

Program Development

Critical Incident Stress Management and the Assaulted Staff Action Program

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ABSTRACT: *Critical Incident Stress Management (CISM; Everly & Mitchell, 1999) is a clinical and administrative approach to address the psychological sequelae in the aftermath of critical incidents. CISM is a comprehensive, multicomponent crisis intervention procedure that spans pre-incident preparedness to acute crisis to post-crisis follow up. The Assaulted Staff Action Program (Flannery, 1998) is a voluntary, system-wide, peer-help, CISM crisis intervention program for employee victims of patient assault. ASAP's crisis intervention procedures and empirical results are used to illustrate the potential power and effectiveness of CISM approaches. The implications are discussed.[International Journal of Emergency Mental Health, 1999, 2, 103-108.]*

KEY WORDS: ASAP; CISM; employee assault; hypervigilance; critical incident stress management

Introduction

Critical Incident Stress Management (CISM; Everly & Mitchell, 1999) is a clinical and administrative strategy to address and mitigate the acute psychological distress that is associated with psychological trauma, and to prevent or mitigate adverse posttraumatic stress disorder sequelae. CISM (Everly & Mitchell, 1999) represents a departure from univariate crisis intervention procedures. It is a comprehensive, multicomponent crisis intervention program that spans pre-incident training through the acute crisis to post-crisis procedures to facilitate closure of the event.

The Assaulted Staff Action Program (ASAP; Flannery, 1998) is a voluntary, system-wide, peer-help, multicomponent crisis intervention procedure to assist employee victims of assault or other acts of violence. ASAP services include individual crisis counseling, group crisis counseling, staff victims' support groups, employee victim family counseling, and private referrals as needed. ASAP (Flannery, 1998) has been associated with providing needed support to employee victims, sustained productivity, and with declines of violence in many facilities where it has been fielded. With its use of multiple interventions tapered to specific organizational needs, ASAP is a prototype model of the CISM approach.

The purpose of this paper is to examine the field of crisis

intervention and emergence of CISM (Everly & Mitchell, 1999), and to use the ASAP program (Flannery, 1998) as an illustrative example of a comprehensive CISM approach.

Critical Incident Stress Management

Crisis/Critical Incidents

A crisis ensues when one's usual coping mechanisms fail in the face of a perceived challenge or threat (Everly & Mitchell, 1999). Typically, these critical incidents are specific, often unexpected, often potentially life-threatening, time-limited events which may involve loss, threat to personal goals or well-being, or a turning point in the person's life (Sandoval, 1995; Wollman, 1993). Individuals may experience these events as direct victims (primary victims) or as witnesses to the painful events in the lives of others (secondary victims) (Flannery, 1994). Critical incidents may result in constricted thinking; restricted coping; states of fear, anxiety, and depression; and any of the symptoms associated with psychological trauma, especially hypervigilance, sleep disturbance, and recurring intrusive memories (Flannery, 1994).

The potential negative impacts of critical events are extensive, and may include human suffering, death, permanent disability, medical injury, disorganization, and untreated posttraumatic stress disorder (PTSD; Flannery, 1995). Such serious consequences have resulted in various single factor interventions to prevent or mitigate

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these harmful consequences.

Individual Crisis Intervention Approaches

Based on the military intervention principles of immediacy, proximity, and expectancy (Grinker & Spiegel, 1947); on the process of grieving (Lindemann, 1944); on the understanding of normal developmental life crisis (Erikson, 1992); and on the nature of emotionally hazardous situations (Caplan, 1964); crisis intervention approaches focus on primary prevention through early intervention to avoid maladaptive problem-solving, and to restore the person to an adaptive level of pre-crisis, independent functioning (Everly & Mitchell, 1997; Sandoval, 1985; Wollman, 1993).

These individual approaches emphasize immediate intervention, listening to the facts of the event, reflecting the victim's feelings, taking direct action, and facilitating social support (Sandoval, 1985). The victim is encouraged to recount the event in detail (Raphael, 1986). While there is no one single model for crisis intervention, these collective approaches have been used effectively with both primary and secondary victims (Auerbach & Kilmann, 1977; Everly, Flannery, & Mitchell, in press).

