Evidence In-Sight:
Staff psychological debriefing model following the death of a patient or a traumatic event
Staff Psychological Debriefing

The following Evidence In-Sight report involved a non-systematic search and summary of the research and grey literature. These findings are intended to inform the requesting organization, in a timely fashion, rather than providing an exhaustive search or systematic review. This report reflects the literature and evidence available at the time of writing. As new evidence emerges, knowledge on evidence-informed practices can evolve. It may be useful to re-examine and update the evidence over time and/or as new findings emerge.

Evidence In-Sight primarily presents research findings, along with consultations with experts where feasible and constructive. Since scientific research represents only one type of evidence, we encourage you to combine these findings with the expertise of practitioners and the experiences of children, youth and families to develop the best evidence-informed practices for your setting.

While this report may describe best practices or models of evidence-informed programs, Evidence In-Sight does not include direct recommendations or endorsement of a particular practice or program.

This report was researched and written to address the question(s):

- According to the literature, are there evidence-based protocols or frameworks for supporting and debriefing staff following a patient death or a traumatic event?

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). We are available at any time to discuss potential next steps.

We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight. Please do not hesitate to follow up or contact us at evidenceinsight@cheo.on.ca or by phone at 613-737-2297.
1. **Overview of inquiry**

The bereavement committee at a children’s hospital has formed a sub-group to examine issues related to the development of a psychological debriefing model to support staff following the death of a patient or when a complex/traumatic event occurs. The sub-group is interested in identifying evidence-based protocols and a framework for debriefing of staff. They would like to determine best practice recommendations to guide the sub-group and to learn about evidence to support models such as peer support models, critical incident stress debriefing (CISD) procedures and employee assistance programs (EAP).

Question statement: Are there evidence-based protocols/frameworks for debriefing staff following a patient death or a traumatic event?

Many of the following studies were based on self-report and retrospective data. They often lacked a rigorous experimental design or the use of a comparison/control group. The sample sizes for these studies were frequently small and response rates were low. Several studies asked respondents to describe their most recent experience of a patient suicide, not their most stressful. Moreover, many of the literature findings did not break down their results into adult and adolescent populations. Due to the largely qualitative and impressionistic results of the studies, the extent of conclusions and generalizability of the results are limited.

2. **Summary of findings**

- Client suicide can lead to wide-ranging and long-lasting reactions of mental health professionals, resulting in possible changes to work practices and social lives.
- Reported emotions include guilt, sadness, depression, demoralization, anger, shock, denial, grief and professional insecurity.
- Staff reactions to inpatient suicide have been broken down into three phases (phase 1: working in shock; phase 2: emergence of overwhelming feelings; phase 3: new growth around emotional scars) with suggestions for staff support at each phase.
- In the event of a client suicide, the event must be openly discussed immediately and outside resources including consultation should be made available for all staff.
- All mental health workers should be prepared and have supports available for the experience of a client suicide.
- Violence toward staff members can result in psychological trauma and post-traumatic stress.
- Peer support is recommended as a preferred source of staff emotional support.
- Canadian psychiatric residents may be hesitant to seek support such as therapy, employee assistance programs and critical incident debriefing due to an inherent conflict over confidentiality and future insurability.
- Evidence has supported the effectiveness of critical incident stress management in the hospital setting following traumatic events.

3. **Answer search strategy**

- We used these databases for our literature search: Google Scholar, PubMed, PsychINFO, Scopus, and NICE guidelines.
- We used varying combinations of these search terms: staff, clinician, nurse, hospital, grief, bereavement, suicide, youth, child, inpatient, mental health, critical incident stress debriefing, peer support, protocol, and timeframes.
4. Findings
Much of the literature focuses on suicide prevention and postvention practices in schools and communities, but little is available for clinicians or hospital staff. Staff reactions to a client suicide are well researched, but hospital-based support programs following the death of a patient or a traumatic event have little evidence. Some reports have provided a breakdown of staff reactions and suggested supports following a client suicide, but more work is needed to confirm effectiveness. Regardless of the state of the literature, many studies report that all mental health workers do need to be prepared to potentially experience a client suicide.

