ACP UK

ASSOCIATION OF CLINICAL PSYCHOLOGISTS

Group Psychological 'Debriefs'

Practice guidance for post-event team reflection (PETR) following distressing events at work

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GUIDANCE

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This guidance document was written for the Association of Clinical Psychologists (UK) by Dr Sadie Thomas-Unsworth, Dr Harriet Conniff, Dr Joanna Farrington-Exley, Dr Zoe Berger and Dr Julie Highfield.

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With thanks to the following experts for their contribution to the reviewing process and development of this guideline:
Dr Jennie Ormerod, Clinical Psychologist, Leeds Teaching Hospital
Dr Tori Snell, Consultant Clinical Psychologist, Member of the Board of Directors, ACP-UK

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Executive Summary

Group psychological debriefing, in its many forms, is a popular intervention to support staff involved in distressing and potentially traumatic events. However, the evidence base in favour of its use is limited and complicated by the number of different processes all referred to by the umbrella term 'debrief'. Furthermore, the efficacy of psychological debriefing has mostly been evaluated in terms of its use as a preventative intervention for post-traumatic stress disorder (PTSD). Yet there is very limited evidence to suggest that it is effective for this and some evidence to suggest it might be harmful. This lack of clarity, alongside a highly influential Cochrane review in 2002, has led many practitioner psychologists to feel unsure about how to support staff involved in these sorts of events.

Nonetheless, on the ground, staff continue to report that finding the opportunity to come together after events can be helpful. Indeed, the value in fostering a sense of safety, calm, connection, efficacy and hope is well established. Therefore, this paper presents a guiding framework for practitioner psychologists and mental health professionals to use to support teams and groups following involvement in distressing or potentially traumatic events – not for the purpose of preventing PTSD but rather to create spaces that foster peer-to-peer support, team cohesion and meaning making. In doing so, it recognises that group support following such events can be one helpful element of post-incident support but should not be taken to replace other critical sources of support such as 1:1 assessment or therapy.

Introduction

The use of group follow-up practices, often called debriefing, to support staff after involvement in clinically adverse events is widespread, and there are various models of debriefing. However, there has been some controversy over their use. Evaluation of the use of debriefing has been dominated by exploration of its role in reducing the likelihood of individuals developing post-traumatic stress disorder (PTSD). A Cochrane review of interventions (Rose, Bisson, Churchill & Wessely, 2002) for the prevention of PTSD concluded that debriefing for this purpose was contraindicated. Others have pointed to the dominance of studies exploring individual debriefing in the review as opposed to groups, alongside the value in looking at debriefing for broader purposes (e.g. team cohesion). Thus for many, there remains a lack of clarity regarding what is and is not clinically indicated when it comes to debriefing after potentially traumatic events. This has left many professionals feeling uncertain about what they can or should offer teams who have been involved in distressing and/or potentially traumatic events. In the absence of robust evidence, some practitioner psychologists have been wary of offering any group support at all, whilst others have attempted to develop local bespoke models of post-incident support or undertaken training in models such as critical incident stress debriefing (CISD).

The current guideline will briefly outline some of the latest evidence base alongside broader psychological theory to support practitioner psychologists and mental health professionals in their work with teams and staff groups following difficult events.

Guidance Scope

Who is this guideline for?

This guidance is principally written with clinical psychologists in mind and as such will refer to 'psychologists' as facilitators throughout. However, we note the potential for a range of mental health professionals to facilitate these spaces. Thoughts about the skills likely to be required are suggested later.

Debunking the term 'debrief' and searching for a better one

In the UK, clinical psychologists working alongside healthcare professionals continue to have requests for group follow up after potentially traumatic events. It is important to provide guidance which allows for a reflective and supportive follow up, which fits with the evidence base and is helpful rather than risking psychological harm. This guideline, therefore, seeks to support psychologists in engaging with group support for individuals who work together and have collectively been involved in distressing and/or potentially traumatic events.

