal mental health services than the general public; but work in a high intensity, high risk environment. Peers are essential in encouraging and supporting help-seeking behaviors among their colleagues.

Certain events, such as the death of a child, the death of a co-worker, and multiple casualty incidents appear particularly stressful for FRs. Any of these events, and a host of others, may cause or contribute to a critical incident or acutely stressful situation.

A critical incident is an unusually challenging event that has the potential to create significant human distress and can interfere with one's ability to access their usual coping mechanisms. The following are examples of incidents that may have significant emotional impact and are appropriate for crisis support intervention:

- Line of duty death, suicide or serious injury to staff member
- Disaster/mass casualty incidents
- Multiple fatality incidents
- Death or serious injury of a child
- Serious injury or death of a civilian resulting from emergency services operations
- Events that seriously threaten the lives of responders
- Loss of life of a patient following extraordinary and prolonged expenditure of physical and emotional energy
- Incidents that attract excessive media coverage
- Prolonged events, especially with loss
- Personal identification with the victim or the circumstances. Events where the victims are relatives or friends of emergency responders
- Any unusual incident in which the potential for immediate or delayed emotional response is high

The groups served by the Agency Name Emergency Services Peer Support Team include:

- Agency staff – fulltime and part-time staff members, including IAFF and classified staff; as well as student placements
- Agency Name staff as approved/appropriate
- External groups (i.e. fire/EMS services) as approved.

The team scope does not include crisis support services for the public; however, team members may make appropriate referrals. Exceptions will be discussed with the program coordinator and clinical director. This Manual is intended to be a resource for the Agency Name Emergency Services Peer Support Team. The content of the Manual is based on CISD: An Operations Manual for CISD, Defusing and Other Group Crisis Intervention Services by J.T. Mitchell and G.S. Everly; adapted with permission from Mayflower Crisis Support Team – Crisis Support and Operational Guidelines.

Back to Table of Contents

I. History of the Peer Support Program

Agency Name's corporate Peer Support/CISM program was established in the early 1990's. While the corporate program included first responders, the County recognizes that staff in first response roles benefit from access to "peers" with lived experience; who understand the work culture. In the fall of 2014, the County's corporate Peer Support program was expanded, adding a dedicated emergency services Peer Support team.

Development of the Peer Support Steering (now Executive) Committee in the fall of 2013 was a collaborative effort between Human Resources and Emergency Services. Initial members of the committee included representatives from Human Resources, Management, corporate team coordinators and the clinical director (mental health provider).

II. Process

Following critical incidents, the Peer Support Team provides interventions primarily within but may also respond to corporate as well as out-of-jurisdiction requests. The focus of the program is to minimize potentially harmful effects of job stress; particularly in crisis or emergency situations as well as address regular life stresses as a means of building resistance and resiliency. The highest priorities of the team are to maintain confidentiality and to respect the feelings of the individuals involved. It is not the function of a team to replace professional counselling, but to provide immediate crisis intervention. Through the crisis support process, team members provide the tools and resources to potentially reduce stress related symptoms.

III. Types of Interventions

The type of intervention selected is based upon the Team's assessment and the plan they develop.

A. Pre-incident Education

Pre-indecent education aims to enhance resiliency; especially in individuals who may be at increased risk due to critical indecent and other forms of stress. Pre-incident education sessions are typically provided by the clinical director.

B. One-to-One Discussion

A brief, informal intervention which can be done in person or over the phone. The goal is to "normalize" the thoughts and feelings of an individual who may have been impacted by a critical incident or other stressful situation.

C. Rest Information Transition Services (RITS) or De-escalation

A brief two-phase, large information group that can be followed by informal discussion. The primary purpose is prevention and education. Only used in the case of disasters or large scale traumatic events.

Back to Table of Contents

D. Crisis Management Briefing (CMB)

Crisis management briefing (CMB) is a practical four-phase group crisis intervention that aims to reduce anxiety by a direct presentation on what is known and unknown about a given critical incident. Typically, information regarding typical reactions to a critical incident as well as a review of coping strategies and resources/supports are provided.

E. Defusing

A small, brief structured group discussion conducted shortly after the incident; typically before staff leave the workplace at the end of the shift. The primary purposes are assessment, triaging and acute symptom mitigation. A defusing is a shortened form of a debriefing and may eliminate the need for a formal debriefing.

F. Critical Incident Stress Debriefing (CISD)

Conducted within 24-72 hours of the incident, but may occur later in some circumstances. A confidential, non-evaluative discussion of the thoughts, reactions and feelings resulting from the incident. Discussion may include education regarding possible stress-related symptoms and coping strategies.

G. Follow-up and Referral Procedures

Commonly post-intervention follow-up consists of two to five contacts with individuals who have been identified as displaying signs of stress. Follow-up may consist of in-person or telephone contact with selected individuals to ensure they are coping well. These are typically brief, informal discussions. Referrals to resources within an outside of Agency Name are a natural extension of follow-up. Disability Management and the Employee and Family Assistance Program are examples of frequently used resources.

Back to Table of Contents

CISM DEFUSING

A. Introduction Phase
B. Exploration Phase
C. Information Phase

Process considerations may include:

- Arrange time and location of services. The location selected should be free from distractions.
- Only staff involved in the incident should be invited to the intervention (i.e. debriefing) and encouraged to attend. Those included will be carefully considered in the assessment and strategic plan developed by the Peer Support team.
- Management and command officers are encouraged to relieve staff who were asked to partake in the debriefing from duty so they are able to attend. The environment should be free from interruptions (e.g., phone calls, radios, media).

CISM DEBRIEFINGS

The Clinical Director or designated mental health professional (or experienced Team member) will be present at the debriefing. The team coordinator or other qualified team member will lead this process. CISD is held within one to ten days (3-4 weeks for mass disasters) after the incident. The CISD is confidential and the following format is used:

A. Introductory Phase
B. Fact Phase
C. Thought Phase
D. Reaction Phase
E. Symptom Phase
F. Teaching Phase
G. Re-Entry Phase

The initial debriefing may result in confidential referrals and/or one on one intervention as necessary.

DEBRIEFINGS AND DEFUSING RULES

- All information discussed (i.e. statements, facts, opinions) shall be considered confidential. Exceptions may include sharing with Team members or as part of the team quality review process.
- Attendance is strongly encouraged for those identified during the team assessment, however is not mandatory. Attendance will be determined and controlled by the team.
- Each attendant will be encouraged to freely express themselves; no criticism or operational review is permitted.
- There will be no formal recordings or written notes of the session.
- Media personnel shall not be allowed to attend a debriefing.
- Interventions will occur in a private location away from outside observation.