An informal support network has been effective in providing staff support following both a client suicide and traumatic event, yet formal protocols or frameworks for staff support are not well described. Some staff, such as psychiatric residents, may be hesitant to seek support from therapists, employee assistance programs, and critical incident debriefing due to confidentiality and future insurability concerns. Critical stress debriefing has been studied with hospital staff exposed to traumatic events, including patient suicide and assault, but research finds mixed results. The evidence has supported the effectiveness of CISM for hospital staff after traumatic events.

4.1 Grief and bereavement reactions in mental healthcare workers
The death of a client by suicide is a relatively common occurrence for professionals working with adults with severe mental health disorders, but we did not find research on this specific to professionals working with children and youth. One in five psychologists and counselors and one in two psychiatrists might lose a client to suicide during their careers (Gutin et al., 2010). Despite its common occurrence, experiencing client suicide can lead to wide-ranging and long-lasting reactions, resulting in possible changes to work practices and social lives (Gutin et al., 2010). There is a well-established body of research on family support bereavement programs but less is available on grief support for health care providers (Lerner et al., 2012).

Staff reactions to a client suicide include a wide range of reported emotions such as guilt, sadness, depression, demoralization, anger, shock, denial, grief and professional insecurity (Bowers et al., 2006; Cotton et al., 1983; Gaffney et al., 2009; Gulfi et al., 2010; Little, 1992; Takahashi et al., 2011; Ting et al., 2006). These reactions are reported by direct-service providers of both child and adult mental health workers across cultures. For instance, frontline mental health nurses in Ireland reported anger, sadness and guilt as the most commonly experienced emotional responses to client suicide (Gaffney et al., 2009). Psychiatrists in Thailand ranked feelings of sadness, depression, hopelessness and guilt as their greatest emotional reactions (Thomyangkoon & Leenaars, 2008). In the United States, social workers expressed denial, anger, grief, and eventual acceptance in the aftermath of a client suicide (Ting et al., 2006), and psychiatrists and psychologists working in psychiatric hospitals in Slovenia also described guilt, grief, depression and loss (Grad et al., 1997). Interestingly, reports of emotions such as anger varied across responses, likely explained by cultural differences (Thomyangkoon & Leenaars, 2008), but the feeling of guilt was a recurrent emotion reported across all cultures studied.

Although the literature reports common themes in response to a client death, reactions are unique to each individual. Differences in caregivers such as experiences, beliefs, values and culture will result in individualized responses (Grad et al., 1997). The type of mental health profession (e.g. social worker or psychologist), number of previous suicide attempts
by the deceased, total number of previous suicides experienced by the practitioner, and age of the practitioner can all influence work practices one month after the event (Gulfi et al., 2010). Also, the closer the therapeutic relationship with the client or the higher the involvement in care, the stronger their reaction to the suicide (Gaffney et al., 2009; Gulfi et al., 2010). A suicide in an institution or its vicinity may cause a stronger professional reaction than if the suicide occurred elsewhere, as mental health workers may feel more involved in the client’s care at that time (Gulfi et al., 2010).

Client suicide can have a measurable impact on working practices, such as increased interest in suicide-related issues, increased caution in treatment and increased colleague consultation (Grad et al., 1997; Gulfi et al., 2010). Many clinicians report isolation and interpersonal discomfort with their colleagues after a client suicide (Gutin et al., 2010). Although results are mixed, some studies have also reported gender differences in mental healthcare workers’ reactions to suicide. Female professionals were found to be more likely to report professional reactions such as self-doubt (Gaffney et al., 2009; Grad et al., 1997; Gulfi et al., 2010), seek consolation, feel shame and guilt (Grad et al., 1997), feel responsible or blamed and were concerned about support for the family of the victim (Gaffney et al., 2009).

