Debriefing During a Mental Health Crisis

Meghan M Galligan, MD, MSHP[1,2,3]*, Dawn DeBrocco, PsyD[1], Eron Friedlaender, MD, MPH[1]

[1]*Department of Pediatrics, Children's Hospital of Philadelphia, Philadelphia, Pennsylvania;* [2]*Center for Healthcare Improvement and Patient Safety, Perelman School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania;* [3]*Leonard Davis Institute of Health Economics, University of Pennsylvania, Philadelphia, Pennsylvania.*

In the wake of the COVID-19 pandemic, hospitals across the country face a crisis in identifying resources for the surging needs of patients with mental health conditions. Compared with 2019, survey and utilization data from 2020 suggest an increase in suicidal ideation and other symptoms among adults,[1] and an escalation in mental health-related visits to pediatric emergency departments, respectively.[2] Unfortunately, mental health resources have dwindled during this period. Available inpatient psychiatric beds and 24-hour residential treatment beds—already on the decline over the past 5 years—have been massively affected by the pandemic due to capacity constraints and facility closures.[3]

These factors have placed general medical hospitals (hospitals) at the front lines of a mental health crisis[4] for which most are ill prepared. Indeed, once a patient with acute mental health needs is "medically cleared," they must wait for an available bed at a psychiatric or residential treatment facility.[3] This waiting period often delays necessary patient care, as most consultation-liaison psychiatry models are not designed to provide intensive services.[5]

This waiting period can also place hospital staff in unfamiliar and potentially unsafe scenarios related to physical and psychological stressors. Staff may encounter patient behaviors that risk harm to patients and staff (ie, behavioral crisis events), which may require seclusion (ie, confinement to a locked room) or restraints (chemical, physical, and mechanical). Even in inpatient psychiatric units, an estimated 70% of nurses have been assaulted at least once during their career.[6] Such violent behaviors and the interventions required to subdue them can be traumatizing for both patients and staff.[7] In fact, the "cost of caring" may be higher for mental health nurses, who often suffer from secondary posttraumatic stress.[8] Staff lacking mental health training may encounter additional stressors from feeling powerless to help their patients.

Facing this crisis, hospitals must develop a strategic response that encompasses the needs of both patients and staff. Beyond intensive interventions (eg, additional staffing resources), this response should include lower-effort interventions. In this perspective, we review two debriefing practices—clinical event debriefing and psychological debriefing—that hospitals can feasibly implement during this crisis. These respective practices can ensure safe and effective care of patients by reducing use of restraints and seclusion while also providing crucial support for staff.

CLINICAL EVENT DEBRIEFING

Broadly defined as a facilitated discussion of significant clinical events, clinical event debriefing (CED) can improve both individual and team performance in resuscitation events and patient outcomes.[9-11] While CED is often utilized for clinical deterioration events, it can also apply to behavioral crises in a diversity of settings.[6]

In recent decades, researchers have developed several frameworks for reducing seclusion and restraint practices in psychiatric care settings.[6] A common framework is Huckshorn's Six Core Strategies,[6,12,13] which can reduce seclusion and restraint use[14] and is feasible to implement.[15] This framework advocates for an immediate CED following behavioral crisis events. A unit supervisor or senior staff member not involved in the event should lead the CED, which has several goals. The first priorities, however, are ensuring the physical safety of all staff and returning the unit to normal operations. More broadly, the CED group should review event documentation and interview staff who were present at the time of the event. These processes can help identify antecedents as well as short- and long-term practices, systems, and environmental modifications to prevent reoccurence.[12] However, little is known about this practice outside of inpatient psychiatric units.

Our pediatric hospital implemented a CED process in our medical behavioral unit (MBU), a 10-bed unit designed for patients with comorbid mental health needs requiring a higher level of psychosocial resources. The MBU is not an inpatient psychiatric unit, yet more than 50% of patients admitted to the MBU at any given time are hospitalized with a primary psychiatric diagnosis requiring intensive services due to a lack of resources in the community.

Preventing use of restraints is an institutional priority for all areas of our hospital. To reduce restraint use in the MBU, staff are asked to perform immediate CED following behavioral crisis events. This process involves both clinical (eg, nurses, physicians, psychiatric technicians) and nonclinical staff (eg, unit clerks, security officers). All staff involved in the event are invited to attend. A senior staff member not involved in the event typically organizes and leads the CED. The group

***Corresponding Author:** Meghan M Galligan, MD, MSHP; Email: galliganm@chop.edu; Telephone: 267-760-7733.

Published online first June 16, 2021.

Find additional supporting information in the online version of this article.

