

A White Paper for Crisis Care Network

**The Business Case for Workplace
Critical Incident Stress Response:
A Literature Review of Clinical-
and Cost-Effectiveness Research**

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ABSTRACT

This paper reviews the research literature on the business value that can be achieved when employers and organizations offer critical incident stress response (CISR) services. CISR services are frequently provided as a specialty service from an employee assistance program (EAP). There is a significant body of applied research conducted over the past 20 years worldwide that offers considerable empirical evidence to support the clinical effectiveness of CISR and related “psychological first aid” kinds of workplace services. There are far fewer research studies available to examine the business case for CISR. The literature obtained features a small number of employer case studies conducted in the 1990s and newer investigations of CISR services that are integrated with other behavioral health and benefit management programs. The research available indicates that CISR services can offer financial savings and business value, primarily from reducing disability and workers’ compensation claims and improving the rate and success of employee return to work after a critical event. The rare event nature of the conditions that create the need for CISR services and their delivery model in applied organizational and workplace settings combine to offer significant challenges to conducting more scientific investigations of the business impact of these services. Nonetheless, additional high quality research is needed before firm conclusions can be drawn about the nature of workplace and claims cost outcomes in this area.

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Introduction

Critical incidents are sudden, unexpected, often life-threatening time-limited events that can inhibit an individual's capacity to respond adaptively. The impact of critical incidents may be debilitating and stems from recurrent intrusive images, persistent fear, displaced anger, guilt, and isolation. Extreme critical incident stressors can even result in personal crises, traumatic stress, and Post-traumatic Stress Disorder (PTSD). Critical Incident Stress Response (CISR) refers to an integrated comprehensive, multicomponent, crisis intervention approach for addressing the psychological aftermath of critical incidents. Over the past 25 years a general model of CISR group debriefing has been developed and which can be used to accelerate recovery from traumatic workplace events. CISR can accomplish psychological closure, prevention, and mitigation of traumatic stress, and promote return to normalcy, benefiting the individual, organization, and the community at large.

CISR services have become popular in the United States (Burton, Gorter, & Paul, 2009), the United Kingdom (Regel, 2007) and in many other countries around the world (Mitchell, 2004). CISR services have been provided in a wide variety of occupational contexts, including firefighters (Mulligan, 2001), medical staff (Flannery, 2001), bank personnel (Miller-Burke, Attridge, & Fass, 1999), and for natural disasters (Attridge, Bergmark & Parker, 2002; Vineburgh et al., 2006). CISR services are often included as part of employee assistance programs (EAPs; VandePol, Gist, Braverman, & Labardee, 2006; VandePol & Gilmour, 2008). EAP services are now widely available to over 90% of large size companies in the US and the majority of all employers in the US and Canada (SHRM, 2008; Csiernik, 2002) and thus CISR services are now available, if needed, to millions of workers.

Clinical Effectiveness of CISR and “Psychological First Aid”

For there even to be a discussion about the business case for these services, it should first be established that they are clinically effective in most circumstances. Several literature reviews have been completed that have critically examined of the dozens of research studies done on the clinical effectiveness and utility of providing CISR services. The conclusion from these reviews is that CISR services, when properly delivered, are helpful in reducing the symptoms of severe stress that affect individuals who have experienced a workplace trauma or critical incidents (Everly, Flannery, & Eyler, 2002; Flannery, 2001; Flannery & Everly, 2004; Flannery, Everly, & Eyler, 2000). According to a review by the National Institutes of Mental Health (2002):

“Early, brief, and focused psychotherapeutic intervention can reduce distress in bereaved spouses, parents, and children.” (p. 2)

The general approach underlying the delivery of CISR services is called “psychological first aid” (PFA) for crisis response (Uhernik & Husson, 2009; VandePol, Larbadee, & Gist, 2006). The basic premise of PFA is to support individual and community resiliency, to reduce acute distress following disaster, and encourage short and long term adaptive functioning (Ruzek, 2007). The PFA approach has been applied to individuals and small groups (Everly, Phillips, Kane, & Feldman, 2006; Everly & Flynn, 2006; Parker, Everly, Barnett, & Links, 2006). There is a clinical practice guide, now in a second edition, for the delivery of psychological first aid that offers standards for this emerging field (Brymer et al, 2008).