4.2 Phases and responses to patient suicide

Previous research has focused on the phases of staff reaction to inpatient suicide and provided suggestions for staff support at each of the phases (Little, 1992; Cotton et al., 1983):

- **Phase 1**: Initial week after event – A stunned sense of disbelief and bewilderment by staff, a sense of loss of control and fear that another suicide will immediately occur. Actions in this phase include holding staff meetings and staff-patient meetings as soon as possible to address communication of accurate facts, general remarks/overview of protocol, identifying a ‘front person’, participation in rituals of death, identifying at-risk patients, expressing feelings, reinforcing the feeling of safety, legitimizing informal peer support and an overview of protocol. In this phase, it is important to discuss the concept that there is an inevitable aspect to patient suicide in spite of good care.

- **Phase 2**: End of first week to two months – Characterized by turmoil, feelings of anger, guilt, anxiety and depression. A sense of exhaustion, demoralization and feelings of self-doubt. The rate of sick leave and absenteeism may increase. In this phase, a staff meeting to discuss experiences and expectations may be useful. Informal peer support has been thought to be extremely valuable in this phase with the utilization of an informal network. An incomplete resolution of this phase may be an indication for therapist referral.

- **Phase 3**: Between two to six months – The intensity of turmoil decreases and growth or prolonged disability may arise. As the intensity of turmoil lessens in this time period it may be appropriate to conduct a suicide autopsy, what happened and what can be learned.

Pallin (2004) builds on this work and provides a feeling and psychological task breakdown after a client suicide.

<table>
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Table 1. Feelings and psychological tasks in the aftermath of a client suicide

4.3 Training and education
The literature has identified a need to prepare all mental health workers for the experience of a client suicide, and to provide them with education on the personal and professional impact of suicide on all survivors (Gulfi et al., 2010). Some organizations have examined the effectiveness of a retreat or workshop presented every two years for mental health providers (Figueroa & Dalack, 2013; Lerner et al., 2012). The goals of the sessions are to increase education, awareness and self-perceived competency in dealing with client suicide (Figueroa & Dalack, 2013). The retreat structure consists of:

1) A review of the literature on the major impact of a client’s suicide on treating clinicians.
2) A brief presentation of a case that ended in suicide from each member of a group panel (social work, nursing, psychiatry).
3) Smaller facilitator-lead group discussions.
4) A summary of the discussion points by facilitators.
5) A summary of potential resources for caregivers to contact as needed for post-client-suicide support and information.
6) Final discussion.

Results of the retreat showed that 93% of respondents who attended felt they could apply the knowledge gained to their clinical practice, and 87% would participate in postvention and grief/loss support groups with colleagues in the future. Respondents felt that hearing reactions to suicide from others and realizing that they are not alone was helpful (Figueroa & Dalack, 2013).

4.4 Trauma in mental healthcare workers
Aggressive behaviours are one of the most common reasons for referral to child and youth mental health services and incidents of aggression in child and adolescent psychiatric inpatient units are common (Dean et al., 2010). Due to developmental and clinical differences between adults and children, findings from adult mental health services may not directly translate to child and adolescent settings. Children displaying aggression may be perceived as less threatening because they may weigh less and be smaller than aggressive adults. Also, the management of aggressive children may be different in earlier developmental stages compared to adults (Sugden et al., 2006).

When patient aggression does occur, it can cause physical injury and create negative emotions such as fear, anger and anxiety in mental healthcare workers (Needham et al., 2005). Staff on a child and adolescent inpatient unit reported being emotionally drained, anxious about attending work, and experiencing impaired sleep and concentration (Dean et al., 2010). Violence toward staff members or other patients can be experienced as traumatic events by mental health workers and can result in symptoms of psychological trauma and even post-traumatic stress (PTSD)(Flannery, Jr. et al., 1991; Caldwell, 1992). However, longer periods of time may be needed to detect PTSD or the persistence of fear and avoidance symptoms (Dean et al., 2010).
4.5 Peer support

