



# *Critical Incident Stress Management Foundation Australia Newsletter*

Volume 7, Issue 1

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## *PRESIDENT'S REPORT Robyn Robinson*

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### **Special Points of Interest in the President's Report**

- **Response to the Tsunami and earthquake disasters**
- **International Critical Incident Foundation bi-annual Congress**
- **CISMFA Conference 2006**

**The Boxing day tsunami and further earthquakes** continue to be in the minds of many people. Assessment and assistance teams from Australia come and go and the needs of people in these regions continue to change. It is clear that different communities and countries have different requirements. In addition to lost lives and damage to property, what has also been lost in some cases is infrastructure and knowledge.

It is not surprising to find that the trauma of the tsunami is not the only trauma that is being responded to. Some people also hold unresolved past trauma experiences. Psychological assistance programs will need to address these matters.

As mental health is assessed, nationals trained and programs implemented, it needs to be recognized that understanding of mental health can differ significantly from country to country. There may be different values and beliefs about causes of human distress and what can help people and what can harm them. Special care is needed in introducing therapeutic approaches. I understand from brief discussions with those involved in the EMDR humanitarian assistance program that they are very aware of this. Several days training are spent prior to EMDR training, for these and other reasons. My own impressions, from running CISM trainings in Bangkok and Kuala Lumpur, are that the common sense nature of



CISM fits well with existing practices and is found to be particularly helpful. Nevertheless, just as for the introduction of therapeutic practices, it is important to understand and respect cultural and religious practices within these regions.

**The International Critical Incident Foundation held its bi-annual congress** in February this year. There were over 1,000 delegates. An excellent program was presented and included several important positive outcome studies. A summary of one of those studies is included in this newsletter and is titled "Worksite Crisis Intervention Helped New Yorkers Curb Level of Mental Distress For Up to Two Years After The World Trade Center Disaster".

The awards are a highlight of the congress and Australian winners included Mrs Trish Newton (who was key in establishing the Sydney surf lifesaving support team), and Mrs Patricia Murdoch who was given an award for life time achievement. Congratulations to both people.

## President's Report (cont).

*"There may be different values and beliefs about causes of human distress and what can help people and what can harm them. Special care is needed in introducing therapeutic approaches."*

On the plane home from this congress, it was my privilege to sit next to Jim Detrick, a retired police officer from Seattle, USA. He put forward the view, based on his lifetime professional experience, that offering peer support post shooting incidents not only supports officers but can increase the accuracy of their recall of incidents. I thought about how often I have heard the argument put that staff should be isolated following their involvement in matters that may come before the courts. The fear is that such contacts will distort their memory of events. Jim was on his way to Pakistan to teach at the National Police Academy in Is-

lamabad. He nevertheless kindly agreed to write an article for the newsletter and it makes interesting reading. Also included in this edition is an article by Peter Kueffer, Treasurer of CISMFA, on maintaining programs within organizations. Important points are raised that we would do well to keep in our mind if we are to run credible and responsible programs.

**The next CISMFA Conference** will be held early August 2006. We are delighted that Dr Atle Dyregrov has accepted our invitation to be one of the key-note speakers.

### *POST SHOOTING CONSIDERATIONS*

*Jim Detrick, Coordinator,  
King County CISM Team, Seattle, USA*

*"People normally react very strongly to gunfire. Time distortion may be increased. Threats seem closer. Perceptions more confused. The ability to give details made more difficult."*

Police Officers involved in shootings and lethal confrontations pose particular problems, especially where officers use force that resulted in the death of a suspect. They also create special considerations for those who wish to assist the officer by providing intervention or Critical Incident Stress Management services. Whether you are a mental health professional or a peer, here are some things to consider before applying your services in these situations.

Lethal confrontations normally require the officer to face a variety of things that they may not deal with in other critical incidents. Besides being life threatening, shootings may cause additional problems. People normally react very strongly to gunfire. Time distortion may be increased. Threats seem closer. Perceptions more confused. The ability to give details made more difficult. These reactions can be easily generated. I do a shooting scenario in classes to show officers what everyone involved may experience and how strong those reactions can be. This is not the type of shooting sce-

nario, where someone dynamically enters a room full of trainees, fills the room with gunfire, runs out, and then participants are asked to supply details about the suspect. In this scenario, participants are told what is about to occur. There are no surprises. The scenario is explained and they are told where the shooters will be standing and what will happen. They are then asked to close their eyes and visualize being involved in a situation where they confront an armed individual, normally in their own house. They are guided through the situation to the point of the confrontation. They then open their eyes to witness the demonstration. It is normally done in a semi darkened room with full charge blanks. A few seconds after their eyes open, the shooting occurs. The demonstration consists of two people with handguns, one on each side of the classroom, at the front. Participants have been told which of the two people they represent in the scenario. Once the shooting has occurred, weapons are concealed from view and participants are asked the following four questions. How many total shots were

