Debriefing following seclusion and restraint

A summary of relevant literature

Te Pou
o Te Whakaaro Nui

Acknowledgements

Contents

Te Pou
o Te Whakaaro Nui

Executive summary

The focus of this report is on practices associated with debriefing after seclusion or restraint events in mental health inpatient units. Debriefing is the practice of reviewing an event, in order to process aspects of the experience and learn from it. In the context of seclusion and restraint reduction, debriefing is considered a tertiary prevention strategy, as it is designed to prevent further occurrences of coercion and is consistent with trauma-informed care and quality improvement principles. Debriefing is the sixth of the Six Core Strategies for Reducing Seclusion and Restraint Use (6CS) (Huckshorn, 2004).

This report is intended to provide a summary of current debriefing practices that have been shown to contribute to successful seclusion or restraint reduction programmes, drawn from a review of relevant literature. The summary provides a foundation for services to develop or modify current debriefing practices in line with evidence-informed guidelines. There is significant and growing research demonstrating the effectiveness of the 6CS in reducing coercive practices and some evidence that discrete interventions such as structured risk assessment and soothing or calming physical environments are particularly effective. However, to date there is very limited evidence of the effectiveness of debriefing as a discrete intervention for reducing seclusion and restraint use. It should be noted that debriefing fits within a quality-improvement framework making it difficult to separate out from other components of organisational change, such as leadership and training. Debriefing is highlighted as a critical element within many quality improvement studies of seclusion and restraint reduction, where change at an organisational level is achieved successfully. Further, the practice is important in its own right because debriefing with service users operationalises trauma-informed and recovery-oriented care and is consistent with the ethos and duty of clinical practice.

The literature that informs the key messages in this report is organised into three sections: 1) Service user debriefing as a strategy to prevent a recurrence of seclusion or restraint, 2) Staff debriefing as a strategy to reduce seclusion and restraint use, and 3) Psychological debriefing to relieve distress. In the first two sections, reported practices and exemplars related to the content and process of debriefing are summarised, along with the indicated characteristics of debriefing facilitators and their training needs. In the third section, attention is paid to the issues attached to psychological debriefing as a strategy for reducing distress, followed by an overview of alternative frameworks for post-incident support including Psychological First-Aid and a 'Screen and Treat' approach. The key messages from each of these sections are summarised in the following page.

Service user debriefing to prevent further seclusion or restraint

This practice involves a review of events leading up to the seclusion or restraint incident and the identification of staff and service user actions that would help avoid further coercion. The literature suggests that there are three key components to service user debriefing: 1) Behavioural analysis, 2) Education, 3) Collaborative problem solving/planning. The literature also indicates that debriefing should occur once service users have had time to recover from the physical and emotional impact of forced containment, so that they are able to provide thoughtful input and gain something from the process. Debriefing should never be forced and service users should have a range of realistic options about who facilitates the debriefing and when it occurs, to help restore a

sense of control in their care. A service user representative in post-incident reviews can reduce power imbalances in the encounter as well as promote the service user's voice at later clinical or organisational reviews.

Staff debriefing to reduce seclusion or restraint use

Staff debriefing is a rigorous event analysis of each incident to address practice issues, identify system problems and prevent recurrences. Despite methodological limitations in most of studies, outcomes consistently point to the contribution of formal debriefing or event reviews in successful seclusion and restraint reduction initiatives. Three levels of staff debriefing are summarised:

- immediate post-event analysis to ensure safety and clarity of documentation
- formal team debriefing as a routinely scheduled quality or practice development activity
- executive level or external review by senior clinical and management staff.

Each level of staff debriefing has a particular focus and different requirements for timing, and each provides a feedback loop for the ongoing improvement of practice, systems and service culture. The preparation of formal debriefing facilitators is particularly important and requires the broad organisational overview of senior leadership who are able to separate facts from feelings in a way that ensures all contributors to the review feel safe and supported.

Psychological debriefing

Distinct to the aims and processes of debriefing for the purposes of preventing seclusion, psychological debriefing is an equally important process of providing post-incident emotional support. This process warrants specific attention because of the variety of practices, potential pitfalls and its importance for rebuilding a therapeutic environment and relationship. This report outlines practice principles and components of:

- Critical Incident Stress Debriefing (CISD)
- Psychological First Aid
- Screen-and-Treat.

