Title

Post-incident responses (debriefing) in mental health services in England: A policy review

Abstract

Introduction

Post-incident responses, also described as debriefing, are structured processes that provide opportunities to address harm and identify learning to prevent future incidents. National guidance recommends post-incident responses after restrictive interventions but provides little indication of the explicit purpose.

Aim

To examine how post-incident responses are defined and implemented according to English NHS mental health trust policies.

Method

A Freedom of Information request was sent to all 52 English NHS mental health trusts to identify policies, guidelines, procedures and training materials about post-incident responses. Data was extracted using an iterative process and assessed using content analysis.

Results

Forty-six trusts responded (response rate 88.5%); 98 policies were included. Responses were inconsistently defined and there was variation in how they are conceptualised and operationalised in practice.

Discussion

The findings demonstrate inconsistencies in the definition, timing, facilitation and content of post-incident responses. The policies offer little guidance to staff in outlining when, how and with whom to conduct them. This likely results in inconsistent practices, potentially limiting the benefits.

Implications for Practice

This study highlights the need for clear, evidence-based, standardised frameworks for post-incident responses to ensure that staff, patients and witnesses receive appropriate support following restrictive interventions. Further research is required to clearly define and describe such responses.

Accessible Summary

What is known on the subject?

1) Post-incident responses should happen after potentially harmful events in mental health wards. They should consist of a supportive and a learning element.
2) There is limited research about what post-incident responses look like. It is not clear what is currently done in practice.

What the paper adds to existing knowledge?

1) The policies from mental health care providers in England about post-incident responses are inconsistent.
2) The purpose, structure and content of post-incident responses are not well understood.

What are the implications for practice?

1) The inconsistencies between policies mean that it is likely that practices are also inconsistent.
2) If post-incident responses are better defined, they can be used more effectively in practice.

Key Words

Mental health nursing

Debriefing

Post-incident responses

Policy

Restrictive interventions

Freedom of Information

Relevance statement

Restrictive interventions are common in mental health inpatient care, with the potential to cause psychological, emotional and physical harm to all involved. Post-incident responses (debriefing) are recognised as a way to mitigate some of this harm, learn from experiences and prevent future incidents from occurring. Despite this, there is limited research on the content and practices of post-incident responses. This review of policies about post-incident responses in English NHS mental health trusts highlights the inconsistencies and lack of understanding of how they are operationalised. If post-incident responses are not well defined, understood or outlined in policies, their interpretation in practice will inevitably vary.

Introduction

Restrictive interventions, namely seclusion, restraint and rapid tranquilisation, are used across mental health inpatient services internationally. They are often preventable yet remain common in many countries despite sustained calls for rights respecting and proactive approaches (Savage et al, 2024). These interventions can cause physical and emotional harm. Patients report feelings of retraumatisation and dehumanisation, whilst staff describe guilt and shame (Butterworth et al, 2022). Both groups report that therapeutic relationships can be damaged. Injuries are also significant for both patients and staff and in some cases have resulted in fatality (Cusack et al, 2018; Renwick et al, 2016). Mental health nurses frequently occupy the frontline of these incidents. They are responsible for enacting restrictive interventions and then supporting patients in the aftermath, often with an expectation that they will help restore safety and rebuild therapeutic relationships. Nurses fulfil these responsibilities in many countries, but the level of training, guidance and organisational support they receive varies widely.

Debriefing is widely viewed as a structured process following a restrictive intervention. It offers a space for patients and staff to reflect on the incident, address psychological, emotional and physical harm, and identify learning to prevent future incidents (McKenna et al, 2024). Debriefing may involve immediate support that focuses on safety followed by a later reflective discussion aimed at sense-making and learning, and these can be separate processes (Cross et al, 2022). Debriefing can help set new goals, facilitate the exchange of information, foster further joint decision-making and identify where systemic or supervisory input is needed. In many settings, nursing staff lead or facilitate these processes. They are often expected to provide emotional support or guide reflection discussions without specific training or a clear framework (Mangaoil et al, 2020). This creates substantial variation in how debriefing is delivered within and across services.

Guidance recommending various forms of debriefing exists in several countries. International reviews identify policy or standards relating to debriefing in New Zealand, Australia, the United States and parts of Europe and Canada (Sutton et al, 2014; Hammervold et al, 2019; Asikainen et al, 2020; Mangaoil et al, 2020). In New Zealand, Te Pou's national guidance on debriefing outlines expectations for immediate support and later review (Sutton et al, 2014). In Australia, state-level guidance is explicit. The Victorian Chief Psychiatrist's guideline on restrictive interventions states that debriefing should be used to help process experiences and identify lessons learned (Victoria State Government, 2024), with similar guidance provided for clinicians in New South Wales (NSW Government, 2020). Canadian provinces take a similar approach. Ontario hospitals operate policy-mandated post-restraint review processes which include structured debriefing with staff and patients (Mangaoil et al, 2020). Although terminology and procedures vary between settings and countries, these documents share a focus on immediate support and later reflection, and link post-incident processes to wider efforts to reduce coercion.