Evaluation of the evidence base and clinical practice has been hampered by the term 'debrief' being used interchangeably to refer to different processes and meetings after challenging events, which might be delivered by different kinds of healthcare staff for a variety of purposes. The following fall under the debrief umbrella: performance debriefing, critical incident stress debriefing, bereavement debriefs and, the broad term, psychological debriefs. Whilst all of these formats are called debriefs, they are delivered for different purposes, in very different contexts

and using varying frameworks. This is important as it seems likely that reflective group interventions that are appropriate for teams following distressing events at work may differ from those required following a distressing, e.g., sad, but not traumatic event.

Therefore, although our non-psychology colleagues may still default to the term 'debrief', what we are in essence describing in this guideline is psychological group reflection following a traumatic or distressing event at work. For the purpose of this guidance, we define a **post-event team reflection (PETR)** very generally as a meeting (usually one-off or short term) after a significant event (such as an unexpected death, an episode of care the staff experience as a challenging or unexpected event) where the intention and focus is on social connection, individual and team coping and, often, to build a broad shared narrative of what happened. In this context, the team is defined as a group of individuals who worked together during the challenging or significant event. Therefore, the focus is not on driving clinical learning but rather enhancing connection and meaning making with the aim of supporting individual and team well-being. We will call these group sessions **post-event team reflection (PETR)**.

For the purpose of this guidance we broaden the DSM-5 definition of a potentially traumatic event to one in which a person experiences exposure to actual (expected but distressing, untimely or unexpected) or threatened death, serious injury, physical or sexual violence in one or more of four ways: (a) the event directly happens to them; (b) witnessing, in person, the event occurring to others; (c) learning that such an event happened to a close family member, work colleague or friend; and (d) experiencing repeated or extreme exposure to aversive details of such events, such as with first responders.

Brief Overview of the Evidence Base for Psychological Debriefs

Reviewing the evidence for and against the use of psychological debriefing has been significantly hampered by the range of definitions and purposes of debriefing. In an attempt to add clarity we break this overview down into:

- Summaries of the evidence for and against the use of group debriefing for the prevention of PTSD
- Summary of what is known more broadly about post-trauma support

The use of group debriefing for the prevention of PTSD

Psychological debriefing has been practised for many decades within emergency services and the term refers to a number of different frameworks and interventions. It follows a more manualised approach in the US, while in the UK, Scandinavia and Europe, it is more process-focused (Dyregrov, 1997). These frameworks have advocated for delivering debriefs for a range of purposes but many falling under the umbrella term of 'psychological debriefing' advocated for the use of debriefs as a method for 'psychological processing traumatic events' by being invited to recall them in as much detail as possible. Therefore, much of the early research tended to focus on use of it as a tool to prevent post-traumatic stress disorder (PTSD). In 2002, a Cochrane Review concluded that the use of individual psychological debriefing in the prevention of PTSD was contraindicated (Rose et al. 2002). The review found a failure to show benefit in terms of preventing PTSD with some studies indicating an increased risk of psychological harm.

However, a number of authors have questioned the validity of these conclusions in relation to debriefing healthcare staff. Firstly, it is important to note that the review was largely based on trials exploring the use of individual debriefing. Recognising this, it concluded that it was 'unable to comment on the use of group debriefing, nor the use of debriefing after mass traumas' (Rose et al., 2002, page 10). Importantly, it also primarily looked at the use of debriefing with individuals who had been admitted to hospital following trauma, e.g. road traffic victims, obstetric trauma. This differs from the context of delivery of healthcare in two important ways. First, as Tamrakar, Murphy and Elkit (2019) point out, the majority of the studies looked at the direct victims of traumatic events; and, secondly, in healthcare contexts, staff commonly experience challenging events as a group because they work in teams, e.g. when attending a crash call, or when a palliative care long-stay child dies on the ward. Therefore, the benefits of coming together as a group may be very different from those group-based interventions offered to people involved in separate traumatic events (which make up the majority of the studies within the 2002 Cochrane Review). Finally, the degree to which the studies included in the 2002 review adhered to the CISD model and consequently were comparable has also been questioned. Hawker, Durkin and Hawker (2011) point out that the 'debriefing' methodology used in many of the studies did not adhere to protocol in terms of timing, length and training.