It is recommended that services develop their own procedures for providing post-incident support, drawing on the principles of psychological first aid and/or a screen and treat approach. Ensuring service users and staff have opportunities to access social, emotional and physical support in the aftermath of seclusion or restraint should be a priority. Recognizing the potential for long term negative effects, and screening for symptoms of post-traumatic stress is also an important consideration in post-incident support.

Te Pou
o Te Whakaaro Nui

1. Introduction

The reduction of seclusion and restraint practices in New Zealand inpatient mental health and addiction services has been highlighted as a priority objective (Ministry of Health, 2010). Inpatient services, both in New Zealand and internationally, have implemented organisational change programmes with the aim of reducing seclusion and restraint use. These programmes typically incorporate some or all of the *Six core strategies for reducing seclusion and restraint use* (hereafter, 6CS) (Huckshorn, 2007). The strategies were developed by the American National Association of State Mental Health Program Directors (NASMHPD, 2005, 2007) and include:

- leadership towards organisational change
- using data to inform practice
- workforce development
- use of seclusion and restraint reduction tools
- consumer roles in inpatient settings
- debriefing techniques.

A growing body of literature supports the implementation of multiple strategies to reduce seclusion and restraint practices (Bowers et al., 2010; Gaskin et al., 2007; Scanlan, 2010). The recent emergence of randomised controlled studies has begun to validate the effectiveness of a multiple-strategy approach to seclusion and restraint reduction (Putkonen et al., 2013; Wieman, et al, 2014). Controlled studies have also demonstrated the effectiveness of some single-intervention approaches derived from the 6CS, such as sensory-based modifications to the physical environment (Borckardt et al., 2011) and structured risk assessment (Griffith, Daffern, & Godber, 2013). Additionally, the volume of qualitative and quasi-experimental studies using the strategies points to a body of evidence that, taken as a whole, is valuable for practice (Gaskin et al., 2007; Johnson, 2010). Of particular note is the fact that several studies report the use of multiple strategies to completely eliminate seclusion and restraint practices over sustained periods of time (Ashcraft & Anthony, 2008; Barton et al., 2009; LeBel et al., 2010; Singh, Subhashini, Davis, Latham, & Ayers, 1999; Smith et al., 2005). As a result of these studies, debriefing is often reported as being one of multiple strategies that can be used in combination to successfully reduce seclusion and/or restraint (Azeem et al., 2011; LeBel, Huckshorn & Caldwell, 2010; Lewis et al, 2009).

In the context of seclusion and restraint reduction, debriefing involves the facilitation of purposeful conversations with the staff and services users involved in an incident, in order to review the event and develop strategies to avoid it reoccurring. Additionally, the increased recognition of the distress and trauma associated with seclusion and restraint has highlighted the need to examine the use of debriefing to mitigate the negative psychological impact of forced containment. However, there is a reported lack of clarity regarding post-seclusion and restraint debriefing and inconsistency in how the intervention is used (Needham & Sands, 2010; Ryan & Happell, 2009). With the aim of developing greater clarity and consistency in the use of debriefing within inpatient mental health services, the following report provides a summary of relevant debriefing literature and aims to highlight evidence-informed principles and frameworks for practice.

2. Method

The construction of this summary document was guided by the principles for producing evidence summaries using a 'rapid review' process (Khangura, Konnyu, Cushman, Grimshaw, and Moher, 2012). This form of review facilitates a streamlined synthesis of evidence and is therefore able to generate practical recommendations within a limited timeframe. A rapid review was also indicated for this topic as no experimental evidence has been published examining the use of debriefing following seclusion and restraint, therefore a review of descriptive qualitative and quantitative research as well as relevant grey literature was necessary.

A systematic search of the literature published since 2000 was conducted through the following databases: Cinahl (Ebsco), Medline, Psyc Info and Scopus. Key search terms used included: Debrief*, Post-incident review, Post-event analysis, Seclusion, Restraint, Psychiatr*, Inpatients, Patients, Nurs*. After screening of the literature through inspection of titles and abstracts, the most relevant articles were read and coded by two researchers independently. Only studies that described or discussed the use of post-seclusion or restraint debriefing and gave some detail of what this involved were included. The concordance of the coding is summarized in the tables found in Appendix A and B.