## Post Shooting Considerations (cont).

fired? Who fired them? What was said? Who said it? Six shots are normally fired by one person. The other gun is always empty. Participants always disagree on the number of shots fired. Answers normally range from three to eight rounds. When asked who fired them, most will get the shooter correct, but in every case, at least one person will have gunfire coming from the empty gun. They will articulate hearing the gun fire and seeing muzzle blast coming from the barrel. I have used this demonstration for twenty five years and whether they are recruits in the academy or experienced homicide investigators, the results are always the same. This is a pretend event, where they know no one will be hurt or killed, and yet they still have the reaction. It drives home the point that, people may not be able to give accurate information right after an incident, especially incidents involving possible lethal results. Victims, witnesses, suspects, officers, are all potential victims to this confusion.

This brings up the first major problem many officers face, **the department investigation**. We know that people process events in an attempt to get what happened to them into perspective, and that this may take a day or two, one of the main reasons that we try to wait 48 to 72 hours before doing debriefings. Many agencies recognize this and will not take a written statement or report from involved officers, until they have had a chance to calm down, process, and have a good handle of what happened. Unfortunately, many administrators won't let officers leave until they have something on paper. Because of the above dynamics, and all of the other stressors, officers may not be prepared to give adequate details. The agency ends up with an inaccurate statement that may not match the physical evidence and it may conflict with the statements of witnesses and even other officers.

Investigators sometimes view these inconsistencies as an attempt to cover up something and start treating the officer as suspect instead of victim. If officers are mandated to give a written statement right away, I encourage them to not put details in the statement, unless they are sure what occurred. By being general in the statement, they have fulfilled the requirement of giving the statement and have not locked themselves into inaccurate information. Once they have had a chance to process, and details of the event are recalled, they can add those details in follow-up statements. It is easier to add detail, than to change it. Once they put details in a written statement, that is what they must testify to in court, so we should do everything we can to see that it is as accurate as possible. Agencies need to learn that if they give the officer time to process and provide support, that the statement will usually be much more accurate. The agency will normally conduct a shooting review to determine if policy was followed. If not, discipline is the normal response, including termination. Besides the department investigation, there is normally a medical examiners inquest to determine cause of death and whether proper force was used.

The information is sent to a prosecutor, who decides if the officer acted appropriately or violated the law and will be charged with a crime. If investigated as a crime, the agency is normally obligated to assist the prosecutor in the investigation. Everyone in the agency may be ordered to not communicate with the subject officer, under threat of discipline. All of this isolates the officer from their normal support system and peers, and worsens whatever trauma they are already experiencing. A clean bill of health from the prosecutor is normally the most important thing I hear from officers. They need to know that they won't be prosecuted. Because of a



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## Post Shooting Considerations (cont).

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backlog in cases, the process may take several months to complete. Way too long for someone to wait for an answer, so the stress builds. Even if the actions are deemed appropriate, the officer may still face civil actions brought by the suspect's family. This process may go on for years, and depending on the agency, the officer may have to bear some of the financial burden themselves.

The "Mark of Cain" may be an issue. Cain slew his brother Abel, and from that we decided it is not socially acceptable to kill our brothers and sisters. "Thou shall not kill" is the basis of all religious beliefs and most laws are based on it. Most officers hope to do their twenty or thirty years without having to use lethal force. When applied, an officer feels they have exhausted all options and had no choice, but to use lethal force as a last result. Afterwards it is common for the Monday morning quarterbacking to start. It will be suggested, maybe even by a friend, that the officer had other options and that lethal force was not necessary. Society, especially the press, may treat the officer as a killer. If justification is lost, the officer may be in serious personal trouble. Officers have killed themselves over this issue. Please remind them, that if it was not a perceivable option to them at the time of the event, then it is not an option later.