Much of the literature suggests that an outlet for verbal expression of emotional shock be part of postvention activities for the bereaved (Takahashi et al., 2011). As Sudak (2007) points out, sharing opinions on suicide and freely discussing concerns can be important for nurses, as well as sharing these feelings with other residents. This process may help staff unite through mutual support (Shimozono, 2003), create a sense of collegial support and reinforce professional competence after a patient suicide (Ting et al., 2006). Both formal and informal systems of support (e.g., supervisors, consultation with colleagues) have been suggested for organizations that experience patient suicide (Gulfi et al., 2010). In situations of violence against mental health staff in an inpatient unit, Farrell (2006) suggests that general support from colleagues and management may be as valued or as effective as more formalized debriefing procedures.

Published evidence has shown the effectiveness of peer support following a patient suicide or traumatic event. Bartels (1987) suggests that peer support is the most vital part of the healing process and can be offered through individual supervision, groups and peer contact. For Canadian psychiatric residents who encountered suicide, some of the most commonly used supports included residents and supervisors (Pilkinton & Etkin, 2003). Other studies have found that a large percentage of staff who experienced patient suicide (approximately 90%) talked to their colleagues and found speaking with colleagues as most helpful (Grad et al., 1997; Thomyangkoon & Leenaars, 2008). Thomyangkoon (2008) stated that colleague support is an adaptive coping strategy that is paramount for surviving the suicide of a patient (Hendin et al., 2006; Litman, 1965; Ness & Pfeffer, 1990). Further study examining support in the aftermath of a suicide stated peer support (24%), and debriefing (6%) were most frequently experienced (Gaffney et al., 2009). Support from an immediate colleague also may be more valued than an external support offered by someone unfamiliar to the mental healthcare worker (Gaffney et al., 2009). In the aftermath of a trauma, co-workers reported that other staff provided the most support in comparison with supervisors or the organization. Peers were described as a superior source of support and the most effective for dealing with staff’s feelings (Michael & Jenkins, 2001).

In addition to experiencing client suicide as a traumatic event, direct service providers may likewise experience client aggression as a traumatic event. Researchers have suggested that an organizational response or implementation of an appropriate mental health care program for staff dealing with a patient suicide or an assault occur in a timely manner (Dean et al., 2010; Takahashi et al., 2011). For example, a voluntary peer-help, system-wide crisis intervention program called The Assaulted Staff Action Program (ASAP) was developed by Flannery et al (1991). This team was created to provide assistance to staff who have experienced assault in order to help them cope with the aftermath of the assault (Flannery, Jr., 1998; Flannery, Jr., 2005). It is a peer-help voluntary crisis counseling program for staff victims and provides individual crisis counseling, entire ward debriefings, a staff victims’ support group, and employee victim family counseling when requested (Flannery, Jr. et al., 1991). This approach has some empirical support for decreasing the frequency of assaults by adults on staff; reducing employee suffering following an assault incident, and increasing recovery times however, is not necessarily generalizable to pediatric settings and requires further study.

4.6 Critical incident stress management and employee assistance programs

Employee assistance programs (EAPs) and Critical Incident Stress Management (CISM) teams have been recommended as supports in the aftermath of a client suicide or workplace trauma (Michael & Jenkins, 2001; Ting et al., 2006). The effects of critical stress debriefing have been studied for staff exposed to traumatic events, including patient suicide and assault, but the results are mixed (Ryan et al., 2008). Professionally reviewing a client’s case or holding a group
debriefing may lessen the weight of responsibility after the death of a client (Ting et al., 2006). Debriefed employee victims of patient assault appear to recover more quickly from the assault (Flannery, Jr. et al., 1994).

A survey of Canadian Psychiatric Residents (Pilkinton & Etkin, 2003) found that only 15% of the residents were willing to seek EAP assistance and up to 32% indicated that they would not use this type of support. The authors suggested that residents may hesitate to seek other supports, such as therapists, employee assistance programs, and critical incident debriefing because these services may be provided by the residents and faculty of the department. This can create an inherent conflict for the trainees and raise concerns over confidentiality and future insurability. Furthermore, this study also found that the postgraduate education directors of the programs reported a similar ambivalence about employee assistance programs (Pilkinton & Etkin, 2003).