Te Pou
o Te Whakaaro Nui

3. Findings

3.1. Service user debriefing for seclusion and restraint reduction

3.1.1 Summary of evidence for service user debriefing

Fourteen studies published since 2000 were identified that explored or reported the use of service user debriefing as an element of seclusion or restraint prevention. Six of these studies were descriptive reports of information derived from questionnaires or interviews and focus groups (Bonner et al., 2002; Bonner & Wellman, 2010; Larue et al., 2010; Needham & Sands, 2010; Petti et al., 2001; Ryan & Happell, 2009). Seven studies reported the use of service user debriefing as one component of a successful seclusion and restraint reduction programme (Ashcraft & Anthony, 2008; Azeem et al., 2011; Fisher, 2005; Jonikas, 2004; Putkonen et al., 2013; Sclafini et al., 2008; Sullivan, 2005). Only one study, a pilot of single-session service user debriefing, included a comparison group (Whitecross, 2013). Length of data collection periods, where specified, ranged from one to 36 months. The average sample size for the studies where this was specified was 42, and these were comprised mostly of clinical staff, but service users were also represented in most studies depending on the aim of the study. Taken as a whole, the evidence base to guide the timing, purpose and delivery of debriefing is not strong, as the literature consists mostly of descriptions of experiences. Quasi-experimental trials that could point toward correlation or causality are absent. Also absent from the literature are descriptions or trials of culturally-specific interventions for the delivery of post-event debriefing. Most studies focused on adult inpatient services, with only three conducted in youth inpatient services (Azeem et al, 2011; Jonikas, 2004; Petti et al., 2001). Specific characteristics of each study in this category of service user debriefing are presented in Appendix A.

Research has highlighted that service user debriefing is not routinely offered and approaches to the intervention are inconsistent, with a lack of clarity as to its primary function, what it consists of, when it should be delivered and who should deliver it (Bonner et al., 2002; Needham & Sands, 2010; Ryan & Happell, 2009). Despite these issues, there remains a strong warrant for the practice and some common features of debriefing are described in studies that have used the intervention as part of the 6CS framework. Service users have expressed a desire for debriefing following seclusion or restraint, including opportunities to understand and change their behavioural responses to distress, anger or frustration (Bonner et al., 2002; Faschingbauer, et al, 2013). The vast majority of service users surveyed in one study agreed that a post-incident debrief was useful (Bonner & Wellman, 2010). Where debriefing was part of a successful seclusion reduction programme, the practice generally involved analysis of the events leading up to the intervention, incorporated perspectives from both service user and team and involved planning to avoid a repetition of the restraint or seclusion (Azeem et al, 2011; Fisher, 2003; Jonikas et al; Sullivan et al., 2005; Visalli & McNasser, 2000).

An unpublished pilot project was initiated in 2012 within the inpatient unit of a large New Zealand District Health Board (Butler & Martin, 2012). The study is noteworthy as it involved a consumer advisor/educator who conducted post seclusion or restraint debriefing with service users. Descriptive data analysis found that the majority of service users who had undergone debriefing had not been involved in further incidents of seclusion

or restraint, indicating a potential role for service user representative or peer support in seclusion and restraint reduction.

3.1.2 Content and process of service user debriefing

The literature suggests that three components of debriefing may support service users to gain knowledge from their experience and to avoid further seclusion and restraint. These can be summarised as 1) behavioural analysis, 2) education and 3) problem solving and planning.

Behavioural analysis

Behavioural analysis involves examining the antecedents, behavioural responses and consequences related to the seclusion and restraint incident. Figure 1 provides examples of questions that may be used to facilitate a behavioural analysis. It is important to note that the analysis focuses on both staff and service user behaviours and on what could be done differently in the future to avoid further incidents.

- Tell me about what happened that led you to being secluded/restrained?
- What sort of things were you feeling leading up to that event and why were you feeling that way?
- So you felt…when...? (Confirm feelings and triggers to develop understanding, trust & engagement)
- Has there been a time when you have experienced those sorts of feelings before and you did something that helped ease them? What did you do?
- What sort of things could staff do that would have helped the situation?
- Are there any things that we haven't already talked about that you or staff could have done differently to prevent this?
- What can we do to make sure these helpful actions happen in the future? (e.g. explore self-soothing options, develop staff and service user skills and strategies, incorporate into safety/crisis/WRAP plans)
- Is there anything else you would like to discuss related to what happened or that we can learn from the experience to ensure this doesn't happen again?