Group Crisis Intervention Approaches

The next stage in the development of crisis intervention procedures was the development of group interventions to address the needs of large numbers of victims exposed to the same critical incident. Designed originally by Mitchell (1983) to assist emergency services personnel, group debriefing approaches seek to provide immediate intervention to restore adaptive coping and pre-crisis levels of functioning. The Mitchell model (1983; Mitchell & Everly, 1996) and the Raphael model (Raphael, 1986) are the most widely known group debriefing procedures.

The seven-stage Mitchell model (Mitchell, 1983; Mitchell & Everly, 1996) is known as Critical Incident Stress Debriefing (CISD), and emphasizes a cognitive emotional-cognitive framework in which the participants consider the facts, thoughts, emotional responses, possible symptomatology associated with PTSD, and strategies for coping. These debriefings last on average from one to three hours, usually occur within two to seven days after the event, and are usually not repeated. The Mitchell model (1983) is the most widely used group debriefing procedure throughout the world (Everly et al., 1998).

Raphael (1986) focuses on the emotional experiences of the participants and begins with the participants' preparedness and initiation to the critical incident. The

participants' own positive and negative experiences are next examined as is the impact of the critical incident on the support networks of the participants. Making the transition back to everyday life and work marks the final step in her process. Single sessions in informal settings are common. As with the data on individual interventions, a substantial body of evidence supports the efficacy of group debriefing procedures especially that of the Mitchell model (Everly et al., 1998; Everly, Boyle, & Lating, in press).

Critical Incident Stress Management Approaches

The third, and current, stage in the development of more effective crisis intervention procedures has been the emergence of CISM approaches (Everly & Mitchell, 1999). As currently evolved, CISM represents seven core integrated elements: 1) pre-crisis preparations for both individuals and organizations; 2) large scale demobilization and group briefing procedures for use with large numbers of individuals; 3) individual crisis counseling; 4) brief small group discussions (known as defusings) for addressing acute symptom reduction; 5) larger small group discussions, based on the Mitchell model (1983); 6) family crisis intervention techniques; and 7) follow-up procedures for additional needed psychological assessment and treatment referral. As with the earlier two interventions, the goal is to restore the person as closely as possible to the individual's level of pre-crisis functioning and to preclude the development of maladaptive responses as the individual attempts to respond to the critical incident.

The range of interventions to select from provides needed flexibility for a variety of organizations to design CISM programs to suit their individual needs. Flannery (1998) has used individual crisis counseling, group debriefing, family crisis intervention and professional referrals for psychiatric health care providers. Leeman-Conley (1990) included pre-incident preparedness, individual crisis counseling, and group debriefing in her work with bank personnel. Tehrani (1995) included individual crisis counseling, management debriefings, and longer-term trauma counseling for postal employee victims. While these approaches are recent in nature, early empirical evidence suggests the efficacy of the CISM multiple intervention approaches (Everly et al., 1998).

Since the ASAP program (Flannery, 1998; Flannery, Fulton, Tausch, & De Loffi, 1991) is one of the earliest and the most researched of the CISM interventions, it is presented here in detail to demonstrate the efficacy of CISM approaches (Everly & Mitchell, 1999).

The Assaulted Staff Action Program (ASAP)

As noted earlier, ASAP (Flannery, 1998; Flannery et al., 1981) is a voluntary, system-wide, peer-help, CISM crisis intervention approach to assist employee victims in addressing the psychological sequelae associated with the aftermath of patient assault. It has its own philosophy, structure, array of service interventions, and related empirical findings. The ASAP model is easily adapted for other types of organization and for the aftermath of other types of crimes in addition to assault. (The ASAP program has a training manual that contains the ASAP theory, directions for all procedures, and all necessary report forms [Flannery, 1998]).

ASAP Philosophy

ASAP does not believe that violence comes with the job. While assaults and other forms of violence may occur, employees should not be placed at undue risk for harm. Secondly, ASAP believes that when violence does occur it may precipitate a crisis in staff members (Caldwell, 1992).

A third supposition is that employee victims are worthy of the same compassionate care that would be extended to any injured person. Further, ASAP does not assume that episodes of assault are the deliberate and intended fault of the employee. Employees may make therapeutic errors that can be addressed through further training, but most employees are not purposefully inflicting harm on patients. (Cases of deliberate harm are dealt with directly by the legal department.) Finally, ASAP assumes that discussion of traumatic events immediately may result in psychological relief in the short-term and avoid the onset of untreated PTSD over the longer term.