CISM has been used to address the aftermath of violent acts and has grown from earlier crisis interventions and group psychological debriefing techniques (Everly, Jr. et al., 2000). It is composed of seven core integrated elements, and the element of specific relevance to the question posed is the critical incident stress debriefing (CISD). It is a session of extended small group discussions to assist in attaining a sense of psychological closure after a crisis and/or to facilitate a referral. A review of the literature (Everly, Jr. et al., 2000) has provided evidence for the effectiveness of CISM in hospitals:

- Researchers conducted debriefings in two hospitals (a total of 35 debriefings) that received dead and injured patients from a football stadium disaster in England. Combined data indicated that 68% of subjects found the debriefing helpful (Shapiro & Kunkler, 1990).
- A systematic inquiry of group debriefings evaluated debriefings held over a 21-month period for 172 subjects (emergency service workers, welfare and hospital personnel). These subjects responded to causality situations, child fatalities, death or serious injury to patients, and similar work-related matters. Ninety-six percent of the emergency services workers and 77% of the welfare/medical personnel experienced a reduction in symptoms at least partly attributed to the debriefing (Robinson & Mithcell, 1995).
- Western Management Consultants (1996) evaluated a CISM program of pre-incident training, individual counseling, model debriefings and professional referrals for nurses in provinces from British Columbia to Ontario (236 nurses with 65% experiencing at least one critical incident per year). Critical incidents included death of a patient, violent death of colleague, patient suicides, and patient assaults on staff. Of those debriefed, 24% were less likely to resign after a CISM intervention and 99% indicated reduced usage of days absent from work (Western Management Consultants, 1996).
- A series of studies (Flannery, Jr. et al., 1991; Flannery, Jr. et al., 1994; Flannery, Jr., 1995; Flannery, Jr., 1998) in a Massachusetts psychiatric setting evaluated the impact of patient assaults on staff. These studies measured CISM (individual crisis counseling, group debriefings, a staff victims support group, employee-victim family counseling, and professional referral). The Assaulted Staff Action Program (Flannery, Jr., 1998), helped support over 91% of the employee victims within 10 days of the assault episode, with reduction of 63% in assault frequency in a two year period, less staff turnover, less use of sick leave, less workers compensation claims and less medical and legal expense.
5. Next steps and other resources

A modified version of group CISD exists to focus on grief and loss after a death:

Maltzman describes an organizational self-care model that may be useful:

Supporting Staff and Patients After a Suicide (2004):
http://books.google.ca/books?hl=en&lr=&id=d6Kw9GaLdzEC&oi=fnd&pg=PA274&dq=%22grief%22+or+%22bereavement%22+and+%22staff%22+or+%22clinician%22+and+%22suicide%22&ots=Nk_zhyjkZ-&sig=TalktCAUhv9jM5swAWec8uTbmKg#!v=onepage&q&f=false

Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive “drivers” related to staff competency, organizational leadership and organizational capacity. These drivers include assessing and monitoring the outcomes of your practice using evaluation or performance measurement frameworks, which are particularly important when there is insufficient evidence in the literature to guide clinical decisions. Choosing a practice is an initial step toward implementation, but the implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful and that clinical staff members are successful in their work.

The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement. For more information, visit:
http://www.excellenceforchildandyouth.ca/what-we-do or check out the Centre’s resource hub at http://www.excellenceforchildandyouth.ca/resource-hub.

For general mental health information, including links to resources for families:
http://www.ementalhealth.ca
References


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Shapiro, D., & Kunkler, J. (1990). *Psychological support for hospital staff initiated by clinical psychologists in the aftermath of the Hillsborough disaster*. Sheffield, UK, Sheffield Health Authority Mental Health Services Unit.