Back to Table of Contents

V. The Crisis Support Process and Team Activation

- The Peer Team can be activated by any individual via Communications (Refer to Appendix II SOP 638A).
- The Peer Team member who accepts the call from Communications (Telestaff) will assume the lead role (i.e. coordinating team member participation and planning the appropriate interventions); in consultation with the Clinical Director. The Team Lead will assess the need and determine the appropriate response (i.e. defusing, debriefing, one on one intervention or a referral). Refer to pages 4-5 for a detailed description of CISM interventions.
- The Team Lead coordinates the response (i.e. selects/schedules available members). To assure the quality of the process, the team will consist of two or three Team members and the Clinical Director where appropriate. Team members who were involved in the incident will not act in a Peer Support role.

VI. Team Standards and Guidelines

- Team members will be selected using the criteria outlined by the International Critical Incident Stress Foundation (ICISF).
- All members of the Team will receive individual/group training in CISM consisting of the following minimum requirements: Assisting Individuals in Crisis and Group Crisis Intervention.
- Team members will be current employees from within.
- Members will attend a minimum of four meetings as well as eight hours of mandatory training per calendar year.
- Team members will participate in at least one intervention annually.
- ICISF protocols will be adhered to for all critical incident stress interventions.
- It is the responsibility of team members to monitor each other's performance. Feedback and concerns should be expressed directly to the peer and then brought to the attention of the team coordinator and clinical director.
- Agency Name corporate policies and procedures will be observed at all times.
- All information acquired by the Team during interventions and Team meetings will remain confidential.
- Team composition and membership will be evaluated annually, and recruitment efforts undertaken as needed to expand the team.

VII. Team Structure

The Agency Name Peer Support Executive Committee provides strategic direction and oversight with respect to the operation of all Peer Support programs. The goal is to ensure best practices, accountability and standards are set and maintained by the team's operating under their direction. Roles are outlined as follows:

A. Team Coordinator (member of executive committee)

The team coordinator is responsible for the overall management and operation of the team. Team coordinators will hold certification in Critical Incident Stress Management (CISM) and extensive knowledge regarding critical incident stress; in a general sense and unique to the emergency services field.

Back to Table of Contents

Qualifications:

- Current, basic and advanced-level CISM training
- Significant employment history within emergency response
- Experience leading debriefings and defusings

Duties:

- Oversee general operation of the Peer Support team
- Ensure team members adhere to applicable policies, procedures and operating guidelines
- Ensure that requests for Peer Support/CISM services are received and responded to in accordance with the ICISF model.
- Partake in the development of team policies and procedures
- Lead the Peer Support team selection and evaluation process
- Coordinate training of the team, officers, and staff in general
- Plan and coordinate team meetings
- Solicit membership interest
- Evaluate membership needs

B. Clinical Director (member of executive committee)

The Clinical Director is responsible for overseeing the delivery and quality of Peer Support services.

Qualifications:

- Regulated mental health professional (i.e. registered psychologist)
- Basic and advanced CISM training
- Experience responding to and providing clinical services to first responders

Duties:

- Integration with Agency Name Emergency Services and Human Resources.
- Work closely with the team coordinator to ensure team performance and quality assurance
- Advise team coordinator regarding the development of written policies and procedures for the Peer Support team, as well as appropriate continuing education
- Advise team coordinator in establishing protocols for debriefings and team selection
- Provide clinical support and advice to team coordinator and other team members as needed
- Develop criteria for selection of team members; assist in selection process
- Arrange for debriefing of staff and coordinate further services as appropriate
- Monitor and deliver debriefing program activities and offer suggestions regarding follow-up services
- Conduct routine reviews of team records, reports, and services
- Conduct annual reviews of individual Peer Support team members regarding fitness to continue in role
- Develop training and deliver seminars for team members every 6 weeks on topics relating to Peer Support

Back to Table of Contents

- Recommend and/or lead cross-training programs for Peer Support team members
- Represent the Peer Support program before Agency Name staff, the public and other organizations as required
- Work with Communications and Administrative Assistant to maintain current list of referral sources

C. Dispatch/Communications Center

Duties:

- Receive requests for services.
- Initiate team call-out as per SOP# 638A Activation – Critical Incident Stress Management Team.

D. Human Resources (member of executive committee)

Work collaboratively with management team representatives to oversee Peer Support team functions. Representatives from human resources, such as those who manage EFAP programs, disability, return to work and related issues will contribute in terms of occupational stress exposure and CISM/Peer Support components of comprehensive wellness initiatives. Human Resources representatives will also respond to requests for information on Peer Support and related programs/resources. Records regarding team activities (i.e. CISM intervention tracking sheets) are forwarded to Disability Management for confidential record keeping.

E. Management (member of executive committee)

Work collaboratively with Human Resources representatives to oversee Peer Support team functions.

F. Administrative Support

Duties:

- Develop and post literature, videos, etc. for distribution and Agency Name intranet (Insider, Yardstick, etc.)
- Develop team resources and reference materials as directed by team coordinators and clinical director
- Manage administrative functions of Peer Support team including scheduling team meetings, writing meeting agendas and minutes; etc.
- Maintain current list of referral resources as outlined by the clinical director
- Maintain current team member contact list

G. Peer Support Team Members

Peer Team members may include representatives from all divisions who have made a commitment to volunteer their time, energy and expertise to the Peer Support program. Peer Support team members function as facilitators of the intervention process and actively promote the Peer Support program among their peers.

Back to Table of Contents

VIII. Team Member Duties and Responsibilities

Duties:

- Receive requests for Peer Support
- Assess and develop an intervention plan based on ICISF CISM principles
- Contact/collaborate with team coordinator and clinical director as required
- Lead group interventions and provide individual consultations where appropriate
- Maintain confidentiality throughout the CISM/PS process
- Attend the mandatory training hours the minimum of team meetings per year (refer to Team Meeting Expectations below for further information)
- Report services delivered using the Initial Contact Checklist and/or Peer Contact Support forms (refer to Appendices IV and V, respectively). Submit completed forms to Disability Management.
- Attend team meetings and training as outlined in the Team Contract (Refer to Appendix V).
- Shall contact the Clinical Director within four (4) hours of having contact with a peer who is at risk of self-harm/suicide.

IX. Team Membership

The following process applies to Team membership:

A. Team members serve for a minimum period of one year.

B. A member wishing to resign their membership should discuss the matter with the Team Coordinator, and submit a resignation in writing.

C. Team members may request a leave of absence for a limited period of time. The following process applies.

- All requests for a leave of absence must be submitted in writing to the Team coordinator via email or letter.
- Requests must specify the length of the leave requested.
- Team members on a leave of any length are placed on the LOA/inactive portion of the Team Roster.
- A leave of up to four months may be granted with automatic return to previous status.
- A leave of four to eight months may require refresher training as determined by previous experience with the Team.
- All Team members on leave of absence must review Team meeting minutes/activities upon their return to work.
- A leave of absence will only be granted after six months of active participation on the team.
- Membership is evaluated annually. Current members may remain on the Team based on attendance and Team participation and function within Team protocols.