It should be noted that there has been some debate about the effectiveness and even harm from use of related interventions following the critical incident stress management (CISM) model (Bledsoe, 2003). However, the majority of these negative views are based on studies of single session “debriefings” provided to individuals (which are not CISM or CISR services) or refer to studies that do not follow the industry standards of practice for CISM (Mitchell, 2004; Robinson, 2004). What is not a debate anymore,

however, is that the research clearly shows that the use of CISM or other kinds of psychological early interventions cannot successfully *prevent* the experience of PTSD (Bryant, 2007; Feldner, Monson & Friedman, 2007). But once someone has developed PTSD or Acute Stress Disorder, there are treatments that do have empirical evidence for their clinical efficacy (see next section).

Clinical Effectiveness of Psychological Treatment for PTSD

Some workers who experience a trauma may later require additional mental health care if their distress continues longer than 30 days after the incident. High-quality treatment studies in the area of posttraumatic stress disorder (PTSD) and acute stress disorders have accumulated over the last 20 years. This research has provided a strong evidence base for directing clinical practice in this area. Led by the evidence summaries and guidelines published by the International Society for Traumatic Stress Studies (Foa, Keane, & Friedman, 2000), clinical practice guidelines for acute stress therapy and PTSD have recently been published in the US by the Departments of Veterans Affairs and Defense (VA/DoD, 2004) and the American Psychiatric Association (2004), as well as in the United Kingdom (NICE, 2005) and Australia (Forbes et al, 2007) and by the World Health Organization (van Ommeren, Saxena, & Saraceno, 2005). Several recent meta-analysis studies of the applied experimental research this area provide further empirical support for the general effectiveness of trauma-focused cognitive-behavioral therapy (CBT) and other acute care psychotherapies in the treatment of PTSD and traumatic events (Seidler & Wagner, 2006; Bisson & Andrew, 2007; Bisson et al., 2007; Roberts, Kitchiner, Kenardy & Bisson, 2009). This kind of psychotherapy treatment is often provided on multiple occasions over the course of the first three months following a traumatic incident. Although the treatment for PTSD is not the same as CISR services (which are delivered much sooner after the critical event), it is good to know that effective treatment of the more serious kinds of post crisis mental health problems is available.

Business Outcomes from CISR

Many employers provide access to CISR services because it is the “right thing to do” and thus may not require a formal business case to justify providing the services. CISR services are provided primarily for the reason of improving the clinical recovery of the individuals affected by the trauma or crisis experience. In the process of this recovery, however, there can also be other outcomes that can benefit the organization as well. The business value for employers from the proper use of CISR services from EAPs is most likely to be found in the outcomes of reduced worker health care costs, reduced disability claim costs, reduced workers’ compensation claim costs, reduced worker absence days, and reduced worker turnover from increasing the number of employees who can successfully return to work from being on disability after experiencing a traumatic event (Smith & Rooney, 1999). These kinds of outcomes are similar to those found in cost-benefit studies of other related workplace services. Most employers and researchers now recognize the overall business value or return on investment (ROI) for EAP and workplace mental health services (Attridge, 2007, 2008; Goetzl, Ozminkowski, Seder, & Mark, 2002; Kessler & Stang, 2006; Langlieb & Kahn, 2005).

The various outcomes that CISR services offer can be grouped into three major areas of business value, according to the conceptual framework of the “EAP Business Value Model” (Amaral & Attridge, 2004, 2005; Attridge, Hyde & Amaral, 2003; Attridge & Amaral, 2003; Attridge, Amaral, & Hyde, 2003). This approach features three major categories of business outcomes: *Workplace Performance Value* – which has cost savings from employee productivity, absence, retention and other human capital areas; *Benefit Cost Value* – which has cost savings from health care, disability and other employee benefits and claims costs; and *Organizational Value* – which has cost savings from risk management, organizational development and health and productivity management. Thus, CISR services contribute to all three categories of EAP business value, while primarily being considered as an organizational level benefit used only rarely for risk management purposes and to reduce their legal exposure for traumatic incidents (Tehrani, 2005).

To achieve these kinds of business outcomes, many EAPs collaborate with occupational health, disability, return to work and workers' compensation programs in a both a prevention fashion and an immediate response role through their CISR programs and the specialty partners who provide them (Attridge, 2005; DMEC, 2008; VandePol, Gist, Braverman & Labardee, 2006; VandePol & Gilmore, 2008). From these experiences comes some evidence from internal industry reports that organizations that reach out to employees at times of workplace disruption do see benefits in how their employees fare over time (Bernacki & Tsai, 2003; Boscarino, Adams & Figley, 2005; Jardine & Liebermann, 1993; Smith & Rooney, 1999; Yandrick, 1993). Indeed, a survey of 185 employee health benefit plan administrators found that 41% agreed that EAPs at their company had "reduced workers compensation costs" (International Foundation of Employee Benefit Plans, 2000). Such data suggests that many employers have a positive experience with actual cost savings from CISR.