A more recent review by Bisson et al. (2021) has provided a useful update and expansion on the initial 2002 review. This reviewed and synthesised the current randomised controlled trial (RCT) evidence available for the prevention of PTSD. Whilst studies exploring the use of individual debriefing continue to dominate the literature, Bisson et al. (2021) includes findings from three group debriefing papers

that specifically look at the use of group debriefing for individuals who have encountered traumatic events in the context of their professional role, e.g. military personnel or firefighters. Two studies looked at the use of group debriefing based on critical incident stress debriefing (Adler et al., 2008; Tuckey & Scott, 2014) and one considered the use of 512 PIM group debriefing (Wu et al., 2012). Whilst Bisson et al. (2021) conclude that the studies have significant methodological limitations; all three studies showed some positive effect for the use of group debriefing delivered to homogenous groups although only Wu et al. (2012) reached significance. Bisson et al. (2021) conclude that in reference to the prevention of PTSD, 'Our results would not support a recommendation for the use of any form of psychological debriefing, but would also not support NICE's recommendation against the use of any form of psychological debriefing (Nice Guideline, 116, 2018)'.

However, whilst the evidence remains unclear about the use of group debriefing in the prevention of PTSD and as a method of 'processing trauma', in organisational settings it is generally not used to prevent PTSD but to support other processes such as fostering team cohesion and harnessing peer support within a unit. In their chapter, Regel and Dyregrov (2012) point out that generally the intention of such sessions is around understanding the trauma response and providing peer support, rather than an intention to manage or prevent PTSD. Kolbe et al. (2021) built on this, outlining the importance in aligning method with intent: in essence, previous psychological debriefing methodology has focused upon the intention to treat (i.e. the Cochrane Review focused on the use of debriefing to manage psychological distress and prevent PTSD). In the context of an invitation to debrief to manage arising distress from an incident, the considered intention is to manage distress rather than intervene, so experiences should not be explored in detail, but the focus is on reactions and creating space (Kolbe et al., 2021).

What do we know about early post-trauma responses?

It is well established that social and peer support is protective of psychological well-being, particularly in a trauma context (Brewin, Andrews & Valentine, 2000; Trickey, Siddaway, Meiser-Steadman, Serpell & Field, 2012). International studies of responses to mass trauma events have indicated that supporting staff to feel connected with each other, understand decision-making processes, engage in peer-to-peer support, connect with their values and find meaning in what they do, can all help boost workplace resilience and decrease the impact of moral distress and risk of burnout (Hobfoll et al., 2007).

In the seminal paper 'Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence' Hobfoll et al., (2007) attempt to distil from the literature what they call 'evidence-informed' guiding principles to support early interventions for post-traumatic events. These are:

- Promote a sense of safety
- Promote calming
- Promote a sense of self and collective efficacy
- Promote connectedness
- Promote hope.

Consistent with these principles, Richins et al. (2020) conducted a scoping review of early post-trauma interventions in 'high risk' organisations (e.g. emergency responders, military and humanitarian aid). They looked specifically at early interventions for workers exposed to trauma within their role. They found that interventions support emergency responders best when they are tailored to the needs of the population, supported by the host organisation and harness existing social cohesion and peer support processes.

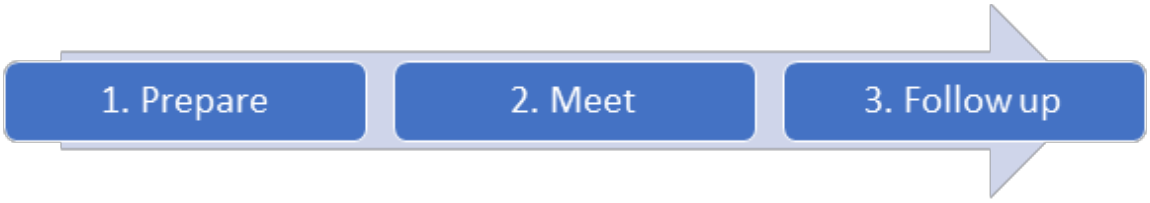
In line with findings such as these, the 2018 NICE Guideline Post-Traumatic Stress Disorder (NG116) recommends providing people with access to peer support facilitated by people with mental health training and supervision.