Back to Table of Contents

D. Selection and Recruitment of Team Members:

- The Team Coordinator will invite nominations and will communicate the process through the appropriate channels within the department. Discussion within the nomination process could include input on the qualities required in a team member, such as: maturity, the respect of peers, ability to maintain confidentiality, sensitivity to people's needs, willingness to function as a team player, and a desire to undertake and maintain the necessary education/training.
- The Team Coordinator or designated team member, as well as the Clinical Director, will conduct interviews with nominated candidates and will send selected individuals onto the required training.

E. Training Levels:

- All Peer Support team members must complete a four-day ICISF approved Basic CISM Training course.

F. Compensation:

- Team members are compensated at 1.5x as per the Collective Bargaining Agreement for their attendance at team meetings and training sessions.
- For information regarding team deployments (i.e. out of jurisdiction requests), refer to Appendix VI – Peer Support Team Deployment Compensation Guide.

G. Team Meeting and Training Expectations:

Participants in regularly scheduled (every 6 weeks) meetings will:

- Indicate attendance status (accept or decline) meeting invites to facilitate agenda planning (i.e., training activities)
- Arrive on time as scheduled
- Be prepared for meetings; includes review of pre-circulated materials
- Attend the minimum number of team meetings per year (4) as outlined in Appendix III – Peer Team Contract.
- Focus the conversation on stated objectives
- Keep all intervention reports and meeting discussions strictly confidential
- Maintain updated contact information with the Team Coordinator; including phone numbers and email address.
- Submit any agenda items the Peer Support Team Coordinator prior to the meeting.

X. Revocation/Suspension of Membership

A. Membership is revocable at the discretion of the Team Coordinator and Clinical Director on the recommendation of a Peer Review Board Revocation is applicable for, but not limited to the following:

- Failure to be present at an assigned intervention, when the Team member has made a commitment to do so.
- Any misrepresentation of the Peer Support Team.
- Continued absenteeism at regular meetings (refer to team contract).

Back to Table of Contents

- Acting against the expressed direction of the Team Coordinator or Clinical Director.
- Violation of confidentiality; except in cases where a team member identifies the risk of harm (need to report to Clinical Director; refer to VII. Team Member Duties and Responsibilities).
- Failure to follow protocols and directives regarding Team activity.
- Any behaviour determined to be unethical by the Peer Review Board.
- Any behaviour that has the potential to damage the reputation or credibility of the Team.

B. Peer Review Board Procedures

1. A Peer Review Board shall be selected by the Team Coordinator and Clinical Director to evaluate any criteria for membership revocation or suspension. The Board will consist of the clinical director and two other active members of the Team if the incident involves a clinical matter. For non-clinical matters, any three (3) Team members may be selected.

2. For clinical issues the following procedures apply:

a. The Peer Review Board shall meet or discuss the problem by phone with the member within 72 hours of notification.
b. The Peer Review Board shall file a written report and recommendations within 48 hours to the Team Program Coordinator
c. The Team Coordinator or Clinical Director will initiate the disciplinary action recommended by the Peer Review Board.

3. For non-clinical issues the following procedures apply:

a. The Peer Review Board shall meet with or discuss the problem by phone with the member within a one-week period following notification.
b. The Peer Review Board shall file a written report with the Program Coordinator within one week of the meeting.
c. The Team Coordinator or Clinical Director will initiate the disciplinary action recommended by the Peer Review Board.

XI. Peer Support and Values

The Peer Support program embraces the department values which align with Agency Name's corporate values of Integrity, Respect, Safety, Fairness, and Co-operation. Peer Support team members demonstrate our values by:

Value	All members demonstrate these values:	Peer Team members also demonstrate these values by:
Respect	We honour those we serve and those who serve with us.	We demonstrate respect in all interactions and approach individual differences in a non-judgmental manner.
Synergy	We work together	We demonstrate equality

Back to Table of Contents

SECTION 7
Response Guidelines for Emergency Services CISM Terms For Major/Significant Incident(s)

7.1 - Purpose

This document adheres to the principles and practices as set out by the International Critical Incident Stress Foundation (ICISF).

These guidelines will assist Critical Incident Stress Management (CISM) teams and local Emergency Services involved in, or exposed to, incidents with potential for Critical Incident Stress (CIS) injuries, and guide the coordinated delivery of CISM resources during and after a significant incident affecting Emergency Service personnel.

For the purposes of these guidelines, incidents like the 2011 Slave Lake wildfire, 2013 Southern Alberta floods, and the 2016 wildfires in the Regional Municipality of Woodland Buffalo are examples of significant incidents.

7.2 - Background

Experience in Alberta with significant incidents has demonstrated that Critical Incident Stress Management is a critical element of emergency response. CISM response should begin as early as possible and be carefully managed, especially for events of long duration.

In Alberta, the primary responsibility for dealing with emergencies, such as a tornado, flooding or transportation accidents, rests with the local municipality as set out in the Emergency Management Act (RSA 2000 Chapter E-6.8) and the Municipal Government Act (RSA 2000 Chapter M-26). The Alberta Emergency Management Agency is mandated to monitor declared municipal emergencies or impending situations in the province, and to assist municipalities with their responses. In general terms, the province supports the community and coordinates response of provincial ministries/agencies to community emergencies.

It is important for all emergency responders, public safety personnel, and non-response personnel acting in a response role (such as municipal staff, volunteers, or members of industry), collectively referred to as responders, to recognize the signs and symptoms of critical incident stress so they can take appropriate actions to mitigate its effects. It is equally important for those responders to help prevent critical incident stress amongst their co-workers.

The delivery of CISM resources/services at any incident relies on the effective management of five key areas:

- Coordination & Command Management
- Assessment of CISM needs of affected personnel,
- Development of strategies and plans for CISM service delivery;
- Implementation of the plan;

Back to Table of Contents

- Reviewing strategies and plans;
- Liaison with agencies, organizations, governments affected/responding to the incident and;
- Supervision and management of the four other key areas of CISM.

Operations Management:

- Deployment/supervision of CISM services (location, timing, trained peers and MHP's coordination, etc.);
- Supervision of CISM operations, and;
- Determination of necessary resources.

Administration/Finance Management:

- Record keeping;
- Purchasing (supplies, accommodations, food, etc.);
- Invoicing;
- Accounting;
- Filing of reports and claims, and following up as necessary, and;
- Other functions as required to support effective team operations.