In the UK, NICE (2015) guidelines specify that the initial stage of post-incident debrief, i.e. the support element, should be conducted by a nurse and a doctor, providing a forum for shared perspectives and support. This is followed by a formal review within 72 hours, focusing on analysis and promoting learning. These expectations sit alongside broader policy frameworks such as Positive and Proactive Care, which positions post-incident support as part of restrictive intervention reduction and sets out aims that include addressing physical and emotional impact, offering support and considering alternative approaches to prevent future incidents (Department of Health, 2014). The Mental Health Act Code of Practice (Department of Health, 2015) also requires that restrictive interventions are lawful, proportionate and dignified and that providers have policies addressing post-incident analysis as part of their governance structures. Compliance with these requirements is monitored by the Care Quality Commission (CQC, 2015), which assesses how services deliver debriefing, its impact on ward culture and its role in preventing further restrictive interventions. Nurses are central to all of these expectations.

Across countries, national policies tend to emphasise legal and procedural requirements. They rarely address the practical realities for nurses tasked with carrying out these policies. Research examining the effectiveness of debriefing is both limited and inconsistent, and varies in quality, making it difficult to establish best practices (Hammervold et al, 2019). Debriefing is often included within wider restraint reduction programmes rather than evaluated as an intervention in its own right. Huckshorn's (2006) Six Core Strategies, widely adopted internationally, place debriefing as the final strategy aimed at analysing incidents, mitigating harm and supporting those involved. These strategies have shown reductions in restrictive interventions across services (Goulet et al, 2017). Safewards (Bowers, 2014), also internationally adopted (Mullen et al, 2022), similarly aligns with post-incident debriefing. Its reassurance intervention involves staff checking on patients after

incidents and offering debriefing where needed (Safewards, 2023). This focuses on the supportive aspect, rather than the formal learning processes of debriefing.

Despite this activity, there remains a lack of conceptual clarity about what debriefing entails, its objectives and its operationalisation in clinical settings. Psychological debriefing, a structured intervention intended to prevent post-traumatic stress, has been more clearly defined but is not widely recommended. A Cochrane review found no evidence to support single-session psychological debriefing and suggested that in some cases, it may even increase the risk of post-traumatic stress symptoms (Rose et al, 2002). A later review reported benefits of multiple session early psychological interventions in preventing post-traumatic stress disorder (PTSD) (Roberts et al, 2019). Although some evidence suggests that debriefing can mitigate harm for staff and patients after restrictive interventions (Mangaoil et al, 2020), its implementation remains inconsistent, with significant variation in practice (Evans et al, 2023; Goulet and Larue, 2016). If the content and purpose of debriefing are not well understood, its interpretation and application in practice will inevitably vary.

This study focused on mental health trusts in England because they operate within a specific regulatory and organisational structure (Care Quality Commission, 2025). Healthcare in the UK is publicly funded and delivered through distinct systems in each country (England, Northern Ireland, Scotland and Wales). Mental health trusts in England provide inpatient and community services, and operate within frameworks such as NICE guidance and CQC regulation (Care Quality Commission, 2025). NICE guidance applies in England and Wales NICE, 2025), while Scotland follows guidance from the Scottish Intercollegiate Guidelines Network (SIGN) (Health Improvement Scotland, 2021). Regulation also differs. The CQC regulates services in England, while Healthcare Improvement Scotland and Healthcare Inspectorate Wales regulate services elsewhere (St Mary's University, 2023).

While this study focuses on England, many of the issues identified have broader relevance. Healthcare systems worldwide face similar challenges in reducing restrictive interventions (Belayneh et al, 2024). Many also face challenges in ensuring that post-incident processes support staff and patients (Berring et al, 2024). Countries with comparable systems, including Australia, Canada and several European countries, have introduced restraint reduction initiatives and post-incident support frameworks (Council of Europe, 2021; National Mental Health Commission, 2023), yet variations in implementation persist (Goulet et al, 2017). Because nurses often lead or deliver these processes in many countries, understanding how debriefing is structured within a defined regulatory system can inform international efforts to standardise post-incident support and improve practice. The nursing workforce sits at the centre of this work, yet national policy in many jurisdictions appears to overlook the complexity of the role.