Guiding Framework

What follows here is a guiding framework based on the evidence base for and against the use of debriefing alongside the broader evidence base around early trauma response. The intention is not to prevent PTSD, but rather to bring professionals together to build a sense of connection driven by the recognition of shared experiences and values. The framework is built around Hobfoll et al.'s 2007 five intervention principles. It can be used after a specific event or at any time a healthcare staff team identifies a need to come together and consider the impact of their shared experiences at work on one another. It is not intended as a manual, or 'one size fits all' approach, but a guiding framework for the practice of post-event team reflection.

The framework is split into three parts:

1. Prepare
2. Meet
3. Follow up



Part 1: PREPARE: Setting up for the PETR

It is critical that, before delivering a psychological debrief, a thorough assessment of need is carried out to see if a psychological debrief is the most appropriate intervention. It is useful to have a consultation with the debrief requester and/or other members of the team prior to the psychological debrief. This can take the form of a face-to-face meeting or call. But taking the time to gather the above information is critical.

Consider the following factors:

1. Who is the target group, and do they consent to participate? It is essential that individuals have individually consented and that it is made clear they can opt out at any stage. All staff must be aware of the range of support options available to them. Consideration should be given to team and wider system dynamics and how these may impact on the ability of individual members to participate (e.g. presence of supervisors/managers etc).

2. What is the nature of the triggering event? Care should be taken around events likely to be classed as highly 'traumatic' as opposed to a distressing event.

3. What is the purpose or intention of offering a group reflection? Facilitators may find it helpful to refer to the guiding principles of Kolbe et al. (2021) to support them to ascertain this.

4. When is the optimum timing to reach all group members? Should more than one session be planned? This needs to relate to the primary purpose. If a key function is supporting staff to understand the facts of the case, then an earlier debrief is likely to be helpful. If, though, a key function is reflecting on the impact on the team a slightly longer gap between event and debrief may be useful.

5. Who is/are the optimal facilitator(s)? How much contextual knowledge is likely to be helpful? What is the psychological safety in the service? What meaning will different facilitators likely have for the team?

To assist with the above, you may wish to look at the questions in Appendix 1.

Part 2: MEET: Post-event team reflection

Psychological facilitation: Summarising, reflecting back, pulling out multiple voices and perspectives about individual and team experience and coping.

Aim to foster peer support and team connection with each other and purpose.

The process set out below is merely to serve as a guide. Which aspects you include should be based on the nature of the event and the purpose of the debrief.

Debrief process	Psychological work going on
Senior clinician to set out context for event and/or debrief request Factual description of the event shared by team members Opportunity for questions to be shared and addressed Opportunity to share individual and team impact of the event Brief psycho-education as required e.g., around trauma or grief Identification of challenges and achievements and where appropriate learning going forward Signpost on to further support	Understanding the how and why can help reduce staff or identify where questions need to be addressed going forward Can prevent concerns about role/fault identifying and/or reassure staff that issues will be explored Normalising responses through hearing other staff have had similar expereinces Enhanced sense of team cohesion/connection through sharing of experiences Strengths and values of the team identified and recognised

Introduction to the session

1. Create boundaries

E.g. confidentiality, timing and ground rules
All contributions should be voluntary and staff should never be pressurised to speak.

2. Frame intention

Set out clearly your hopes and intention for the session and check that fits with the hopes and needs of the attendees.

3. Create a sense of calm

Staff may need time to adjust to the mental 'change in gear' that is required for a reflective space. Inviting participation in a brief grounding exercise may help; e.g. five senses grounding exercise.

4. Option

Where the reflection pertains to a complex medical pathway or medical event you may find it helpful to identify a senior member of the health care team to share a brief overview of the history and what led to the reflection being requested.

Facilitated reflection

5. Sharing reactions and responses

We encourage staff to contribute to a group discussion that tells their story of what happened to them during a particular episode of care or event.

The facilitator gently supports the story telling, taking care not to invite detailed sensory descriptions. The focus may be on putting the 'pieces of the event together' or on the impact of the event on the individual and team. Care should be taken not to ***require*** staff to recall or share specific thoughts or feelings during the event.