Logistics Management:

- Securing locations and/or equipment for operations and service delivery;
- Arranging accommodations, transportation, communications, and other required infrastructure and supports to allow for effective delivery of services.

Planning Management:

- Collecting, evaluating and disseminating CISM tactical information;
- Preparing forecasts for future needs;
- Reacting to incidents/emergency demands and subsequent CISM demands, staff/resources, etc.

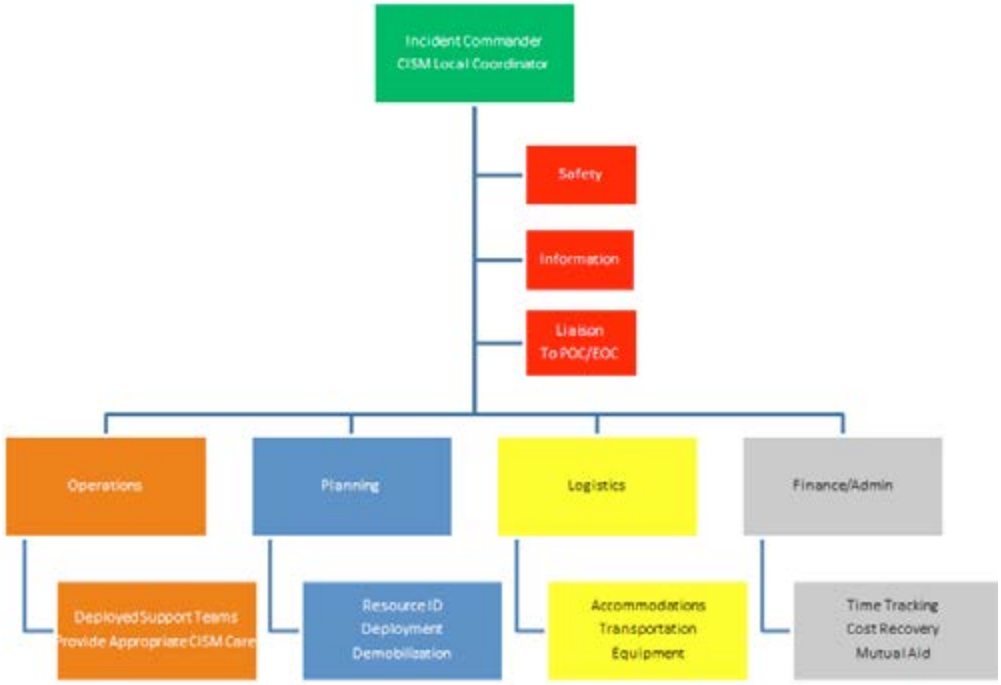
NOTE: Unless otherwise delegated, these functions/considerations must be accounted for by the Incident Commander.

CISM response will follow Incident Command Systems principles and techniques to promote interoperability and effective collaboration. While other terms and organizational considerations may be adopted, ICS is the incident management framework that underlies the CISM deployment efforts.

Personnel deployed in support of CISM response should have, at minimum, Incident Command System Level 200 training to operate effectively and support CISM incident response.

Back to Table of Contents

7.3 - Initial Engagement of CISM Resources



Initial Response

- It is typical that CISM team(s) at or near the incident will be the first CISM personnel to be aware of any major or significant event. The local or near-incident CISM team is expected to initiate a response to the incident.

7.4 - Appointment of the CISM Local/Incident Coordinator

- The Incident Commander in the EOC or local command post should determine the need for CISM resources if not yet activated.
- If sufficient resources are available and not yet activated, the Incident Commander will appoint a CISM Local Coordinator, assemble a CISM Team and initiate response to the incident.

The Local Team is expected to:

- Establish an operational contact point.
- Appoint a CISM Local/Incident Coordinator if the Incident Commander has not yet done so.
- Make an assessment of the potential CISM response needed and make calls to the POC and partner agencies for assistance as early as possible.

Back to Table of Contents

- Access additional resources early enough so as to prevent undue burden, stress, or harm to Team Members or FRs.
- Provide services appropriate to the need and to the level possible

Initial requests for assistance can be directed to:

- Alberta Critical Incident Advisory Committee/Alberta Critical Incident Provincial Network
  Go to **www.abcism.ca** *to find current contact list for the province of Alberta*
- Alberta Health Services EMS CISM Provincial Coordinator
- Alberta Police Departments: Resources/programs department specific, consult local contacts according to municipality/region/RCMP CISM Coordinator
- Fire: Contact through Office of the Fire Commissioner through the POC
- Local Employee Assistance/Family Assistance Programs as available
- The International Critical Incident Stress Foundation: phone - (410)-750-9600 M-F 9:00AM-5:00PM; fax - (410)-750-9601; **www.icisf.org**
- ICISF Emergency Hotline: (410)-313-2473; For emergency workers ONLY, if they require guidance in working through the stress of a distressing situation.

Major Emergency CISM Response:
The coordination of CISM responders can be facilitated at the local level or from a remote location, such as the Provincial Operations Center (POC) or local EOC/ECC, or both.

The Local Coordinator's role is to:

- Assume role of Incident Commander for CISM support efforts.
- Be the primary CISM contact for personnel involved in the incident.
- Provide a strategy and action plan for CISM resource development.
- Ensure that five key management areas (Coordination/Command, Operations, Planning, Administration/Finance and Logistics) are being addressed.

The Remote Coordinator's role is to:

- Support the local role.
- Plan for CISM personnel acquisitions and deployment.
- Work with the Local Coordinator to ensure that five key management areas are addressed.
- Assist in financial management as required.
- Liaise with the POC to ensure coordination of resources at the local and provincial levels.

Back to Table of Contents

7.4 - Appointment of the CISM Local/Incident Coordinator

NOTE: This is the CISM staff work area, not an area for reactive service delivery.

NOTE: People may be required to staff the location for several days. Consider providing costs, sleeping bags, a refrigerator, microwave oven, and other day-to-day necessities. If the POC has assigned a provincial CISM coordinator, consider contacting them for assistance.