Received: February 18, 2021; **Revised:** March 26, 2021; **Accepted:** March 27, 2021

uses a facilitative guide to (1) review the patient's history; (2) identify potential triggers for the event; (3) reflect on areas of strength and weakness in unit response; (4) identify systems issues impacting the patient or the unit response; and (5) generate a strategy to prevent reoccurrence. The process is designed to take 5 to 10 minutes. The guide also serves as a data collection tool that unit leaders use to screen for generalizable learnings and improvement ideas (Appendix). For example, if a behavioral trigger is identified for a patient, unit leaders disseminate this information to create situational awareness and to ensure care plans are updated.

PSYCHOLOGICAL DEBRIEFING

Psychological debriefing is an application of Critical Incident Stress Management, a comprehensive approach that was developed in the 1970s to help emergency service workers process the thoughts and emotions arising from their exposure to trauma in their work.[8,16] More recently, it has become a standard practice in many settings, including healthcare. Notably, psychological debriefing and event debriefing are often conflated. While not mutually exclusive, psychological debriefing has the unique aim of providing support to groups who work together in stressful situations.

Strategies for psychological debriefing are less well described in healthcare. However, our hospital has found it to be a useful tool for MBU staff. Operationally, this process takes the form of a weekly multidisciplinary team meeting with unit clinical staff. Typically, a psychologist or social worker initiates this meeting, which is held at a dedicated time and in a protected space. Discussion centers on patients who have been admitted to the unit for more than 30 days. A goal of the meeting is to review and update patient care plans, but there is also an important goal of emotional processing (Appendix).

In this meeting, staff reflect collectively on the unique stressors they encounter in their work, and they generate situational awareness and potential interventions for these stressors. The psychosocial providers often share recommendations, such as strategies to promote effective communication with patients and families. Peer support is a major component of this meeting and is often utilized to navigate stressful situations, such as disagreements with families regarding behavioral management. Staff also review and reinforce the Positive Behavioral Interventions and Supports framework—a preventive framework that can reduce seclusion and restraint use in pediatric psychiatric units, among other positive outcomes.[17] This framework includes setting expectations for patients and families regarding behaviors on the unit. In reviewing these guidelines, staff are encouraged to recognize and report inappropriate behaviors (from patients or families) that can be traumatizing, especially over prolonged hospitalizations. This framework also provides a common language for staff to express behavioral expectations in a positive manner (eg, "Let's use our walking feet" rather than "No running"). Overall, staff view this meeting as a resilience-building activity that empowers them in their routine work.

IMPLEMENTATION CONSIDERATIONS

While the MBU is a specialized unit with dedicated psychosocial resources, the debriefing practices we describe can be translated to multiple care settings. However, successful implementation relies on intentional process design. First, debriefing indications must be made clear to staff (eg, events of restraint). There should be a role or group accountable for organizing and leading debriefings, which should be held at a time that promotes participation from frontline staff, particularly for CED. Debriefings—especially psychological debriefings—should be held in a protected space. They should have a clear organization, such as use of a survey-based debriefing guide that allows for data collection. Importantly, there should be a unit or hospital leader accountable for disseminating learnings and improvement ideas to relevant staff and ensuring action items are completed. Finally, accountable leaders should evaluate the process' feasibility, efficacy, and sustainability to inform implementation.

Hospitals must also consider how to train debriefing leaders to facilitate difficult conversations. Some hospitals may have formal communication training programs, but it may also be helpful to leverage the skills of social workers and psychosocial staff.

OTHER CONSIDERATIONS

Debriefing relies on a climate in which staff of diverse backgrounds and professional status feel comfortable speaking up. Psychological safety is critical in any crisis, and hospital leaders should consider how to make staff feel comfortable during this mental health crisis.[18] Leaders must also be prepared to support staff beyond debriefing if resources are required for secondary posttraumatic stress, burnout, or compassion fatigue.[8,19,20] Employee assistance programs may be a useful resource.

CONCLUSION

Debriefing practices can help hospitals contend with the unique challenges facing patients and staff in a mental health crisis. While debriefing may vary based on need and setting, hospitals should consider CED as a strategy for reducing seclusion and restraint use, which adversely impact patients and staff. Psychological debriefing can also help staff mitigate the psychosocial stressors of their work.

Disclosures: The authors have no conflicts of interest to disclose.