Although most of the international literature uses the term ‘debriefing’, the concept is often poorly defined and interpreted in different ways across settings. Several of the studies we have cited distinguish between immediate support after an incident and later reflective learning, even if this distinction is not always made explicit or named consistently (Cross et al 2022; Goulet and Larue 2016; Hammervold et al 2022). During the wider study that this policy review is part of (DRIVE-MH, NIHR206344), members of the patient and carer Expert Stakeholder Group reported that debriefing felt too clinical and did not reflect their experiences of post-incident conversations. They preferred the broader term ‘post-incident responses’, which captures two linked processes: post-incident support, focused on immediate physical and emotional wellbeing, and post-incident reflection and learning, focused on understanding the incident and preventing recurrence. In this structure, debriefing can be one part of a post-incident response, most often aligning with the reflective learning element, although the literature varies in how the term is used. We therefore use post-

incident responses as our working term in this study while engaging directly with published evidence and policies on debriefing.

Study aim

This study critically examined how debriefing is defined and operationalised within policies following restrictive interventions in mental health inpatient wards in England, drawing on Freedom of Information (FOI) requests submitted to NHS mental health trusts. It explored the extent to which debriefing is formally embedded in policy, whether approaches are consistent across trusts, and how existing policies align with relevant guidelines and legal frameworks. By mapping and critically analysing the current policy landscape, this study aimed to identify gaps in standardisation and inconsistencies in practice, and to identify areas where greater clarity or standardisation may be needed.

Methods

A Freedom of Information (FOI) study was conducted to identify and obtain policies related to debriefing from all NHS mental health trusts in England. This approach leverages the legal right to access data held by public authorities to collect information pertinent to research objectives. In the United Kingdom, the Freedom of Information Act 2000 grants public access to data maintained by public institutions, enabling researchers to obtain valuable datasets that might not be readily available through other means (Clifton-Sprigg et al, 2020). FOI requests have been used increasingly in mental health research to review organisational policies and practices, including studies examining engagement and observation policies (Ashmore, 2020), guidance for informally admitted patients (Ashmore, 2024) and staff support processes following workplace trauma (Berry et al., 2024). These examples demonstrate how FOI requests can yield unique and otherwise inaccessible policy data that inform service evaluation and research.

Trusts were identified through a two-stage process. First, we consulted the Health Psychology Management Organisation Services (2023) list, which is to the best of our knowledge the only overview of NHS mental health trusts, but is out of date in places. We therefore cross-checked this list against the organisations included in the NHS Staff Survey (2024). The NHS Staff Survey website provides the names of all participating NHS organisations in England, including Mental Health Trusts. We compared both sources, removed organisations that no longer existed and confirmed which trusts were providing mental health inpatient services during the study period. This reconciliation process generated a final list of 52 trusts, which was used for the FOI requests.

An FOI request was submitted in writing to each provider in accordance with the Freedom of Information Act 2000, requesting copies of policies, guidelines or procedures that referenced debriefing or post-incident review following restrictive interventions. Additionally, any training materials or staff guidance on conducting debriefing sessions were requested. The FOI request was standardised for all providers and was submitted by two researchers between February and April 2024. Two trusts that were missed in the original requests were contacted in January 2025. Follow-up FOI requests were sent to trusts that provided documents referencing relevant policies, but which were not sent. Received policies were screened for relevance, with inclusion criteria encompassing any document referring to debriefing regardless of title.

Framework analysis was used to extract and organise data in the policies (Carroll et al, 2013). It is a structured approach suited to applied health research and involves five stages: familiarisation,

identifying a framework, indexing, charting, and mapping and interpretation. Following familiarisation with the policies received through reading and rereading, an initial *a priori* framework was developed based on Restraint Reduction Network and NICE (2015) guidance, the Mental Health Code of Practice (Department of Health, 2015) and clinical experience, corresponding with the 'identifying a framework' stage. During indexing this framework was applied systematically to each policy. As new content was identified the framework was refined iteratively, resulting in a final set of 19 items. Six items were binary (e.g. whether the policy explicitly addressed debriefing or included witness debriefing), while the remainder required free-text responses such as definitions of debriefing, details of staff facilitating debriefing and whether facilitators had been involved in the restrictive intervention. Free-text data were also when policy content did not fit predefined categories. Charting involved grouping related items under broad thematic headings to support reporting and comparison. Mapping and interpretation were completed by reviewing the framework matrices to compare content across trusts. Data were extracted by a single researcher (RD) and verified by a second researcher (NH) for accuracy and completeness.