Figure 1: Sample Questions for Service User Debriefing

Education

The literature suggests that education should be provided based on individual needs, which may become apparent through the process of behavioural analysis. For example, some service users have reported that they did not understand the reasons for their seclusion or restraint and perceived that staff used these practices as mechanisms of power and control (Meehan et al., 2004). Therefore, the provision of information about why seclusion and restraint was used and the general aim of the practices may be needed (Horsfall & Cleary, 2003; Norris & Kennedy, 1992; van der Merwe, 2012; Whitecross et al., 2012). However, it should be noted that hearing staff justifications for their use of seclusion and restraint may not be an immediate priority for service users who may initially place more importance on emotional support (Bonner et al., 2002; Ryan & Happell, 2009; Larue et al, 2010). If PRN medication has been used in the process of containment, then information about the effects and side effects of this may be needed. Additionally, information about acute stress responses following a traumatic event could be indicated for some service users, in order to validate their experience, help

Te Pou
o Te Whakaaro Nui

them to distinguish their acute response from other mental health symptoms and recognise the possibility of re-traumatisation from earlier events (Deahl, 2000; Giddens, 2008).

Problem-solving and planning

The final aspect of service user debriefing cited in the literature is the development of solutions to the issues identified during the behavioural analysis. Debriefing provides an important opportunity for service users to make explicit what they and staff could do differently in possible future crises and record this in their advance directives, recovery, WRAP and safety plans.   Collaborative problem-solving and developing a set of constructive coping strategies (Georgieva, 2012; Hendryx et al., 2010; Martinez, Grimm & Adamson, 1999) contribute to successful seclusion reduction programmes. One five-year prospective study demonstrated the effectiveness of collaborative problem solving for preventing restraints in a youth inpatient unit (Martin, Krieg, Esposito et al., 2008).

Needham and Sands (2010) argue that service users should be routinely informed of the availability of post-seclusion debriefing and the nature and potential benefits of the approach when they are oriented to the ward. The literature also suggests that opportunities for debriefing are offered as soon as possible, but only conducted when the service user wants and feels able to provide thoughtful input (Petti et al. 2001; Fisher, 2004; NETI, 2005; Whitecross et al., 2013). The content and process of debriefing may need to be adapted to suit each individual's preferences and needs (e.g. attention span, memory, cultural needs and level of trust). This includes choice of debrief facilitator and other participants. The presence of people in service user roles such as advocates, peer support, consumer advisors have been found to be helpful, and non-involved staff may be perceived as being safer and more objective than staff involved in the incident (Ryan & Happell, 2009; NETI, 2005).
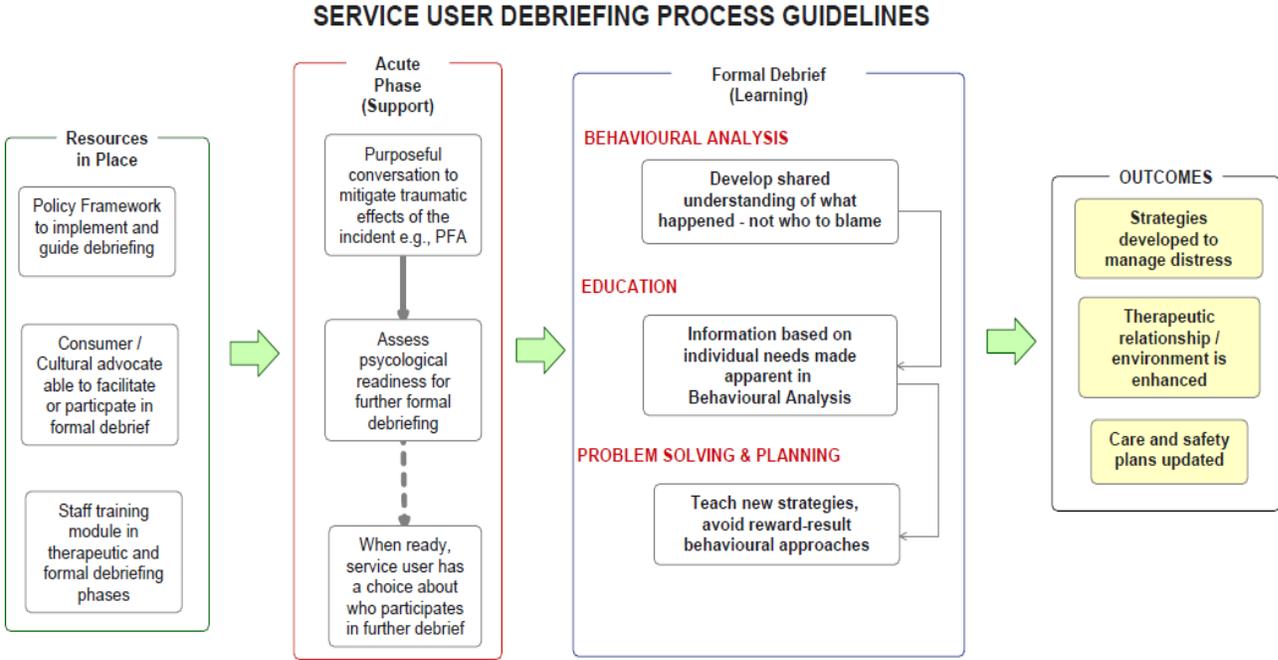