There are some specific circumstances when we would urge caution around re-telling in detail the story of the event. These include when any of the team were likely to have felt their personal safety was at risk (e.g. in incidents of threat or violence) and/or if the event itself was particularly traumatic to witness (e.g. a very difficult end of life). It is also important to take care if you do not have a homogenous group with reference to exposure to the event being reflected upon. In these circumstances, it may be more appropriate to focus on a more general guided reflection, recognising that not all staff attending will want to hear all the details in the reflection itself.

6. Guided learning about responses and connecting with each other

During the session, staff are encouraged to reflect on the shared challenges they encountered during the delivery of care, their strengths and resources as individuals and as a team, their values and self-care/coping strategies.

It can be useful to offer brief psychoeducation about common responses to anxiety/trauma and moral distress which can assist with both fostering connection but can also be calming.

7. Answering questions

Staff are encouraged to reflect on unanswered questions, and the facilitator supports the team answering this for each other. For many staff, this can be a hugely beneficial experience as worries about not knowing what happened, or if they did something wrong, may be the root of their distress rather than the incident per se.

Ending

8. Fostering efficacy/hope and connection

With careful facilitation, attendees are supported to identify their individual and group strengths and intentions behind the work they did. Teams often reflect on teamwork and working well together. Where the reflection has centred around an incident or episode of care that fell below the standards of care the group might expect for itself, attendees can benefit from being supported to connect with their intention in the work.

9. Signposting

Specific information about further sources of support should be shared prior to, during and following the psychological debrief. Ideally this should include support available across a range of domains (e.g. written information/access to 1:1 support etc). You should ensure all attendees are able to access evidence-based follow-up support should they wish. 10. Closing

Eliciting clinical learning points is not the aim of the meeting; however, sometimes the group may decide on actions that need to be taken out of the meeting. For some staff, it appears to aid their emotional recovery when they have concrete learning points to take forward, especially if they are actively changing clinical practice personally and in their teams with the aim to prevent the event/error happening again. A post-event group reflection does not replace any other meetings or governance processes required by the hospital system, such as those within the patient safety framework or other learning and improvement meetings.

Part 3: FOLLOW UP: After the PETR

Documentation

Local guidance around documentation for reflective practice and incidence response should be followed. It is also important to think about the purpose of any documentation as well as the impact on those attending.

Assurance and governance: checklist

If you elect to not take notes of the psychological debrief itself, it is likely still to be important that you document that you have taken appropriate care in how you have set up the PETR and the processes followed. This is a powerful psychological process and there must be transparency around what you did and did not do. For this reason, we recommend considering the use of a checklist or quality assurance table so that, whilst the clinical details of the psychological debrief may not be documented, you are able to document the intervention you delivered. An example is included in Appendix 3.

Follow up

As referenced above, it is essential to ensure appropriate follow up is in place. It is best practice for the lead facilitator to contact the debrief requester about one to two weeks after the PETR and check in both with regard to the staff experience of the psychological debrief itself but also to see how the team are doing following this difficult event.

Attendees at the PETR must also be aware of where they can access follow-up support and this should be shared verbally and in writing (e.g. through the provision of a leaflet or website link alongside discussion at the session itself). This support may include access to psycho-education materials, 1:1 support from a mental health professional, access to formal peer support and sometimes routes into more formal clinical assessment.

Evaluation

It is essential to collect staff experience evaluation data. It is recognised that this is a new and emerging area, and in the absence of a robust evidence base, it is particularly important that teams monitor the acceptability and perceived effectiveness of the interventions. **Example feedback forms and an example checklist are included in the appendices. It is essential that local governance arrangements are considered fully before delivering a post-event team reflection and that you have a method for evaluating and recording your interventions.**

Who Facilitates Psychology-Led Post-Event Group Reflections?

This guidance is written with clinical psychologists in mind. However, we note the potential for a range of mental health professionals to facilitate these spaces. It is important to ensure that any staff providing support following stressful or traumatic events have the appropriate knowledge, skills and ongoing support and supervision of their practice.