ASAP Structure

While ASAP teams are modular and flexible, the typical team is composed of first responders, ASAP supervisors, and an ASAP team leader. Team membership is voluntary and is comprised of staff from all disciplines as well as interested administrators. Team members' services are covered by malpractice insurance; members volunteer for at least one year and receive no paid compensation.

First responders rotate daily coverage and are notified of assaults by page beeper. When an assault or other aggressive act occurs, the charge nurse on the unit is mandated to call the facility switchboard and request the ASAP team services. The ASAP team member on-call is summoned and is directed to the site where the assault has occurred. The team member ascertains the facts of what has happened and offers the

services to the employee victim, who is free to refuse. Should the employee accept the service, the team member provides individual crisis counseling at the site and calls the employee victim three and ten days later to monitor the employee victim's progress. First responders attend a weekly ASAP meeting and an ASAP monthly in-service training.

ASAP supervisors are also on-call by page beeper. They serve as consultants to first responders, when necessary; provide individual crisis counseling in cases of multiple assaults; and co-lead Mitchell model (1983) group debriefings for ward units when that is indicated. Supervisors attend the weekly team meetings and the monthly in-service training for all ASAP personnel.

The ASAP team leader is responsible for the overall administration of the program and for monitoring the quality of all ASAP services delivered. The team leader co-leads group debriefings, conducts the weekly staff victims' support group, conducts the weekly ASAP team meetings, provides in-service education, and monitors all team members for possible traumatization as secondary victims.

ASAP Services

Consistent with a CISM approach, ASAP offers a number of interventions to the health care facilities that it serves. Although pre-crisis training is not a component unique to the ASAP program, all employees in facilities where ASAP is fielded are trained in one standardized system of nonviolent self-defense, restraint and seclusion procedures, alternatives to restraint and seclusion, and effective communication skills with patients. ASAP staff offers individual crisis counseling, a staff victims' support group, group debriefing for ward units, family counseling for employee victim family members, and professional referrals to specialists in treating psychological trauma.

Individual Crisis Interventions. As noted earlier, when an assault occurs, the ASAP first responder arrives on-site. If the employee victim accepts the ASAP intervention, the first responder reviews the actual facts of the incident, assesses the presence of any symptoms associated with psychological trauma, and helps to stabilize the employee victim by restoring a sense of reasonable mastery, by restoring the victim's network of caring attachments, and by helping the victim to make some meaningful sense of what has happened. The employee victim is advised that the same team member will call within three days and again within ten days to see how the employee victim is progressing. If the employee is in acute distress and in need of additional support, the victim is

immediately referred to the staff victims' support group.

Staff Victims' Support Group. This group is available to employee victims needing extra assistance in dealing with their critical incidents. The group meets weekly to provide pre-crisis functioning in the domains of mastery, attachment, and meaning.

Group Interventions. Occasionally, some episodes of assault disrupt entire ward communities. In these cases, the ASAP team employs the CISD group debriefing model (Mitchell 1983; Mitchell & Everly, 1996) to assist the ward in reviewing the facts of the incident as well as any thoughts, feelings, or symptoms that may have arisen. In the CISD format (1983), each ward group debriefing closes with a review of strategies for adaptive coping in the ensuing days.

Employee Victim Family Interventions. ASAP family interventions provide family outreach, when family members are fearful of the employee's returning to work. This intervention provides a forum for family members to express their concerns and receive needed support. This intervention is especially helpful in single-parent families, where the unexpressed fear of the children is that they may become orphans, if the parent returns to work.

Professional Referrals. Sometimes an episode of violence at work will remind an employee victim of a past episode of personal victimization unrelated to the workplace. The ASAP program provides immediate short-term stabilization to these employee victims and refers them to a specialist in treating psychological trauma, if they wish.

ASAP Outcomes

The first ASAP program began in a traditional state mental hospital setting in April, 1990. By May, 1998, ASAP programs were fielded in eleven sites, including hospitals, community mental health centers, community residential programs, and shelter programs. Membership had grown to 170 team members who responded to over 600 assaults, and who had provided 250,000 hours of volunteer services to their facilities. There are currently four additional health care facilities preparing to field ASAP teams.