SERVICE USER DEBRIEFING PROCESS GUIDELINES

Figure 2: Service user debriefing processes

3.1.3 Characteristics and training needs of service user debriefers

The majority of the reported service user debriefing was conducted by nursing staff from the service user's treatment team, either one to one or with a team, although there are reports of successful deployment of clinical researchers, service user representatives and senior nurses from another ward to act as an 'on-call witness' (Bonner et al., 2002; Ryan & Happell, 2009; Butler & Martin, 2012; Lewis et al., 2009). Research has highlighted that service users may be distressed with the staff directly involved in their seclusion or restraint (Meehan et al., 2000), and where that is found to be the case, staff not directly involved in the incident should act as debriefers (NETI, 2005). Service users should have a range of realistic options about who facilitates the debriefing, which may help to restore a sense of control (Ryan & Happell, 2009). The presence of a skilled service user representative in post-incident reviews can level perceived power imbalances in the encounter and provides someone to promote the service user's voice at later clinical or organisational reviews (NETI, 2005).

None of the reviewed intervention studies specifically examined the training requirements of debriefing facilitators. However, findings from several studies of service user experience have led to recommendations for specific types of staff training, including:

- specific training in debriefing practice, incorporating behavioural analysis, collaborative problem solving and understanding service user support needs (Faschinbauer et al., 2013; Horsfall & Cleary, 2003)
- regular updates of therapeutic communication skills, including verbal mediation strategies (Georgeiva et al, 2012; Hendryx et al, 2010; Horsfall & Cleary, 2003; Needham & Sands, 2010; Petit et al., 2001)
- training in how to coach effective coping skills including anxiety management techniques (Faschinbauer et al., 2013; Mabey & Servellen, 2014) and sensory based de-arousal activities (Champagne & Stromberg, 2004)
- the cultural competence of staff has also been highlighted as a key consideration in the facilitation of a shared understanding and collaborative problem solving with Māori service users (Te Pou o Te Whakaaro Nui, 2013).

It has been suggested that excessive use of seclusion and restraint prevents clinical teams and service users from acquiring the knowledge and skills to implement strategies for managing distress, overwhelm and aggression (Donat, 2003). This may lead to a vicious cycle, in which service users experiencing aggressive distress are treated by inexperienced, risk averse clinical teams that perceive the need for increasing levels of coercion (Qurashi et al., 2010). The provision of adequate staff training and effective service user debriefing appear to be important elements in breaking this cycle of negatively reactive practice, through encouraging shared responsibility and an increased sense of control in crisis situations.

Te Pou
o Te Whakaaro Nui

3.2. Staff debriefing for seclusion and restraint reduction

3.2.1 Summary of evidence for staff debriefing

Fourteen studies were found that reported the use of formal staff debriefing within a treatment team or at an executive review level. The characteristics of these studies are tabled in Appendix B. There are two stages of staff debriefing with distinct purposes: 1) Immediate debriefing for the staff members involved in the incident to ensure safety of service users and staff and that information about the event is captured and documented, and 2) Quality improvement or organisational development, involving formal reviews with direct care and administrative staff. The focus of the selected studies is on formal staff debriefing as part of organisational and performance improvement, and are descriptive by design, using a baseline of rates for measurement of change. Formal debriefing as a tool for practice and organisational development is a rigorous event analysis of each incident to address system problems and prevent recurrences. Less than half of the selected studies involved service users in this debriefing process. Outcomes included significant reductions in the number of events and duration spent in seclusion and restraint in the intervention wards. For example, Lewis et al. (2009) found that debriefing service users with staff not involved in the event, as well as next-day formal team review was linked to a 75% reduction in seclusion and restraint events with no increase in injuries to service users or staff. When one organisation lowered the threshold for review, raised the frequency of reviews and increased the level of leadership and external expertise, the review process was found to be the single most potent factor responsible for the reduction of seclusion and restraint in comparison with a variety of other organizational strategies (Donat, 2003).