CISM Local Coordinator/Incident Commander/Near-Site Coordinator:

- Establish a CISM operations location that allows a CISM incident coordinator reasonable access to incident command staff, emergency operations Center, CISM responders, etc.
- Ensure that the CISM operations location has the required tools (e.g., paper and pens/pencils, flipchart/markers, on phone access, two-way radios, electrical power, heating/cooling, washrooms, etc.) and is secure.
- Ensure that all CISM responders have adequate identification
- Advise the incident command staff, local coordinators, supporting/assisting agencies, etc. of function, capabilities and limitations (i.e., CISM assessment, pre-deployment, Crisis Management Briefings, on scene support, RITS, defusings, CISDs, etc.) of the Local Coordinator/Incident Commander.
- Provide advice and assistance to Incident Commanders regarding ongoing stress management, shift rotations, work engagement, and meeting the rest, nutrition, personal needs (washing, showers, toilets, etc.) of the team.
- In conjunction with command staff/EOC., locate and set up areas for reactive services.
- Attend EOC operational debriefings, as required.
- Contact the AEMA field officer as dictated by the situation.
- Ensure availability of appropriate clinical supervision for CISM personnel as required.
- Determine staff levels (peers and/or MHP) required to facilitate CISM services, and other necessary resources.
- Establish schedules for CISM personnel. NOTE: 24/7 scheduling for any or all of the CISM response. The maximum recommended incident contact time for CISM responders 4 to 7 days.
- Brief all incoming CISM personnel on the incident, CISM services being delivered, CISM staff at the incident, and CISM supervisory hierarchy.
- Provide the opportunity for all departing CISM personnel to be debriefed.
- Provide education sessions for partners of emergency services and EOC staff at conclusion of incident, or after release from all incident duties.
- Keep accurate and detailed records of services, contacts and other activities.
- Provide for relief of the CISM incident coordinator and ensure that the coordinator and relief staff are not directly involved with the delivery of CISM services.
- Identify when CISM resources are no longer required, or when CISM resources need to be relieved for sustainment purposes.
- Coordinate with the Provincial CISM Coordinator, POC, and local IC for demobilization instructions for CISM resources.

Back to Table of Contents

- Ensure that demobilization takes place according to established procedures and that the Provincial CISM Coordinator arranges post-incident follow up with CISM resources.

Note: This could also be a remote coordinator working away from the incident or outside the affected area, but ideally within the POC or in close proximity to it.

Provincial CISM Coordinator:

- Receive briefing from the IC/EOC director and as soon as possible after appointment. The CISM Coordinator and Operations Manager will identify items requiring immediate attention.
- Establish and maintain regular contact with local CISM coordinator or deployed CISM team(s).
- Maintain adequate and accurate records for duration of the emergency.
- Contact local CISM team(s) involved or affected to determine their status and needs.
- Conduct an assessment of the emergency and/or affected area as required.
- Assist local CISM resources.
- Be prepared to inform Emergency Services, EOC's, and other involved service providers, regarding Critical Incident Stress, how it can be mitigated, and contacts for trained CISM team(s).
- Alert non-affected CISM team(s), as appropriate, to the emergency and potential for their deployment. Alerted teams should be updated at least every 48 hours throughout the emergency, and be informed of termination or stand down as soon as possible.
- Contact the ICISF Hotline, as required.
- Provide for relief of provincial the CISM coordinator and ensure that the coordinator and relief staff are not directly involved in delivery of CISM services.
- Identify when CISM resources are no longer required, or CISM resources need to be relieved for sustainment purposes.
- Coordinate with the CISM Incident Coordinator, POC, and local IC for demobilization instructions for CISM resources.
- Ensure demobilization takes place according to established procedures.
- Liaise with the POC and municipalities/organizations to ensure appropriate post-incident resources are made available and followed up with deployed CISM personnel.

Back to Table of Contents

1. Establish practical, efficient strategies to reach set goals.
2. Establish short term (8-12 hours) practical objectives to measure progress.
3. Assign responsibilities to specific people and timelines for specific events.
4. Maintain open communication with all team members and the officials on site.
5. Review and revise all plans as necessary.
6. Manage demobilization procedures and coordination of follow-up resources.
7. Acknowledge completion of deployment.
8. Conduct an operational debriefing to celebrate the successes and determine learnings.
9. Follow up with CISM Teams and other personnel deployed at the incident.

Implementation of Guidelines:

1. 1. Threat Assessment - Is there a risk factor to the responders and the community? If threat exists, a threat mitigation strategy must be completed and implemented before peers are sent in. If the threat is not able to be mitigated, set up a staging area for peer support in a safe zone.
2. Target - What target population will most likely need assistance or support, and what is the priority order for those people within the community being served? What can be done to provide the assistance/support for that target population?
3. Type - What specific types of interventions will be needed or required?
4. Timing - When will each of the selected interventions be implemented so as to be most effective, and for how long and at what frequency? When is appropriate to conclude the interventions?
5. Themes - What factors may serve to modify the psycho/social impact of the event, nature of the intervention, and/or decisions impacting CISM personnel and the community at large?
6. Team - What internal resources will be required to maintain effective and efficient assistance? What resources are required to provide effective interventions/support at the right times and places, and for how long? The CISM team members providing supports and interventions should be aligned with the target population (peers align with peers) as there may be variation between some peers due to training, history, and experience. Some team members may be more qualified to provide certain interventions due to training and experience. These CISM team members should also be available and committed to follow through all the way to the end.
7. Follow-Up Engagement with the community, Emergency Operating Council of the community, the community at large, and CISM teams to determine the timing and type of interventions to be assessed, on an as-needed basis.
8. Operational Evaluation - Determining adherence to guidelines and protocols and discussion of what worked and what did not, leading to recommendations for changes that are likely to positively impact the resourcefulness of the team?

Back to Table of Contents

SECTION 8
Quality Improvement & Research

8.1 - Quality Improvement

A Quality Improvement (QI) program involves systematic activities organized and implemented by an organization to monitor, assess, and improve the quality of services it delivers.

The understanding, planning, and proper implementation of a QI program is essential to improving efficiency, safety and outcomes for the service providers and recipients. Successful QI programs and processes are developed and implemented with five core principles:

1) Establish a culture of quality.
    - Processes and procedures should be integrated within, and support, QI efforts.
    - "QI Culture" looks different for every organization. Adhering to core principles ensures a dedicated QI process, as does holding regular QI meetings and/or providing regular QI information to service providers and recipients
    - Creating policies around the QI goals.
2) Determine and prioritize potential areas for improvement.
    - Identify and understand the ways in which services could be improved.
    - Examine the population served and identify;
        - barriers to services,
        - frequently diagnosed chronic conditions,
        - groups of high-risk situations or individuals at high risk and,
        - operational or provider issues such as morale, communication, burnout.
3) Data collection and analysis lie at the heart of quality improvement.
    - Data will help you understand how well your systems work, identify potential areas for improvement, set measurable goals, and monitor the effectiveness of change.
    - It is important to collect baseline data before you begin a QI project, commit to regular data collection, carefully analyze your results at the end of the project, and make decisions based on your analysis.
4) Communicate your results.
    - QI efforts will affect your staff members and those receiving support, and must be managed so as to mitigate negative impact. As you plan and implement a QI project, communicate your project needs, priorities, actions and results to the entire practice, including supported individuals. Remember to celebrate and acknowledge your successes.
5) Commit to ongoing evaluation.
    - Quality improvement is an ongoing process.
    - A high-functioning practice will strive to continually improve performance, revisit the effectiveness of interventions, and regularly solicit feedback from staff and supported individuals.