A Line of Duty Injury may bring a variety of issues to the officer who was shot or seriously injured. They may lose confidence and question their tactics and/or training. They may have a fear factor of being injured again or involved in another lethal confrontation and question their ability to do the job. If disabled, and returning to duty becomes a question, they may not believe that there is life after police work. If you hear, "I don't know what I would do if I couldn't be a cop anymore", the officer may become self destructive if presented with the possibility. The reality of police work may present itself. "This isn't

'cops and robbers' anymore, people get killed out here." Many officers avoid aggression or shy from the hot call. They can't play at that level anymore. Some have trouble firing their weapon at the range. Others will become overly aggressive in an effort to prevent being injured again. "Kill or be killed." Many of these issues will be resolved with time, training, intervention, counselling, support, and having another incident where they are successful.

### ***The following intervention is suggested.***

Get support to the officer as soon as possible, preferably by a peer at the scene. Most officers will want to talk, but it needs to be with someone who understands what the officer is going through and someone safe. The officer may ramble on about what happened and what they did. In the United States, some states have laws protecting the communication between the officer and a peer as long as the peer has been designated to act as such by the Chief of Police or Sheriff. This allows the officer to vent without fear of the information being used against him/her. Remove the officer from the scene as soon as practical. Peers can help the officer in calling home and handling things around the station before they go home. Peer support should be offered to the officer once they do go home. Peers can provide information and support to family members. They can answer the phone, deal with media at the door, or help with any situation that the officer and family aren't prepared for right now. Do not isolate the officer.

Attorneys will advise the officer to keep quiet and not talk to anyone. They usually advise the officer to not attend debriefings or talk to peers. This further isolates the officer from the very people that they need to be with. They are only hurting officers by not letting them participate in the intervention process. Others at the debriefing want to support the offi-

*"Most officers will want to talk, but it needs to be with someone who understands what the officer is going through and someone safe. The officer may ramble on about what happened and what they did."*

## Post Shooting Considerations (cont).

cer and they need the officer there to resolve some of their issues. Involved officers can participate in defusings, debriefings, and one on ones, without jeopardizing their legal rights. We need to educate attorneys on CISM issues and let them know that we are not a threat to the officer or their case. Even if it is determined that the officer will be prosecuted for their actions, we can still support them through the process. In almost every case, the officer will return to duty. Many will state that the things that happened to them after the incident were worse than the incident itself. Intervention and ongoing support through the process can eliminate most of this.

Many agencies require that officers receive psychological counselling and evaluation prior to returning to duty. If that is not part of the policy, I strongly recommend that all peers refer officers for professional psychological care after one of these incidents. Peers can support the officer in many ways, but we are not equipped to handle some of the things the officer will face.

If the agencies you work with do not have a Critical Incident Policy, please help them establish one. It covers all of the issues discussed here and lets personnel know how they will be treated when one of these situations arise and what support will be provided. It also provides guidelines for the agency to follow, which will ensure that the process does not do more damage than the incident. Train peers in the agency, giving them the extra tools they need to support the involved officer through the process. The biggest concern that I hear from those providing peer support in these situations is, "I got there and I didn't know what to do or say." Teach them the way.

*Jim Detrick is a retired police sergeant with 23 years service. He has been involved in formal peer support since 1983. He has been CISM co-ordinator of the King County CISM Team, Seattle, Washington USA since its inception in 1988. He is also Washington State Criminal Justice Training Commission instructor on critical incident survival and peer support training. Jim is a shooting survivor. He can be contacted on [detrickjw@aol.com](mailto:detrickjw@aol.com)*

***"Attorneys will advise the officer to keep quiet and not talk to anyone. They usually advise the officer to not attend debriefings or talk to peers. This further isolates the officer from the very people that they need to be with. They are only hurting officers by not letting them participate in the intervention."***

## ADMINISTRATIVE COORDINATOR'S REPORT *Debbie Rogers*

We have just returned from a short, but well earned break over Easter and once again our thoughts are with those in Nias and surrounding areas who are enduring the aftermath of a terrible earthquake.

The Foundation has had another busy start to the year with eight courses being run. Two were held in Melbourne, two in regional Victoria, two interstate and two overseas (Thailand and Malaysia).

We have some wonderful comments from course participants but I thought this one was extremely timely.