This study did not require ethical approval as it was based on publicly available information obtained through FOI requests. No personal or identifiable data were collected and all responses were received in accordance with the Freedom of Information Act (2000). The study is reported according to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines (von Elm et al, 2007).

Results

Response rate and policy inclusion

In total, all 52 mental health NHS trusts in England were contacted. No NHS trusts refused to comply with the request, but six did not respond, resulting in a response rate of 88.5% (46/52). The 46 responding NHS trusts provided 102 policies, with 22 trusts submitting more than one. The follow-up FOI led to two additional policies, while one trust did not respond and another confirmed that the referenced policy was no longer active. Six policies were excluded as they did not mention debriefing or post-incident responses, resulting in 98 policies included in the review.

Types of policies

The policies covered a variety of topics related to restrictive interventions and post-incident management. While few explicitly addressed debriefing (n=8), most incorporated post-incident responses within wider policies on violence prevention, restrictive practices and risk management. The distribution of policy types was as follows: Prevention and Management of Violence and Aggression (n=19), Seclusion and Long-Term Segregation (n=12), Restrictive Practices/Interventions (n=10), Use of Force (n=10), Rapid Tranquilisation (n=9), Support/Safe Interventions (n=9), Restraint and Physical Interventions (n=9), Debrief (n=8), Risk/Incident Management (n=6), Post Incident Response (n=5), Incident Reporting (n=2), Tear Proof Clothing (n=1), Mental Health Act (n=1) and Mental Capacity Act (n=1).

Post-incident responses in policy content

The extent to which debriefing or post-incident responses were addressed explicitly in policies varied considerably. Only eight policies were labelled specifically as debriefing policies, providing the most detailed guidance on its implementation. However, 60 additional policies contained sections on

debriefing, but these were generally less detailed. The remaining 30 policies made only brief reference to debriefing, offering limited information on how it should be conducted or its intended purpose.

There was also considerable variation in how debriefing was defined within policies. Of the 98 policies reviewed, 72 provided a definition of debriefing, while 26 referred to debriefing without defining it. Where definitions were included, debriefing was typically described as fulfilling multiple functions, including:

- Providing emotional support
- Ensuring physical safety
- Facilitating reflection on the incident and its impact on those involved
- Offering an opportunity to learn from incidents to prevent reoccurrence.

Some policies outlined key discussion points for debriefing, which included:

- Identifying and addressing ongoing risk
- Exploring the emotional and physical impact
- Reviewing triggers, antecedents and other contributing factors
- Evaluating the effectiveness of the restrictive intervention
- Considering alternative strategies for future incidents.

However, there was no standardised framework across mental health NHS trusts. While most policies agreed that post-incident responses should serve both a supportive and a reflective function, there was less clarity on how it should be operationalised in practice.

Policies also varied regarding who debriefing was intended for. Of the 46 trusts that provided resources, 45 (97.83%) included provisions for both patient and staff post-incidents. In contrast, only 30 (65.21%) trusts explicitly mentioned responses for witnesses to incidents, indicating that this group is less frequently considered in formal debriefing policies. The relative lack of attention to witness debriefing highlights a significant gap in post-incident care.

Terminology

Policies also used a wide range of terms to describe post-incident responses. Across the 98 policies reviewed, 51 different terms were identified, including post-incident review, hot debrief, support, defusion and decompression. These terms were often used interchangeably and were not consistently defined. This variation contributed to ambiguity about whether these labels referred to supportive conversations, reflective learning, or both. The inconsistent terminology is likely to affect how staff interpret policy expectations and how debriefing is operationalised across settings.

Structure of post-incident responses

Despite widespread references to staff and patient post-incident responses, there was inconsistency in how these were structured. Some policies outlined distinct processes for different groups, while others combined staff and patient debriefing into a single process without differentiating their specific needs. Among the policies that included patient responses, there was variation in how this was framed. Two policies stated debriefing should occur when the patient is ready and that it is a patient led process, while others imposed strict timeframes without reference to patient readiness. Additionally, 30 policies extended responses beyond staff and patients to include other individuals affected by the incident, namely family or carers or advocates.

Many policies referenced a multi-stage approach, with 33 specifying that responses should take place in at least two phases. In all cases, the first stage was described as supportive in nature, variously referred to as support, hot debrief, defusion or decompression. Among these, 26 described a two-stage process, with the second phase being a review or learning phase (n=18), an unspecified follow up (n=6), a follow up TRiM assessment (n=1) or a formal Critical Incident Stress Debriefing (CISD; n=1). Six policies described a three-phase process, with variations that included CISD, peer support debrief, formal external post incident review and follow up review. One policy specified a four-phase model, incorporating support, review, patient debrief and local debrief. Despite these differences, there was a general consensus that post-incident responses should begin with immediate support before progressing to a structured review phase to facilitate reflection and learning.