3.2.2 Structure and process of staff debriefing

Within the 6CS guidelines, Huckshorn (2008) recommends the use of debriefing after every seclusion or restraint event to create a culture of enquiry and change. This is achieved through conducting a rigorous analysis of the event in order to facilitate an improved outcome for all concerned. Debriefing is future focused, as the goal is to prevent problems rather than placing blame for the event that occurred (Caldwell, 2005). Huckshorn (2004) divides debriefing procedures for staff into two different phases: The first debriefing opportunity involves a post-incident analysis that occurs as soon as possible after the event. The second debriefing is a more formal process that takes place a few days later and includes rigorous methods of analysis and problem solving in relation to the event. The literature describing these forms of debriefing will be discussed, followed by a third level of executive review that was reported in several studies.

Immediate post-incident analysis

Huckshorn (2004) suggests that the purpose of immediate debriefing is to ensure the safety of all involved, review documentation, talk with staff and others who were present, and attempt to return the unit to its pre-crisis milieu. The benefit of this process is that staff learning is supported while information about the incident is fresh and can support meaningful plan revisions (Azeem et al., 2011; Fisher, 2003; Lewis et al., 2009). The use of 'witnessing' during immediate debriefing was also reported by studies (Allen et al., 2009; Lewis et al., 2009). Huckshorn describes 'witnessing' as a primary intervention to elevate the visibility of seclusion and restraint events where each incident is reported and discussed with a Clinical Director within 24 hours. Studies found

that the use of standardized terms and clinical jargon in recording incidents restricted learning for subsequent shifts or in later reviews of the events (Pettit et al., 2001; Needham & Sands, 2010). For example, the term 'aggressive behaviour' could be reframed descriptively as "Joe hit Bill" to allow more accurate analysis and the development of targeted prevention strategies.

Formal team debriefing

Formal debriefing builds on knowledge gained from the immediate debriefing and provides an opportunity for a more in-depth analysis of events. Key professional, administrative and support staff within the service may attend this meeting to review and analyse the event. The service user's perspective is seen to be critical and can be presented by an advocate if the service user is unable or chooses not to participate (Bluebird, 2004). Studies that reported using formal staff debriefing (Azeem et al., 2011; Fisher, 2003; Lewis et al., 2009) described the importance of applying root cause analysis (RCA), a structured process for deeper problem solving, during the debriefing process. The advantage of RCA is that it encourages staff to take a no-blame approach to problem solving, as the analysis is of the setting, situation and system rather than on any treatment or care provided by an individual (Williams, 2001; Woodward et al., 2004). Huckshorn (2006) provides guiding questions to structure the RCA (see Fig. 3)

- Had a treatment environment been created where conflict was minimised?
- Could the trigger for conflict (symptoms, personal, environmental) have been prevented?
- Did staff notice and respond to events?
- Did staff choose an effective intervention?
- If the intervention was unsuccessful was another chosen?
- Did staff order S/R only in response to imminent danger?
- Was S/R applied safely?
- Was the individual monitored safely?
- Was individual released as soon as possible?
- Did post-event activities occur?

Figure 3: *Sample Questions for Staff Debriefing*

Executive level and external review

The literature suggests that executive level and external review committees meet less frequently than other debriefing groups and have two main functions: 1) to support the treatment team by providing expertise in addressing the behavioural and support needs of particular service users and 2) to provide administrative level support for quality improvement and broader systems change for seclusion and restraint reduction (Donat, 2003; Foxlewin, 2012; Qurashi et al, 2010; Vissali et al., 2004). Review committees described in the literature involved senior clinical representatives and administrative staff from the inpatient services, but also input from external consultants with behavioural or service user-focused expertise. Some studies reported that the views of service users and staff involved in the incidents were incorporated and it was highlighted that external consultants helped to identify and validate the need for additional resources for individualised care, supported culture change amongst treatment staff and encouraged the revision of policies.