QI and ACIAC – CISM

Quality improvement will be included in the implementation and ongoing operation of the Provincial Network of CISM. QI shall be monitored through establishing protocols that enable peers and provider submission. The peer resource guide and standards of operation, along with the peer contract, will outline expectations for this feedback.

Back to Table of Contents

8.1 - Quality Improvement

Collection of data will be the responsibility of the Provincial CISM Coordinator and Clinical Director. The data will be reviewed and analyzed three times per year, and reported to stakeholders at least once per year. Ongoing review of policies and operational guidelines will be conducted to ensure that any emerging issues, gaps, or additional resources are identified and addressed.

Key component of QI reporting and monitoring will be:

- Peer Activity Monitoring
- Peer Rating of the quality of their activities and interactions
- Customer Service Surveys, rating the quality of peer interactions.
- Emerging trends and issues
- Department Surveys
- Stigma Reduction
- Change in key areas such as attrition, lost time, disability costs
- Utilization and Accessibility
- Emerging trends and issues
- Program Utilization
- Service Successes and Gaps
- Training Successes and Gaps
- Quality of Approved Instructor Training
- Emerging trends and issues in the target populations

8.2 - Overview of CISM Research

Historically, understanding the behavioural sciences has been based on data generated from well-controlled efficacy research[1].

Efficacy research typically uses randomized experimental designs[2] with one or more control groups contrasted against an experimental group, which is done to address issues of internal validity[3]. The methods produce a valid representative sample of a larger population where the results can be generalized to the larger population and are representative of the larger population. This process is called external validity[4].

Pioneering psychologist and past president of the American Psychological Association, Dr. Martin Seligman, has argued for the power of nonrandomized experimental and even survey designs (Seligman, 1995). Seligman argues that, given the currently available tools and logistics, efficacy studies may be inappropriate for researching crisis responses because the data collected omits critical characterization of real-time elements, such as the competence level of the interventionist, the real-time self-correcting nature of the intervention, and the complex nature of precipitating stressors (Mitchell, 2010). Instead, Seligman recommends using effectiveness studies rather than efficacy studies. Effectiveness studies[5] differ from efficacy studies in that efficacy determines whether an intervention works under ideal circumstances (i.e., randomized-control-trials), while effectiveness addresses whether the intervention works under ordinary or real circumstances (i.e., non-randomized-control-trials).

Back to Table of Contents

8.3 - State of Past Research

Past research is presented as a means of highlighting the methodology used, and the type of data and conclusions that can be derived. ACIAC encourages participation and contribution to the body of research in Peer Support and CISM. ACIAC supports academic and research partnerships that can inform and support ongoing research in this area. When used properly, surveys can be valuable methods for acquiring data analysis on a CISM intervention or program.

Example 1

Robyn Robinson and Jeffrey Mitchell (1993) used a survey design to assess the effectiveness of one of the CISM interventions; Critical Incident Stress Debriefing (CISD). Participants in the study consisted of 288 Australian emergency services, welfare, and hospital personnel who had taken part in 31 CISDs from December 1987 through August 1989. Responses were received from 172 (60%) of the surveyed group. The emergency services personnel, and the welfare and hospital personnel, reported a reduction in crisis-related symptoms by 96% and 77%, respectively, which they argued was due to CISD (Mitchell, 2010).

Example 2

Nancy Bohl (1991), assessed mandatory CISD on law enforcement officers who had experienced a critical incident. The effectiveness6 of the CISD was assessed 3 months post-incident, utilizing standardized written psychometrics. Officers who had received the CISD within 24 hours of the incident (n=40) were compared to officers who received no CISD (n=30). Those who received the CISD reported being less depressed, less angry, and having fewer stress-related symptoms than those who received no CISD. This study has been accepted as valid and reliable research that demonstrates that CISD can have an impact (Mitchell, 2010). These findings have been replicated in at least two other studies (Bohl, 1995; & Hokanson 1997).

In a follow-up investigation, Bohl (1995) studied the effectiveness of CISD upon 30 firefighters who received the CISD compared with 35 firefighters who did not receive the CISD at about 24 hours after a critical incident. Anxiety symptoms measured at 3 months post-CISD were found to be lower in the CISD group compared to the control group (Mitchell, 2010).

Example 3

The Los Angeles County Fire Department (LACoFD) CISM program was evaluated through the dissemination of 3000 research surveys (Hokanson, 1997). Of the 3000 disseminated, 2124 were completed for a 70.8% return rate. Of the 2124 respondents more than 600 indicated that they had participated in a CISD (Mitchell, 2010). The survey assessed for both perceptions of the CISM Program and the reduction of pre-post symptoms. They used a Cochran's Q test to compare the distributions and found that the probability of significant symptom reduction within one week or less was significantly higher when respondents participated in a CISD (74.7%) than when they did not (64.8%). For those incidents for which there was a CISD offered, respondents reported significantly less time bothered by symptoms than for those incidents that there was not a CISD offered (Hokanson & Wirth, 2000).

Back to Table of Contents

8.4 - Future Research

More longitudinal research[7] in the area of CISM is required in order to evaluate its effectiveness and, if possible, its efficacy. CIPSRT at the University of Regina recently published a blue paper supporting the use of Peer Support models and advised adopting a single standardized model of program delivery to facilitate research (Carleton, et al., 2016). According to the blue paper, the improvement and effectiveness of Peer Support and crisis-focused intervention programs would benefit from an increase in research using standardized methods and the incorporation of rigorous methodological designs and outcome measures. The blue paper suggests that increased uniformity for Peer Support and crisis management models would ensure that minimum standards are followed, facilitate research, and provide enhanced support for first responders and other public safety personnel who endure regular exposures to potentially traumatic events as part of their work.

CISM should not be compared to psychotherapy or studied as if it were psychotherapy. CISM should be studied as a package of integrated and phase sensitive interventions, as none of the individual components of a CISM program were designed to be used as independent from the other components. Those studying CISM should be thoughtful in choosing outcome measures as CISM does not purport to cure a disease or prevent any mental health disorder (e.g., PTSD). Thus, CISM must be assessed for its intended purposes and not for those beyond its scope.

Back to Table of Contents

Seligman, M.E.P., (1995). The Effectiveness of Psychotherapy. American Psychologist, vol. 29, (12), 965-974.

Mitchell, J., (2010). Group Crisis Support: Why it Works, When & How to provide it. CHEVRON Publishing Corporation.

Bohl, N., (1995). Measuring the effectiveness of CISD. Fire Engineering, 125-126.

Hokanson, M., (1997). Evaluation of the effectiveness of the Critical Incident Stress Management Program for the Los Angeles County Fire Department. Los Angeles: LACoFD.