Seventeen trusts provided forms or toolkits to structure the debrief for both staff and patients; 10 provided separate forms for staff and patient debriefing; three had only a patient debrief form; two had a combined form for staff and patient debrief; and two provided only a staff debrief form. Two of the patient debrief forms were in easy read format. None of the tools separated the support and learning elements of the debrief. Despite differing formats, there was a general consensus of the content of the debrief: checking physical, emotional and psychological safety; what support is needed; triggers and antecedents; what went well and what could have gone better; where any other interventions attempted; what coping strategies were used or could be used in future; what steps can help prevent reoccurrence; has care plan or positive behaviour support (PBS) been updated; learning from the incident; and action plan.

Sixteen policies specifically mentioned structured debriefing models, with seven different models/frameworks identified:

- Critical Incident Stress Management/Critical Incident Stress Debriefing (CISM/CISD; n=6) (Mitchell et al, 2003).
- TRiM (Trauma Risk Management; n=5) (Whybrow et al, 2015)
- IBERA (introduction, background emotional impact, resourcefulness, action, and close; n=2); cited in one policy but with a broken link.
- COPING (control, orientate, patterns, investigate, negotiate, give support and encouragement; n=2) (Crisis Prevention Institute, 2013).
- Gibbs reflective cycle (n=2) (Gibbs, 2013).
- DEBRIEF (describe, evaluate, banish emotions/beliefs/assumptions, review, establish follow up, feedback; n=1) (Burman, 2018).
- Decompression (n=1) (Kinchin, 2007).

Of the seven models cited, CISD and TRiM were originally developed for staff or occupational settings, while Gibbs' reflective cycle is widely used in professional and educational contexts. The intended audience for IBERIA, COPING, DEBRIEF and decompression was either unclear or not stated in policies. While these models offer structured approaches to debriefing, their implementation varied, with some policies providing detailed guidance and others only referencing the model without further elaboration. In most cases, policies did not specify whether the model was intended for use with staff, patients or both. Where it was stated, models were more commonly applied to staff debriefing.

In addition, a small number of policies referred to broader, service-level approaches relevant to post-incident practice, including Safewards (n=4) and the Six Core Strategies (n=3). These were not presented as structured debriefing models but were cited to contextualise reflective practice or trauma-informed care.

Timing of post-incident responses

Policies varied significantly in their recommendations regarding when post-incident responses should take place. Of the 69 policies that reported a timeframe, 52 stated that a debrief should occur immediately or as soon as possible following an incident. Eleven policies recommended waiting until participants had regained their composure and their level of distress had reduced, while two specified that debriefing should be delayed until risk had decreased and it was safe to proceed.

While most policies endorsed immediate debriefing, 27 specified distinct timeframes for different stages of responses. In these cases, debriefing was often structured as an initial session, followed by a second, more reflective debriefing or review within a defined timeframe. The most cited timeframe was within 72 hours (n=17), in alignment with NICE guidelines. However, recommendations varied considerably, with suggested timeframes ranging from 'before the end of the shift' to between two- and four-weeks post incident.

There were also inconsistencies in how longer-term debriefing interventions were framed. One policy referenced using the Critical Incident Staff Support Pathway (CRISSP), a framework that incorporates CISD, recommending a timeframe of 3 to 28 days post-incident. Another policy that also referenced CISD suggested a timeframe of 72 hours to 14 days, indicating substantial variation in how structured models were applied.

Facilitators

Policies varied in their specifications of who should facilitate post-incident responses. The most commonly designated facilitators were nurses (n=8), the person in charge of the shift (n=6), and a combination of a nurse and a doctor (n=6). Some policies specified that a debriefing should be undertaken by clinicians with training in debriefing or trauma support (n=5), experienced staff (n=3) or an allocated debrief team (n=4). Two policies referenced debriefing by service users or experts by experience, suggesting a model in which those with lived experience play a key role in supporting post-incident reflection.

Only one policy explicitly acknowledged NICE guidelines, which recommend that both a nurse and a doctor should be present for patient debriefing. However, this policy stated that, in practice, the debrief would typically be facilitated by a nurse, unless a doctor was deemed necessary or specifically requested by the patient. Some policies (n=12) distinguished between different stages of debriefing, with the review or learning phase often led by a ward manager, psychologist, matron or service manager.