Te Pou
o Te Whakaaro Nui

Typically a formal debriefing consists of discussion of the 'facts' followed by a discussion of feelings, leading to planning for service and practice change. Engaged leadership and committed direct care staff appear to be critical factors in a successful debriefing process. A synthesis of practices indicate that staff debriefing may occur across 3-phases, as presented in the Figure 3. A post-event debrief should happen as soon as possible to ensure safety, clear documentation, and a return of the unit to pre-event atmosphere. Formal team debriefing should happen within a few days, with studies suggesting a range of one to seven days. Executive review might occur fortnightly to monthly depending on the number of incidents and urgency of need. Service users should, where possible, be interviewed before any formal team debriefing so that their perspectives can form part of that review. In the formal team and executive level reviews, the level of management and external expertise escalates according to the complexity of the situation under review.
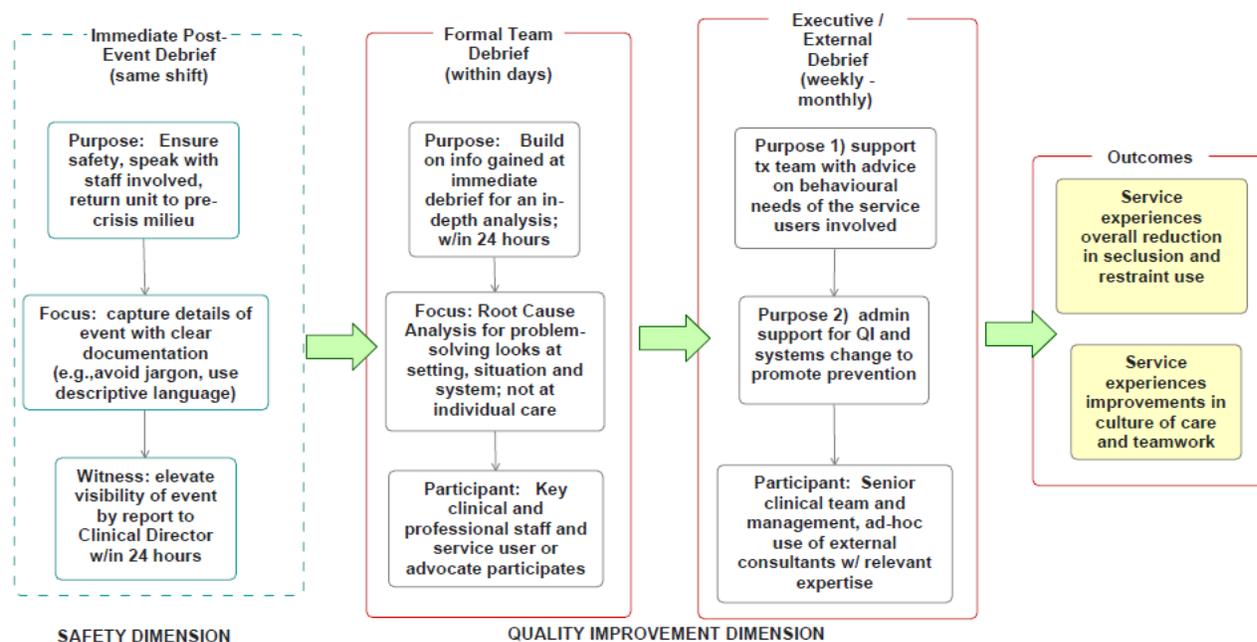
STAFF DEBRIEFING PROCESS GUIDELINES

Figure 4: *Staff Debriefing Processes*

3.2.3 Characteristics and training needs of staff debrief facilitators

Guidelines recommend that facilitators of formal debriefing for organisational change should be senior staff members or trained clinical responders. The staff member should not have been involved in the seclusion or restraint incident and ideally would have advanced training relevant to debriefing (Huckshorn, 2007, 2008; NETI, 2005). The recommended specialised training areas include: 1) Seclusion and restraint policy and procedures, 2) Therapeutic communication and 3) Facilitating objective problem solving (root cause analysis) within formal debriefing (Huckshorn, 2007, 2008; NETI, 2005). Additionally, facilitating debriefing requires group facilitation skills, and the capacity to separate concrete behaviours and contextual factors from the emotion associated with the event. Facilitators need to be sensitive to the needs of those participating, so that a safe environment is created where staff and if possible service users, can engage in the review (NETI, 2005). It is

suggested that senior managers are in a better position to remain objective, avoid being side tracked by special relationships with certain staff members or to make staff feel guilty, and are able to set the tone by role modelling positive analysis, problem solving and efficient planning (NETI, 2005).