Carleton, R. N. et al., (2016). Peer Support and Crisis-Focused Psychological Intervention Programs in Canadian First Responders: Blue Paper. University of Regina, the Canadian Institute for Public Safety Research and Treatment. The Full Report can be found at: **http://www.justiceandsafety.ca/rsu_docs/blue_paper_full_web_final_production_aug_16_2016.pdf**

Robinson, R., & Mitchell, J., (1993). Evaluation of Psychological Debriefings, Journal of Traumatic Stress, 17, issue 5, 367-382.

Back to Table of Contents

i) Research Terms

EFFICACY STUDIES: Research projects that use randomized experimental designs with one or more contrasted groups, typically in laboratory environments, to assess the impact of a given program or intervention.

RANDOMIZED EXPERIMENTAL DESIGNS: A study in which people are allocated at random to receive one of several clinical interventions. One of these interventions is the standard of comparison or control. The control may be a standard practice, a placebo, or no intervention at all.

INTERNAL VALIDITY: In Randomized Control Trials (RCT), each subject has an equal chance of being assigned to control groups or experimental groups. This isolates the treatment (independent variable) as the primary source of measured effect or outcome (dependent variable). Thus, randomization is a process, not an outcome.

EXTERNAL VALIDITY: Refers to the generalizability of research data. Subjects must be a representative sample of the larger population to which results are to be generalized.

EFFECTIVENESS STUDIES: Research projects that use non-randomized experimental designs to assess the impact of a given program or intervention within a natural environment, as opposed to laboratory environments that can control more variables.

EFFECTIVENESS: The degree to which an intervention is successful at producing a desired result. When something is deemed effective, the results indicate the intervention does what it was intended or expected to do.

LONGITUDINAL RESEARCH: A longitudinal study is an observational research method in which data is gathered for the same subjects repeatedly over a period of time. Longitudinal research projects can extend over years or even decades.

Back to Table of Contents

ii) Additional Research Terms

CROSS-SECTIONAL RESEARCH: A form of observational study where analyzed data was collected from a population, or a representative subset, at a specific point in time.

DESCRIPTIVE STUDIES: Observational studies which describe the patterns of disease occurrence in relation to variables such as person, place and time. Descriptive studies provide knowledge about which populations or subgroups are most or least affected by disease. This enables persons such as public health administrators to target particular segments of the population for education or prevention programs and can help allocate resources more efficiently. Descriptive studies identify descriptive characteristics, which frequently constitutes an important first step in the search for determinants or risk factors that can be altered or eliminated to reduce or prevent disease.

EFFECT SIZE: A quantitative measure describing the strength of a phenomenon. Examples of effect sizes are the correlation between two variables; the regression coefficient in a regression; the mean difference; or even the risk with which something happens, such as how many people survive after a heart attack for everyone person that does not survive. For each type of effect size, a larger absolute value always indicates a stronger effect. Effect sizes complement statistical hypothesis testing, and play an important role in power analyses, sample size planning, and in meta-analyses. They are the first item (magnitude) in the MAGIC criteria for evaluating the strength of a statistical claim. Especially in meta-analyses, where the purpose is to combine multiple effect sizes, the standard error (S.E.) of the effect size is of critical importance. The S.E. of the effect size is used to weigh effect sizes when combining studies, so that large studies are considered more important than small studies in the analysis. The S.E. of the effect size is calculated differently for each type of effect size, but generally only requires knowing the study's sample size (N), or the number of observations in each group (ns).

QUASI-EXPERIMENTAL RESEARCH: Involves the manipulation of an independent variable without the random assignment of participants to conditions or orders of conditions. Quasi-experiments are subject to concerns regarding internal validity, because the treatment and control groups may not be comparable at baseline. In contrast, with random assignment, study participants have the same chance of being assigned to the intervention group or the comparison group.

STANDARDIZED MEASURES OR TESTS: Any form of assessment of test that (1) requires all test takers to answer the same questions, or a selection of questions from common bank of questions, in the same way, and that (2) is then scored in a "standard" or consistent manner, therein allowing for comparing the relative performance of individual respondents or groups of respondents. While different types of tests and assessments may be "standardized" in this way, the term is primarily associated with large-scale tests administered to large populations of respondents; for example, a multiple-choice test given to all the eighth-grade public-school students in a particular province.

Back to Table of Contents

SECTION 9
Appendix

9.1 - Acronym Legend

A

ACIAC: Albert Critical Incident Advisory Council
AEMA: Alberta Emergency Management Agency

C

CCISF: Canadian Critical Incident Stress Foundation
CI: Critical Incident
CIS: Critical Incident Stress
CISD: Critical Incident Stress Debriefing
CISM: Critical Incident Stress Management
CIPSRT: Canadian Institute for Public Safety Research and Treatment

E

EAP: Employee Assistance Program
ECC: Emergency Command Centre
EMR: Emergency Medical Response
EMS: Emergency Medical Service
EMT: Emergency Medical Technician
EOC: Emergency Operation Center

F

FR: First Responder

I

IC: Incident Command
ICISF: International Critical Incident Stress Foundation
ICS: Incident Command System

L

LACoFD: Los Angeles County Fire Department
LOA: Leave of Absence

M

MAGIC: Magnitude, Articulation, Generality, Interestingness, Credibility
MHP: Mental Health Practitioner
MVC: Motor Vehicle Crash

P

POC: Provincial Operations Centre
PSP: Public Safety Personnel
PTS: Post-Traumatic Stress
PTSD: Post-Traumatic Stress Disorder

R

RCT: Randomized Control Trials
RITS: Rest, Information, and Transition Services

S

SAFER-R: Stabilize, Acknowledge, Facilitate, Encourage, and Refer - Revised
SCES: Agency Name Emergency Services
SOP: Standard Operating Procedure

Back to Table of Contents

B

BEST PRACTICES IN CRISIS INTERVENTIONS: Refers to the standards of practice that the accrediting body ICISF promote and adhere to. These standards include, but are not limited to:

1. Early Psychological Intervention is valued
2. Specialized crisis intervention training is necessary
3. An integrated multi-component intervention system is required
4. First responder programs rely heavily upon "Peer Support"

C

COMMUNITY SUPPORT SERVICES: Includes, but is not limited to, victim services; services intended to provide psychological supports to secondary groups that are larger and more diverse than a primary group, such as local or rural communities.

COORDINATION: The process of systematically analyzing a situation, developing relevant information, and informing appropriate command authority of viable alternatives for effective combinations of resources available to meet specific objectives. The coordination process (which can be either intra- or inter agency) does not involve dispatch actions. However, some personnel who are responsible for coordination may also perform command or dispatch functions within the limits established by specific agency delegations, procedures, and legal authority.