Beyond facilitator roles, policies also differed in whether the debrief should be led by someone independent of the restrictive intervention. Only 29 policies explicitly considered the issue of facilitator independence, but among these, there was consensus that debriefing should be conducted by someone who was not involved in the restrictive intervention. Only two policies stated that debriefing could be led by staff who had been involved in the incident, one specifying the person in charge of the restraint and the other indicating someone who witnessed the incident. Two policies described expert by experience-led debriefing rather than a staff-led approach. One policy provided conflicting guidance, stating in separate sections that staff both should and should not have been involved in the restrictive intervention, highlighting inconsistencies in policy interpretation.

There was limited reference to patient choice in selecting a facilitator. Only six policies stated that patients should have a say in who facilitates their debrief. One policy specified that while patients

should ideally choose their facilitator, this should be someone who was not directly involved in the restrictive intervention.

Staff training and guidance

References to staff training in debriefing were identified in 28 instances across policies and additional responses from trusts in their FOI responses. Six policies explicitly referred to staff training in debriefing as part of their mandatory training programmes, most commonly prevention and management of violence and aggression (PMVA) training, or conflict management and physical intervention training. However, these documents did not specify the extent, content or duration of the training provided, leaving the level of skill development unclear.

Nine policies provided further detail on how staff were trained to facilitate debriefing. This included references to training specific models such as TRiM, peer support debriefing, defusion, IBERA debriefing and CISM. Two trusts indicated that staff practitioners had received external TRiM training, suggesting some variation in access to formalised training. Two trusts also mentioned the existence of dedicated debrief teams trained in these approaches. Twelve trusts provided additional information about staff training in their FOI responses. In most cases, training was described as brief guidance incorporated in PMVA training, rather than standalone debriefing-specific training.

Discussion

This study highlights significant variation in how debriefing and post-incident responses are defined, structured and implemented across NHS trusts, despite widespread recognition of its importance. These inconsistencies have practical consequences, particularly for mental health nurses who are often responsible for facilitating debriefing but receive little clear guidance on how it should be delivered. Nurses must do so with little formal training, theoretical guidance or support structures, and the resulting ambiguity can undermine both confidence and consistency. Differences in multi-stage debriefing structures, the availability of supporting tools and the choice of formal models indicate a lack of standardisation. Consequently, while legal and regulatory frameworks mandate debriefing, there is little detailed guidance on its content and implementation, contributing to inconsistent practices. This lack of standardisation is reflected in the research evidence, as most studies on debriefing do not provide a clear conceptual framework for its content or implementation (Mangaoil et al, 2020).

A key area of concern is the overall quality of policies. While we did not set out to formally assess quality, many policies provided scant detail and significant variation in practice, with some containing only minimal references to post-incident responses. Many focused on its function rather than outlining clear processes. Some policies provided detailed descriptions of debriefing. The Mental Health Act Code of Practice (Department of Health, 2015) requires providers to have policies that cover debriefing, yet only eight trusts had specific debriefing policies. Many policies contained only brief reference to debriefing, offering little practical guidance for staff or patients. The Restraint Reduction Network (2019) recommends clear policies and procedures to trigger post-incident learning; evidence suggests that inadequate post-incident learning is detrimental to all participants (Burman, 2018). The absence of clear operational guidance places disproportionate pressure on frontline staff, particularly nurses, who must make sense of vague or conflicting policies in the midst of complex and often emotionally charged incidents.

The content and structure of post-incident responses also varied widely. Some policies aligned responses with restrictive interventions, while others did not specify when they should occur or what incidents would trigger it. Many policies lacked clear stages of responses, with only around a third referencing a structured multi-stage approach, as recommended by NICE (2015), the RRN (2019) and research (Goulet and Larue, 2016), which includes an initial supportive phase, often delivered by nurses, followed by a structured review phase. Importantly, patient perspectives on post-incident responses highlight a need for the supportive phase to provide reassurance, a sense of safety and affirmation that staff still care about them (Ridley and Leitch, 2021).

Terminology across policies varied considerably. Fifty-one different terms were used to refer to debriefing, including post-incident review, hot debrief, defusion and a range of other labels. These terms were often applied in similar ways but without clear definitions, making it difficult to determine whether policies were referring to supportive conversations, reflective learning or both. The term debriefing has military origins (Gardner, 2013) and has been described as procedural rather than relational (Restraint Reduction Network, 2019). Several authors have argued for more consistent terminology, suggesting alternatives such as 'post-seclusion or restraint review' (Goulet and Larue, 2016) or 'post-incident review' (Hammervold et al, 2019). This mirrors the views shared in the wider DRIVE-MH study where the patient and carer ESG described debriefing as too clinical and preferred broader language that separates immediate support from later reflection. Their input informed the term 'post-incident responses' used in this study.