Case Examples of Business Value from CISR Services

Some examples of business-related outcomes from CISR services are found the following reports:

- A study examined company data before and after initiating a CISR program following bank robberies in Australia (Leeman-Conley, 1990). Data from over 100 employees was used to compare worker absence days and combined medical and worker's compensation costs for one year without the CISR program to the next year with a CISR program. Results showed that worker absence days were reduced by 60% (from 281 sick days experienced in the week after the robbery without CISR to 112 days with CISR; from 668 sick days in the six months following the robbery without CISR to 265 days with CISR) and average medical benefits and other workers' compensation costs were reduced by 66% (down from \$18,488 average per person for the period without CISR to \$6,326 with CISR).

- When CISR services were provided after raids at post office businesses, employee sickness and absence levels were reduced by 50% (Tehrani, 1995).
- A program that offered peer support and access to trained mental health professionals for staff at an Australian prison who experienced traumatic incidents documented CISR program outcomes of a 90% reduction in costs of assisting stressed employees and also lowered sick time utilization, turnover of personnel and premature retirements (Ott & Henry, 1997).
- In a study of 236 nurses in Canada (Western Management Consultants, 1996), over two-thirds of the staff had experienced at least one critical incident each year (such as in the death of a child, attempted or actual physical assault, break-ins, threats and assaults, or suicide attempt or completed suicide of a patient). Almost all of these nurses reported that the CISR program had helped them to reduce the number of sick days taken on the job (and a review of three years of sick time company records confirmed the survey finding). Also, about 1 in 4 nurses who experienced a critical incident had contemplated leaving their jobs, but did not quit after the CISR intervention. The estimated return on investment for this CISR program was a \$7.09:\$1.00 benefit-to-cost ratio.
- A 3-year longitudinal study was done of CISR services for 18 firefighters who worked in a school at which 9 children were killed after a tornado (Mitchell, Schiller, Etlar, & Everly, 1999). The study found that PTSD symptoms were reduced for 44% of the firefighters and 5 of the 6 staff who had left service after the tragedy had later returned to firefighting duties.
- A more recent report (Honig & Sultan, 2006) describes how the standard group debriefing for police critical incidents is gradually changing toward a system of triage and individual intervention for those identified as most at risk. The initial findings were that no workers' compensation claims were filed after adopting the customized CISR intervention.

A Caveat about Research Methodology

The above studies all offer evidence for the positive business impact of CISR services. However, none of these reports used high quality experimental research methods in their study design, such as control groups of people who did not receive CISR services from the same or similar events or random assignment of people to be in such control groups or CISR treatment groups. Rather, all of the evidence reviewed in this paper is best categorized as applied single-group longitudinal research that was conducted in real-world settings and included the use of both self-reported outcomes and archival records of outcome measures. Although less than ideal, the use of these kinds of applied research methods is quite common in the field of EAP and workplace health promotion in general (Aldana, 2001; Attridge, 2001). There are many reasons for this lack of methodological rigor (Pompe & Sharar, 2008), but much of it has to do with delivering services in actual worksites and the need to collect metrics and outcome measures in a retrospective, rather than prospective, manner. Furthermore, the staff that are involved in the delivery of EAP and CISR services are typically clinical and business personnel and are not researchers. Furthermore, the rare event nature of the conditions that create the need for CISR services and their delivery model in community and workplace settings combine to offer significant challenges to conducting experimental scientific investigations of the business impact of these services (Litz, 2008; Sonis et al, 2007). Despite these practical obstacles, more high quality research is needed before firm conclusions can be drawn about the nature of workplace and claims cost outcomes in this area.

Conclusion

This paper reviewed the research literature on the business value that can be achieved when employers and organizations offer critical incident stress response (CISR) services. There is a significant body of applied research conducted over the past 20 years worldwide that offers considerable empirical evidence to support the clinical effectiveness of CISR and related “psychological first aid” kinds of workplace services.

Most of this research has focused on the clinical issues of CISR participants and not other areas such as changes in health care costs, insurance claims, and employee work performance and absence. These kinds of outcomes are often of interest to justify the financial expense from employers for sponsoring CISR services. The financial – or business case – evidence for supporting CISR services, however, is not as strong as the evidence for its therapeutic value, but there is some support from analysis of business outcome variables in several studies and from the emerging research on CISR services that are integrated with other behavioral health and benefit management programs, particularly for reducing absence days, disability and workers' compensation claims after a critical event. More research on workplace performance and financial outcomes associated with participants in CISR services is needed.

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