REFERENCES

1. Czeisler MÉ, Lane RI, Petrosky E, et al. Mental health, substance use, and suicidal ideation during the COVID-19 pandemic—United States, June 24–30, 2020. *MMWR Morb Mortal Wkly Rep.* 2020;69(32):1049-1057. https://doi.org/10.15585/mmwr.mm6932a1
2. Leeb RT, Bitsko RH, Radhakrishnan L, et al. Mental health–related emergency department visits among children aged <18 years during the COVID-19 pandemic—United States, January 1–October 17, 2020. *MMWR Morb Mortal Wkly Rep.* 2020;69(45):1675-1680. https://doi.org/10.15585/mmwr.mm6945a3

3. Rapoport R. 'Every day is an emergency': The pandemic is worsening psychiatric bed shortages nationwide. *Stat News*. December 23, 2020. Accessed January 22, 2021. https://www.statnews.com/2020/12/23/mental-health-covid19-psychiatric-beds/
4. A step to ease the pandemic mental health crisis. *Scientific American*. February 1, 2021. Accessed April 14, 2021. https://www.scientificamerican.com/article/a-step-to-ease-the-pandemic-mental-health-crisis/
5. Sharpe M, Toynbee M, Walker J. Proactive Integrated Consultation-Liaison Psychiatry: a new service model for the psychiatric care of general hospital inpatients. *Gen Hosp Psychiatry*. 2020;66:9-15. https://doi.org/10.1016/j.genhosppsych.2020.06.005
6. Mangaoil RA, Cleverley K, Peter E. Immediate staff debriefing following seclusions or restraint use in inpatient mental health settings: a scoping review. *Clin Nurs Res*. 2020;29(7):479-495. https://doi.org/10.1177/1054773818791085
7. Needham I, Abderhalden C, Zeller A, et al. The effect of a training course on nursing students' attitudes toward, perceptions of, and confidence in managing patient aggression. *J Nurs Educ*. 2005;44(9):415-420. https://doi.org/10.3928/01484834-20050901-06
8. Missouridou E. Secondary posttraumatic stress and nurses' emotional responses to patient's trauma. *J Trauma Nurs*. 2017;24(2):110-115. https://doi.org/10.1097/JTN.0000000000000274
9. Blankenship AC, Fernandez RP, Joy BF, et al. Multidisciplinary review of code events in a heart center. *Am J Crit Care*. 2016;25(4):90-98. https://doi.org/10.4037/ajcc2016302
10. Wolfe H, Zebuhr C, Topjian AA, et al. Interdisciplinary ICU cardiac arrest debriefing improves survival outcomes. *Crit Care Med*. 2014;42(7):1688-1695. https://doi.org/10.1097/CCM.0000000000000327
11. Tannenbaum SI, Cerasoli CP. Do team and individual debriefs enhance performance? A meta-analysis. *Hum Factors*. 2013;55(1):231-245. https://doi.org/10.1177/0018720812448394
12. Huckshorn KA. Reducing seclusion restraint in mental health use settings: core strategies for prevention. *J Psychosoc Nurs Ment Health Serv*. 2004;42(9):22-33.
13. Goulet MH, Larue C, Dumais A. Evaluation of seclusion and restraint reduction programs in mental health: a systematic review. *Agress Violent Behav*. 2017;34:139-146. https://doi.org/10.1016/j.avb.2017.01.019
14. Azeem MW, Aujila A, Rammerth M, Binsfeld G, Jones RB. Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *J Child Adolesc Psychiatr Nurs*. 2017;30(4):170-174. https://doi.org/10.1111/jcap.12190
15. Wieman DA, Camacho-Gonsalves T, Huckshorn KA, Leff S. Multisite study of an evidence-based practice to reduce seclusion and restraint in psychiatric inpatient facilities. *Psychiatr Serv*. 2014;65(3):345-351. https://doi.org/10.1176/appi.ps.201300210
16. Everly GS. A primer on critical incident stress management: what's really in a name? *Int J Emerg Ment Health*. 1999;1(2):77-79.
17. Reynolds EK, Grados MA, Praglowski N, et al. Use of modified positive behavioral interventions and supports in a psychiatric inpatient unit for high-risk youths. *Psychiatr Serv*. 2016;67(5):570-573. https://doi.org/10.1176/appi.ps.201500039
18. Devaraj LR, Cooper C, Begin AS. Creating psychological safety on medical teams in times of crisis. *J Hosp Med*. 2021;16(1):47-49. https://doi.org/10.12788/jhm.3541
19. Bride BE, Radey M, Figley CR. Measuring compassion fatigue. *Clin Soc Work J*. 2007;35:155-163. https://doi.org/10.1007/s10615-007-0091-7
20. Figley CR. Compassion fatigue: psychotherapists' lack of self care. *J Clin Psychol*. 2002;58(11):1433-1441. https://doi.org/10.1002/jclp.10090