ASAP findings to date are presented in three categories: clinical care, declines in assaults, and dollar-cost savings.

Clinical Care. ASAP programs have consistently provided needed support to employee victims. Several staff victims reported feelings of fright and anger as well as symptoms of hypervigilance, sleep disturbance, and intrusive memories. For most employee victims, these psychological sequelae resolved within 3-10 days, rather than a possible

several months, and most regained a sense of reasonable mastery, had a stable network of caring attachments, and been able to make some meaningful sense of why the critical incident had occurred.

Declines in Rate of Assault. An unexpected outcome of the ASAP program has been sharp reductions in the frequency of assault in many facilities, after ASAP programs have been fielded. In the first ASAP program, in a state mental hospital the assault rate declined from a base rate of 30 assaults per month when ASAP began, to a base rate of 11 assaults per month when the hospital was closed for fiscal reasons. Similarly, the assault rate declined in *each* of these additional state mental hospitals from an average base rate of 32 assaults per month for all three facilities to an average base rate of 7 per month within one year. The most recent similar finding has been reported in a community mental health center inpatient unit, where the assault base rate declined from 3.25 assaults per month before ASAP to only one assault for the first 18 months after ASAP was fielded. All of these declines are statistically significant (Flannery, 1998; Flannery, Hanson, Penk, Goldfinger, Pastva, & Navon, 1998).

Hospital Costs. Each ASAP team in a hospital costs an estimated \$40,000 per year in ASAP staff salaried hours. In the first ASAP program, an average of 15 employees left the facility for reasons related to patient assaults. After ASAP was fielded, only one employee left for this reason. With an ASAP team costing an estimated \$40,000 and with an estimated cost of \$12,000 per replacement, this one outcome measure saved the first facility \$268,000 over a two-year period (Flannery, 1998). Additional savings have been realized in subsequent ASAP programs with less medical injury, less sick leave and industrial accident claims used, less medical and legal expense, and sustained productivity.

Discussion

The ASAP program (Flannery, 1998) is similar to those of Leeman-Conley (1990) and Tehrani (1995), and demonstrates how a comprehensive, multicomponent CISM approach (Everly & Mitchell, 1999) can be developed for specific organizational needs. CISM components are modular in design and flexible in application so that specific victim needs can be addressed as they emerge. For example, ASAP began with individual crisis interventions and group debriefings. As the program became known, the need for a staff victims' group and family counseling emerged. Later, it became clear

that a list of professional psychological trauma counselors was needed.

CISM flexibility is also helpful if difficult times arise. At one point, the health care system in which many ASAP programs are fielded faced a severe financial shortfall. This resulted in downsizings and layoffs. As staff resources were curtailed, ASAP was able to curtail the staff victims' support groups temporarily and to have this need filled by the ASAP team leaders per required need. This CISM flexibility has allowed ASAP to continue to provide needed support through a variety of interventions.

Why the fielding of an ASAP CISM program would result in declines in the rate of assault is unknown at the moment. Anecdotal evidence suggests that employees who feel supported are less anxious. As the staff becomes more calm, the patients may become more calm, and, thus, the threshold for violence may be favorably raised. Staff who can manage their angry feelings after an assault with the support of ASAP may also serve as role models for both patients and other staff. However, many factors in conjunction to ASAP could be at work in the modification of the culture of these facilities.

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- Advances in medicine, staff training and experience, and the halo effect are some possible examples of variables that need to be considered.
- More research is needed on these and other CISM procedures. The critical incident literature as a body of data needs further refinements in the operational definitions of traumatic events investigated. In addition, measures of outcomes need to be improved and standardized, and intervention procedures need to be implemented in clearly defined standardized formats.
- As this basic research proceeds, future CISM studies will need to assess the effectiveness of this range of interventions with different types of critical incidents, with primary versus secondary victims, and with other basic and common variables such as past history of violence, personality styles, and coping responses. Individuals and organizations are not helpless in the face of violence and its aftermath. The ASAP program (Flannery, 1998) as a CISM approach (Everly & Mitchell, 1999) provides the needed tools to address human suffering and to reduce unnecessary risks.
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