Policies also lacked rationale for the models endorsed. While around one in five referenced a structured model, there was no justification provided for the choice of framework. Some policies referenced IBERA, a model for which no source could be identified, raising concerns about the validity of the guidance. Six policies referenced CISD, despite ongoing debate about its effectiveness (Elhart et al, 2019). An early review suggested that CISD does not prevent PTSD and may, in some cases, exacerbate stress-related symptoms (Bledsoe, 2003). Around the same time the World Health Organization (2003) cautioned against certain forms of single-session psychological debriefing. The inclusion of models with unclear or conflicting evidence bases suggests a lack of critical evaluation in policy development.

Notably, none of the models cited in policies were explicitly developed for use with patients. The most commonly referenced frameworks, CISD and TRiM, were developed in occupational or military contexts to support staff following traumatic events (Mitchell et al, 2003; Whybrow et al, 2015). While they offer structured approaches for emotional processing or risk assessment, their assumptions and structure do not translate easily to post-incident engagement with patients. Similarly, models like Gibbs' reflective were intended for professional learning and do not account for the power dynamics, trauma histories or emotional safety concerns central to patient experience. Other models, such as IBERA, COPING and DEBRIEF, are inconsistently defined and their intended audience is rarely stated. There is currently no agreed theoretical foundation for staff debriefing and no established model for debriefing with patients.

The lack of an established theoretical foundation for patient debriefing does not mean relevant concepts are absent elsewhere. Trauma-informed care offers a useful starting point. It emphasises safety, choice, trust and empowerment (Saunders et al, 2023), all of which are directly relevant to post-incident engagement with patients, where coercion or restraint has occurred. However, despite growing adoption across mental health services, there is limited evidence that trauma-informed care consistently produces meaningful or sustained change, particularly in inpatient settings (Wilson et al, 2021).

Relational approaches, including models of relational safety, also highlight the importance of attunement, power sensitivity and safety (Finlay, 2025; McAllister et al, 2019; Podolan and Gelo, 2024). These frameworks shift the focus, and rightly so, from extracting information or delivering procedural feedback towards rebuilding trust and acknowledging harm. Narrative and dialogical models bring something different again. Their emphasis on voice, meaning-making and shared understanding feels much closer to how patients make sense of events (Gravett, 2019; Peters and Besley, 2021). While not designed specifically for debriefing, they may help shape more appropriate patient-facing approaches. Taken together, trauma-informed, relational and narrative approaches offer something more aligned with therapeutic intent than the procedural or occupational models that appear in many policies. These traditions are conceptually distinct but share a focus on safety, meaning and human connection, which makes them a more appropriate foundation for developing patient-facing approaches to debriefing. They may also provide a more useful foundation for mental health nurses, who are often responsible for facilitating debriefing but left to do so with little theoretical guidance. Whether and how these approaches could be adapted into a coherent model remains an open question, but it is a gap that cannot be ignored.

Timing of post-incident responses was another area of inconsistency. While most policies recommended immediate debriefing, there was no agreement on when follow-up responses should occur, with timeframes ranging from within 72 hours to several weeks post-incident, with no clear rationale for these variations. Several policies referenced arbitrary timeframes, such as requiring debriefing before the end of a shift; this may impose constraints that limit the quality of the process (McKenna et al, 2024). The lack of consensus on timing highlights the need for clear, evidence-based recommendations regarding when different elements of debriefing should take place.

Facilitation of post-incident responses also varied significantly. The policies indicated a variety of professionals should be involved. NICE (2015) guidelines stipulate that a doctor and nurse should be present. Burman (2018) states that debriefing should be facilitated by experienced staff and that patient debriefs should be facilitated by someone with whom they have a good therapeutic relationship. The RRN (2019) emphasises that post-incident learning requires a skilled facilitator rather than a specific professional role. In the same guidance, patients identified having a good relationship with the facilitator as important for effective post-incident support. The MHA Code of Practice states that ‘post incident-review or debrief’ should be facilitated by someone who was not involved in the incident (Department of Health, 2015). Some policies designated nurses, doctors, psychologists or trauma-trained staff as facilitators, while others allowed facilitation by those directly involved in the incident, contradicting the MHA Code of Practice.

Only around 6% of policies referenced patient autonomy in selecting a facilitator, reinforcing concerns that debriefing may lack a person-centred approach (Lawrence et al, 2024). Additionally, both NICE (2015) guidelines and Positive and Proactive Care (Department of Health, 2014) state that patients should have the opportunity to discuss incidents with an advocate, family or carer. This was, however, minimally reflected in policies, with only around one third referring to family, friend or advocacy involvement in debriefing. It is possible that such opportunities occur informally or outside of structured debriefing processes, but without explicit inclusion in policy, their application may be inconsistent and subject to variation across settings.