*"...essential skill development and practice, the uncertainty of trauma and disaster is very real, things can happen anytime, anywhere..."*



## *ONCE THE HONEYMOON IS OVER – REFLECTIONS ON A PEER SUPPORT PROGRAMME*

*Peter Kueffer, Clinical Director - VICSES, Treasurer - CISMFA*

**Success [of CISM] has highlighted a number of issues and problems which need to be addressed:**

- **Establishment versus Maintenance**
- **Attrition**
- **Education**
- **Event versus Symptom**
- **Clinical Direction**

The Victoria State Emergency Service (VICSES) has a very successful Peer Support Programme which provides services to some 5500 volunteers across the state. We focus on Critical Incident Stress Management because this combats the highest risk for our members and is the area in which Peers are most effective. We also follow the CISM model and utilize interventions which are learned, practiced, implemented and reviewed by the Peers, the Clinical Assistants and myself as Clinical Director. Over the past four years the programme has grown in numbers, profile, acceptance and utilization. However, success has highlighted a number of issues and problems which need to be addressed. It is not my intention to go into these issues in detail but to draw attention to them and suggest that they may become apparent in Peer Support Programmes in a variety of organizations.

### **Establishment versus Maintenance -**

The enthusiasm which accompanied the establishment, or in our case, the reestablishment of the programme became infectious, particularly in the case of new Peers who emerged from initial training skilled, enthusiastic and ready to Defuse, Debrief and Educate. Without activity, guidance, ongoing training and support, disillusionment may follow. Maintaining the programme has proven to be a bigger challenge than establishing it.

**Attrition** – We have lost Peers for a variety of reasons. In spite of a thorough selection process, inappropriate choices are sometimes made by both the new Peers themselves and we who manage them. Some simply lose interest, face growing family commitments, are frustrated by lack of activity or become overwhelmed by secondary trauma. Careful and caring support is critical in these cases.

**Education** – It has become apparent

that this is probably the single most important and effective Peer activity. We are fortunate that VICSES has a clear policy, from the Director, regarding the requirement to call for Peer Support following Critical Incidents. However, only so much can be achieved by direction. A related policy of Pre Incident Education or Unit Awareness Training brings Peers into SES Units on an annual basis. This has been very successful, helps our volunteers understand the programme and puts names and faces to the Peers. Certainly these sessions have led to a greater utilization of our services.

**Event versus Symptom** – As an early intervention, CISM must be event rather than symptom driven. The early intervention of Defusing, implemented within the first 24 hours of a critical incident, logically precedes the appearance of symptoms or reactions in most people. Thus the approach is preventative and designed to minimize the reactions if and when they impact on our volunteers. Acceptance of this argument and approach has required a shift in thinking amongst members, management and even Peers and the battle is by no means won yet. Our experience shows again and again that a Defusing following a high impact event is usually sufficient to reassure and “normalize” our members. The longer the delay, the more difficult and time consuming a successful intervention becomes and the less of a role the Peers can play. I would prefer not to lead Debriefings and work one on one with traumatized volunteers if the issue could have been managed by the Peers.

**Clinical Direction** – CISM is a psychological service delivered primarily by trained Peers. However, clinical support, guidance and direction have proven to be essential to maintain the

## Once the Honeymoon is over – Reflections on a Peer Support Programme (cont).

integrity of the methodology and to reassure and support the Peers. For example, the steps in a Defusing are basically quite simple but their application in a group of post operational emotionally charged rescuers can be quite a challenge. Reassurance for the Peers to have faith in the methodology and its proven results and to use its structure as a point of reference when things become difficult continues to be important. As the Mental Health Professional I couldn't do my job without the close working relationship I have with the Peer Coordinator, the Regional Peer Team Leaders and the Peers themselves. At the same time, these volunteers could not deliver the results without my involvement. This partnership is

fundamental to the programme.

So, why is the honeymoon over? There is no negative intent in this comment but rather an observation that the first flushes of enthusiasm, success and excitement have given way to a more mature programme. With this come greater complexities and additional challenges. We need advanced training for our experienced Peers, to include families in our education programmes, to reinforce early intervention as a priority, to retain Peers and attract recruits, to expand our range of interventions and to manage the growing number of requests for support, and, unfortunately, PTSD cases. Its exciting, rewarding, exhausting and stimulating work but I sometimes reflect on how much simpler it was in the early days!