COORDINATION CENTER: A facility used for the coordination of agency or jurisdictional resources in support of one or more incidents.

COST SHARING AGREEMENTS: Agreements between agencies or jurisdictions to share a set of designated costs related to critical incidents. Cost sharing agreements are typically written, but may also be oral agreements between authorized agency or jurisdictional representatives, reached at the incident.

CRISIS INTERVENTION: A temporary, active, and supportive entry into the life situation of an individual or group during a period of extreme distress.

CRISIS MANAGEMENT BRIEFING (CMB): A practical, four-phase, group crisis intervention that aims to reduce anxiety by a direct presentation on what is known and unknown about a given critical incident. Typically, this includes information regarding reactions to a critical incident, as well as a review of coping strategies and resources/supports.

CRITICAL INCIDENT: An event that is of the nature to elicit overwhelming, terrifying, disgusting, or unusually challenging occurrences that disrupt usual coping abilities, and have the potential to create either positive growth or significant psychological distress.

CRITICAL INCIDENT STRESS: Stress that results from exposure to a traumatic situation and where the individual's reaction to the event may involve intense fear, helplessness, or horror.

CRITICAL INCIDENT STRESS DEBRIEFING (CISD): A confidential, non-evaluative discussion, typically conducted within 24-72 hours of the incident, but may occur later, of the thoughts, reactions and feelings resulting from the incident. Discussion may include education regarding possible stress-related symptoms and coping strategies.

Back to Table of Contents

C

CRITICAL INCIDENT STRESS MANAGEMENT (CISM): A comprehensive, integrative, and multi-component crisis intervention system. CISM is considered comprehensive when the system consists of multiple crisis intervention components that functionally span the entire temporal spectrum of a crisis. CISM interventions range from the pre-crisis phase, through the acute crisis phase, and into the post-crisis phase. CISM is also considered comprehensive when the system consists of interventions that may be applied to individuals, small functional groups, large groups, families, organizations, and even communities. The 7 core components of CISM are summarized in TABLE 1. - ICISF Primer

CRITICAL INCIDENT STRESS MANAGEMENT TEAM (CISMT): A Critical Incident Stress Management Team is responsible for providing CISM Peer Support Services to their designated peers within their own department or region. The CISMT consists of CISM trained team members who operate under the supervision and guidance of a mental health professional, a CISM Coordinator, and a Team Lead.

D

DEFUSING: A small, brief, structured group discussion conducted shortly after the incident; typically, before staff leave the workplace at the end of the shift. The primary purposes are assessment, triaging, and acute symptom mitigation. A defusing is a shortened form of a debriefing and may eliminate the need for a formal debriefing.

DUAL OR MULTIPLE ROLE-RELATIONSHIP: When an individual assumes more than one role at a time when engaging with a person to whom they are providing Peer Support.

E

EMERGENCY OPERATIONS CENTERS (EOCS): The physical location at which the coordination of information and resources supporting. incident management activities. takes place. An EOC may be a temporary facility, or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, and medical services), by jurisdiction (e.g., Federal, State, regional, county, city, tribal), or some combination thereof.

EMERGENCY OPERATIONS PLAN (EOP): The plan that each jurisdiction develops and maintains for responding to appropriate hazards.

EVENT: A planned, non-emergency activity. ICS can be used as the management system for a wide range of events (e.g., parades, concerts, or sporting events).

F

FOLLOW-UP AND REFERRAL PROCEDURES: Post-intervention follow-ups commonly consist of between two and five contacts with individuals who have been identified as displaying signs of stress. Follow-up may consist of in-person or telephone contact with selected individuals. These are typically brief and informal discussions.

Back to Table of Contents

I

INCIDENT: An occurrence or event, natural or human-caused requires an emergency response to protect life or property. Incidents can include major disasters, emergencies, terrorist attacks, terrorist threats, wildland and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

INCIDENT ACTION PLAN (IAP): An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. The plan may identify operational resources and assignments. The plan may also include attachments that provide direction and important information for management of the incident during one or more operational periods.

INCIDENT MANAGEMENT SYSTEM (IMS): An organized system of roles, responsibilities and standard operating procedures used to manage emergency operations.

O

ONE-TO-ONE DISCUSSION: A brief, informal intervention which can be done in person or over the phone. The goal is to "normalize" the thoughts and feelings of an individual who may have been impacted by a critical incident or other stressful situation.

P

PEER SUPPORT: A formalized, acute psychological support technique that focuses on the peer-to-peer relationship between members of an existing, cohesive, homogenous group that have an established culture and shared experiences.

PRE-CRISIS PREPARATION: Stress management education, stress resistance, and crisis mitigation training for both individuals and organizations.

PRE-INCIDENT EDUCATION: Evidence-based education designed to enhance resiliency through various avenues (e.g., stigma reduction, resource access information) and typically provided by the Clinical Director.

PREPAREDNESS: Preparedness is the process of identifying the personnel, training, and equipment needed for a wide range of potential incidents, and developing jurisdiction-specific plans for delivering capabilities when needed for an incident.

PREVENTION: Actions taken to avoid the occurrence of negative consequences associated with a given threat; prevention activities may be included as part of mitigation.

R

RECOVERY: refers to the ability of an individual, a group, an organization, or an entire population to literally recover the ability to adaptively function within the cognitive, emotional, physical and behavioural domains in the wake of a significant clinical distress, impairment, or dysfunction subsequent to critical incidents.

REIMBURSEMENT: Mechanism used to recoup funds expended for incident-specific activities.

Back to Table of Contents

R

RESOURCE MANAGEMENT: The efficient and effective utilization of an organization's resources. Such resources may include Financial, Inventory, Human Skills, Production, or Information Technology.

RESOURCE TRACKING: A standardized, integrated process conducted prior to, during, and after an incident, by all emergency management/response personnel and their associated organizations.

RESOURCES: Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations, and for which status is maintained. Resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or emergency operations center.

RESPONSE: Immediate actions to save lives, protect property and the environment, and meet basic human needs. Response also includes the execution of emergency plans and actions to support short-term recovery.

REST INFORMATION TRANSITION SERVICES (RITS) OR DE-ESCALATION: A brief, two-phase, large group presentation of information that can be followed by informal discussion. The primary purpose is prevention and education. Only used in the case of disasters or large scale traumatic events.

S

STANDARD OPERATING GUIDELINES (SOG): A set of instructions having the force of a directive, covering those features of operations which lend themselves to a definite or standardized procedure without loss of effectiveness.

STANDARD OPERATING PROCEDURE (SOP): Complete reference documents or an operations manual that provides the purpose, authorities, duration, and details for the preferred method of performing a single function or a number of interrelated functions in a uniform manner.

Back to Table of Contents