In particular, we believe these post-event psychology-led reflective spaces should be facilitated by at least one member of staff who is a registered mental health professional with knowledge of risk factors for PTSD and who has training in delivering psychological interventions with groups.

Post-event team reflections should normally be facilitated by two facilitators so that one staff member can monitor the 'emotional temperature' of the room and, if required, follow up with anyone who may require additional support. Those facilitators should have a working knowledge of the local context, understand and know the team or service and be based on a thorough assessment of need. In addition, psychological group reflections should not be offered in isolation and should always be part of a wider package of support. This includes ensuring staff have access to 1:1 support in addition/or instead of group support. Where this is not possible, and facilitation is sought from external sources, interventions must not be delivered in isolation and care should be taken to ensure they work alongside other locally available packages of support, e.g. Trauma Risk Management and Occupational Health Services.

Self-Care as a Facilitator

It is easy to underestimate the impact of delivering these interventions on the facilitator. Delivering psychological debriefs can be extraordinarily rewarding, but they are frequently very draining both because of the emotional content but also the high levels of concentration required. It may be helpful to consider:

- Doing a grounding exercise at the start (either with the group or individually) as well as consciously setting your intention before joining the call or walking into the room.
- Making sure you do not have to go straight onto anything else after and avoid facilitating two in one day; consider how many you are doing across a period of time.
- Ensuring you have access to the appropriate training and supervision to support you in the delivery of psychological debriefs and group interventions of this nature.

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Appendix 1: Useful Preparation Questions

Precipitating factors

- Why is this being asked for now?
- Whose idea was this? Who is asking for this?
- Has a particular event(s) triggered this request?

Predisposing factors

- What is the context of this group's difficulties?
- What made the team vulnerable in the first place to experiencing these challenges?

Perpetuating factors

- What are the factors that are contributing to this problem? What else is going on? What is happening in the 'system' e.g. not enough resources /staff?
- What does this request tell you about the needs of the person/group requesting it?

Protective factors

- What protective factors are there?

Relationship to help(ers)

- Has anything already been tried to help with this situation or other similar situations in the past? Was it effective? How did the group respond?
- Do the staff want this intervention? Is the manager in support of this group intervention?
- What expectations do the group or requesting person have of the group intervention?

Others

- Whose needs could this intervention meet?
- Who can tell me more about the needs of the group?
- Is it a group intervention that is needed or something else?
- Who needs to be here? What will be the impact of including or not including particular individuals/groups?

In particular for the person who is considering delivering the intervention:

- What is your own relationship to the request for help? Are you being pulled into a particular position through this request, e.g. rescuer, to make things better, to chastise, to minimise?

- What is influencing your understanding of the group's issues? Are you able to stand back and be objective? It might be helpful to consider your role in the system you are supporting and whether that enhances or hinders your capacity to support this process.

Appendix 2: Do's and Don'ts for PETR Facilitation

Do's and don'ts for facilitators

Do:

- Set up the session well: e.g. meet with and prepare the lead clinician/team manager ensuring they know what to expect, their role and rationale for the session.
- Ensure detailed information has been sent out to all invitees so they know what to expect and can make an informed choice regarding whether to attend.
- Be clear about the boundaries of the meeting, e.g. confidentiality.
- Use active listening skills.
- Encourage discussion.
- Listen out for and highlight the resources and strengths within the team and invididuals whilst also allowing time for the expression of difficult emotions (e.g. sadness, anger, loss).
- Pay attention to strong feelings in the room, responding with empathy so that the speaker feels heard.
- Consider power and hierarchies and the possible discrimination of certain staff groups and how this may impact on safety to speak up/be in certain groups.
- Consider other contexts that may be at play, e.g. ethnicity, class, age, sexuality and gender of staff members, and how this relates not only to their participation in a group but also their experience of the event.
- Challenge colleagues if they are being disrespectful, blaming or critical, e.g. by reminding them of the ground rules, requesting the discussion is taken outside of the meeting.
- Offer signposting to follow up support.