### *WORKSITE CRISIS INTERVENTION HELPED NEW YORKERS CURB LEVEL OF MENTAL DISTRESS FOR UP TO TWO YEARS AFTER THE WORLD TRADE CENTER DISASTER*

*Press Release - The New York Academy of Medicine*

NEW YORK CITY, Feb. 17 - New Yorkers who received emergency crisis counseling in the workplace following the World Trade Center disaster suffered from significantly fewer mental health problems **for up to two years** after the disaster occurred, according to a new scientific study by The New York Academy of Medicine. Research results will be presented at the 8th World Congress on Stress, Trauma and Coping on Saturday, Feb. 19 in Baltimore, and will be published in March in the Winter issue of the *International Journal of Emergency Mental Health*, a quarterly peer-reviewed journal.

City residents who participated in just two to three brief counseling sessions at work after the Sept. 11, 2001, attacks enjoyed less long-term risk for binge drinking, alcohol dependence, posttraumatic stress disorder (PTSD)

symptoms, major depression, anxiety, and overall mental health impairment than those who did not, Academy scientists have found.

This study has major implications for the use of emergency mental health treatment following terrorist attacks and other traumatic events worldwide, said principal investigator Joseph Boscarino, Ph.D., M.P.H., Senior Scientist in the Academy's Division of Health and Science Policy. Although crisis counseling is widely used after disasters, its clinical effectiveness, safety, and long-term benefit was unknown prior to this research and has been challenged by other studies. Much of the prior knowledge was based on anecdotal observations and patients' reports of satisfaction after counseling sessions, with little or no long-term follow-up. Scientists have been generally

***"City residents who participated in just two to three brief counseling sessions at work after the Sept. 11, 2001, attacks enjoyed less long-term risk for binge drinking, alcohol dependence, posttraumatic stress disorder (PTSD) symptoms, major depression, anxiety, and overall mental health impairment than those who did not."***

## Worksite Crisis Intervention Helped New Yorkers Curb Level of Mental Distress For Up to Two Years After the World Trade Center Disaster (cont).

*"Based on our current findings, we suggest that crisis intervention services should be considered as a first line of emergency management for those potentially affected by large-scale community disasters," principal investigator Joseph Boscarino, Ph.D., M.P.H., Senior Scientist in the Academy's Division of Health and Science Policy.*

reluctant to conduct research among disaster victims for fear of causing additional suffering, Boscarino said, which doesn't occur as long as proper safeguards are used.

"Based on our current findings, we suggest that crisis intervention services should be considered as a first line of emergency management for those potentially affected by large-scale community disasters," he said. Mental health professionals often recommend crisis counseling for those affected by events like natural disasters, school shootings, terrorist attacks, and other sources of mass psychological trauma.

Researchers interviewed 1,681 adults one year (2002) and two years (late 2003/early 2004) after Sept. 11, analyzing alcohol abuse patterns and mental health status (including symptoms of PTSD and major depression) in the past year. They also analyzed lifetime history of depression, and current stressors other than Sept. 11 that may have increased their risk for poor mental health. Participants were also asked whether they had attended any counseling at work. Interviews were conducted via telephone in both English and Spanish.

Altogether, seven percent of survey participants - representing approximately 420,000 New York City adults - received some form of crisis intervention at their worksite by mental health professionals following Sept. 11. Most (85 percent) reported attending between one and three sessions. About two-thirds (60 to 70 percent) said they were instructed about stress symptoms,

coping and relaxation strategies, positive thinking, stopping negative thoughts, evaluating thoughts, and dealing with emotions.

Researchers found that by participating in just two to three counseling sessions, workers were effectively protected from becoming binge drinkers, becoming dependant upon alcohol, and developing PTSD symptoms or depression during the one year follow-up period.

"It appears that worksite crisis interventions provided by many New York City employers following the events of Sept. 11 had a beneficial impact on the mental status of employees across a spectrum of outcomes," Boscarino said. Since most New York City adults didn't seek community-based counseling following Sept. 11 even though several agencies offered it free of charge, bringing counseling to the workplace appears to be the most effective mental health intervention.

The research was supported by the National Institute of Mental Health. Co-investigators on this study are Richard Adams, Ph.D., a Research Associate in the Academy's Division of Health and Science Policy, and Charles Figley, Ph.D., of the Traumatology Institute at Florida State University. The New York Academy of Medicine, one of the country's premier urban health policy and intervention centers, focuses on enhancing the health of people living in cities through research, education, advocacy, and prevention.

### CISMFA COURSES

#### CISM BASIC

15<sup>th</sup> & 16<sup>th</sup> August 2005  
Melbourne



#### CISM ADVANCED

18<sup>th</sup> & 19<sup>th</sup> August 2005  
Melbourne