Some trusts attempted to structure post-incident responses through the use of forms and toolkits, but these were not consistently designed. Around one third of trusts provided structured forms, yet none explicitly separated the support and learning elements of debriefing. While structured tools may improve consistency (College of Policing, 2020), they also risk turning post-incident responses into procedural tasks rather than meaningful, trauma-informed processes (Macaulay and Winyard,

2012). Given the high prevalence of trauma histories among mental health inpatients (Gatov et al, 2019) and staff (Henderson et al, 2025), ensuring that post-incident responses aligns with trauma-informed principles is essential to prevent further harm (Hallett et al, 2025).

Strengths and limitations

A key strength of the study lies in its systematic use of the Freedom of Information Act (FOIA) to obtain data from all NHS mental health trusts in England. By invoking a legal right to access public records, the study ensured high transparency and reduced selection bias, as all public bodies are obliged to respond under the Act. The study achieved a robust response rate of 88.5%, offering a wide-ranging and representative overview of current debriefing policies. It is important to note, however, that private providers of NHS-funded services are not subject to FOIA and therefore any policies held by these organisations have not been captured, potentially limiting the comprehensiveness of findings.

Rather than relying on self-reported practices, the study requested original policy documents, allowing for an examination of how debriefing is conceptualised and operationalised across NHS mental health services. This approach allowed us to capture formalised policy positions rather than informal or aspirational accounts. The use of a standardised FOIA request enhanced consistency across data sources, while the structured, iterative content analysis tool, developed in line with established guidance and clinical expertise, strengthened the reliability of the analysis. Additionally, free-text data extraction enabled the identification of nuanced themes and policy language that could have been missed using strictly quantitative methods.

The study is not without limitations, however. The reliance on trusts to locate and submit relevant documents introduces the potential for inconsistencies; key materials may have been overlooked, particularly where debriefing content was embedded in documents not explicitly labelled as such. It is also important to note that policies may not accurately reflect routine clinical practice. The study did not set out to evaluate whether debriefing is implemented as described, nor to assess the perceived effectiveness or experiential quality from the perspective of patients or staff.

Moreover, the focus on England restricts the direct applicability of findings to other jurisdictions where legal frameworks, healthcare governance structures and professional cultures may differ. Despite this, the findings remain relevant internationally as many countries reference NICE guidance to shape policies and practice. The issues identified, such as inconsistent definitions and unclear procedures, are not unique to England (Hammervold et al, 2019). These findings can contribute to international discussions on standardising debriefing practices in mental healthcare.

The absence of formal quality appraisal of the submitted policies represents another limitation. While the review identified variability in comprehensiveness and content, these assessments were interpretive rather than based on standardised criteria. Finally, although a wide range of debriefing models were identified, the rationale for their selection was unclear, and the evidence underpinning these frameworks was either limited or not articulated, raising questions about their appropriateness in clinical settings.

Conclusion

This study has found that post-incident responses are poorly defined, with significant inconsistencies in how they are interpreted and implemented in policy across NHS mental health trusts in England. While existing guidelines and legislative frameworks mandate such responses, there remains little

clarity regarding what this entails in practice. Policies varied widely in their approach to the responses, with differences in structure, timing, facilitation, and content. Furthermore, the lack of a clear definition contributes to variation in how post-incident responses are applied across settings, leaving frontline staff, particularly nurses, to navigate ambiguity in high-stakes situations.

There is limited research on post-incident responses or debriefing, and much of the available literature does not provide a conceptual framework for its content. This gap is reflected in the policies reviewed, where the purpose and structure of post-incident responses were often ambiguous or inconsistently described. Without clearer guidance, there is a risk that responses may be inconsistently implemented or fail to achieve their intended purpose of supporting staff and patients while preventing future incidents. This is particularly problematic for nurses, who are often expected to lead post-incident responses without formal preparation and who must continue working with the same patients afterwards, regardless of how well the process went.

Further research is required to define post-incident responses clearly and explore the essential components to ensure that they can better support staff and patients. Establishing precise guidance on how and when post-incident responses should occur will facilitate their use in practice, supporting nurses and other practitioners to deliver effective post-incident care. Post-incident responses aimed at patients should contribute to the provision of proactive support, enhance relational safety and well-being, and thus reduce harm and mitigate retraumatisation. Policymakers should consider developing evidence-based frameworks that align with trauma-informed principles to support the standardisation of post-incident responses in mental health services.

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