Don't:

- Explictly or implicitly pressurise staff to attend and consider the specific needs of lead clinician/manager/identified victim (e.g. in the case of a incidence of violence and aggression) in this context.
- Encourage detailed sensory description of the event. The purpose of the space is not to 're-process' the event.

Key considerations when delivering a post-event psychology led reflective practice session

- It is critical that holding a psychological group session is recognised as being only one element of a support package for staff.
- Attendance at the meeting is voluntary; staff should be able to to choose whether to attend. It is important that staff are able to use their own natural coping strategies, which may not include talking to colleagues about how they are feeling in relation to the crisis/or specific event/period of time.
- For many, access to other interventions such as 1:1s, rest, space to relax and unwind away from the role will be more appropriate.
- Before delivering a psychological debrief, assess whether the difficulty can be safely discussed in a group setting.
- Post-event reflective spaces are most helpful when attendance is explicitly supported by senior members of the team. Wherever possible, this should include cover being provided so that staff can attend in work time. This signals an important message about how we value staff.
- It may be useful to keep an attendance list of staff who attended the meeting and their role. However, it is important to consider carefully how appropriate it is to keep content notes. If these are kept, consider also the purpose of keeping them and from that a decision must be made on how/where they are stored. Confidentiality and consent are important aspects of this space, and it must be agreed with the group what, if any, information is to be taken out of the meeting, e.g. actions or learning points and where it will be shared/stored (e.g. leadership team).
- All staff should have access to further follow up if needed and should therefore be signposted to further sources of support.

Appendix 3: Example Checklists

(Used by Psychological Health Services, University Hospital Bristol and Weston)

Post-event team reflection (PETR) checklist for ward/team
Actions to be agreed when setting up the session

DETAILS OF REQUEST		
Date of request:		
Name of person requesting the PETR:	Name	
	Job Role	
	Ward/Dept.	
	Telephone	
	Email	
Medical Lead identified to attend debrief (if required). If different to requester, please give name and contact details:	Name	
	Job Role	
	Ward/Dept.	
	Telephone	
	Email	
Patient Initial:		
Brief outline of patient journey/event and key information facilitators need to be aware of:		

CHECKLIST – ROLE AND RESPONSIBILITIES OF MEDICAL LEAD/TEAM LEAD: as lead requesting and supporting this session, please could you confirm the following shared understandings. Please note it is not always necessary to have a team or medical lead attend – the value will depend on the requester's hopes for the session		
Name and role of Lead:		
I understand my attendance is mandatory. You will be required to give a 5-minute outline of the medical part of the story, and be available to answer medical questions at the end of the PETR. The psychologist facilitator will arrange a time to discuss the details of the debrief and provide guidance for this role.		
I understand that attendance by staff is voluntary. The aim of a session is to offer a safe and supportive space for all staff involved to reflect on their own and others' experiences and feelings of an event or episode of patient care; to fill in any gaps leading to a better understanding of the patient/family journey; and to take some time to talk about self-care.		
I understand the session is confidential. Please do not share outside the session what your colleagues have shared inside the session.		
I understand that an attendance record will be taken and given to the ward/department manager to be stored separately from patient records.		
TO BE AGREED:		
Who will book a room and/or video conferencing facilities?		
Who will send out email invitations and joining instructions and supporting leaflets (below) to staff? (This should ideally be a week ahead of the proposed date so that staff can be notified and have sufficient time to arrange to attend.)		
Has the email invitation with supporting leaflets been sent to the requester to forward to invitees?	Email invitation	
	'Post-event reflective practice' leaflet	
	'1:1 Well-being check in' leaflet	
	Psychology-led well-being debriefs – important information and shared understanding	
	Optional depending on reason for debrief: 'Trauma' leaflet 'When a patient dies' leaflet	

CHECKLIST FOR AFTER THE PETR	Allocated to:	Completed by (initial & date):
Send follow-up email to attendees (or manager to forward), to include: Evaluation links Resources if agreed		
Record of Attendance to be sent separately to manager to store.		
Record debrief on activity data MS form.		
Consider checking in with any staff members who may have found the debrief particularly difficult.		

FOLLOW UP/ACTIONS to be taken forward by psychologists	Allocated to:	Completed by (initial & date):


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