3.3 Debriefing as a tool to reduce psychological distress

Despite increased recognition of the negative psychological impact associated with coercive practices there is little research or guidance on psychological debriefing or other forms of post-incident support in mental health settings (Grubaugh, Zinzow, & Paul, 2011; Jacobowitz, 2013). This issue is complicated by the fact that the impact of trauma is contextually determined and that recovery processes are unique to individuals (Litz, 2008; Suveg, 2007). This challenges one-size-fits-all approaches to post-incident support and makes the generalisation of psychological debriefing research across populations and contexts problematic. Most of the literature related to psychological and emotional support following traumatic events has examined the use of psychological debriefing following natural disasters, war or with emergency service workers (Rose et al., 2002). However, none of the research has explored the application of psychological debriefing with people experiencing significant mental health issues following traumatic incidents. In fact, people with psychiatric disorders are frequently excluded from clinical trials of trauma-related interventions to limit the impact of confounding factors on the outcomes (Grubaugh et al., 2011; Rose et al., 2002). In the absence of relevant intervention studies, the available literature highlighting considerations for post-incident psychological support will be briefly reviewed, followed by a summary of possible approaches to post seclusion and restraint psychological debriefing.

3.3.1 The need for post incident psychological support

While there is little evidence available to guide trauma-informed debriefing in acute mental health services, there is a substantial body of research into the harm seclusion and restraint inflict on staff and service users (eg. Frueh et al., 2005; Martinez et al., 1999; Weiss, Altimari, Blunt & Megan, 1998). This includes shame, humiliation, loss of dignity, helplessness, physical harm and re-traumatisation (Kontio et al., 2010; Whitecross et al., 2013). Exacerbating these feelings, service users report feeling as though they have been punished and are isolated and ignored rather than supported, following containment (Bonner et al, 2002). Staff are frequently left feeling traumatized, fearful, guilty and powerless (Jacobowitz, 2013; Sequeira & Halstead, 2004). Studies of restrictive practices have highlighted an urgent need for improved post-incident support for both service users and staff (eg. Larue et al., 2010; Meehan et al, 2000; Ryan & Happell, 2009).

Five studies were identified that directly discussed debriefing to mitigate distress following seclusion and restraint (Bonner et al, 2002; Bonner & Wellman, 2010; Ryan & Happell, 2009; Needham & Sands, 2010; Whitecross et al., 2013). However, these studies provided limited guidance on the content or process of psychologically focused debriefing, highlighting the need for improved understanding of service user and staff needs and the development of frameworks for post-incident support. Guidelines state that post-incident support can be provided through validating service users' experience of distress and allowing for angry reactions and expression of feelings (Huckshorn, 2007). This approach is supported by studies that report that service users value having someone who will listen and validate their experiences following seclusion and restraint (Allen, Carpenter, Sheets, Miccio, & Ross, 2003; Meehan et al., 2000).

Some studies stressed the importance of choice and flexibility in meeting the support needs of individual service users. This includes consideration of the individual's readiness for debriefing as well as gender and culture differences, which may affect who the person is most comfortable talking to, the time required to establish rapport and where and when the debriefing is held (Hendryx et al, 2010; Needham & Sands, 2010; Tyler, Beckley 2012; Whitecross et al., 2012). For example, Whakawera-Mika, (2012) has suggested the piloting of a Māori debriefing and reflection process for tangata whaiora within a kaupapa Māori framework. The incorporation of cultural advisors, family/whanau, and practices such as mihi and karakia, as well as spaces such as Mārae would support engagement in debriefing for many Māori service users. Some individuals might not feel comfortable discussing emotional experiences at all and the provision of practical and sensory-based strategies such as a walk, cup of tea, offer of a shower or sensory room may be more appropriate (Fisher, 2003).

It is important to stress that participation in post-event debriefing should not be mandated, as forced debriefing may increase distress and cause individuals to shy away from accessing psychological services in the future (Bisson, McFarlane, & Rose, 2000; Litz, 2008). Table 1 provides a summary of pre-cautions in relation to the use of psychological debriefing.

Psychological debriefing literature suggests that the following practices should be avoided:
- forcing individuals to talk about their experience, when they are actively avoiding it or 'shutting down'
- discussing the experience when the person is still agitated, or experiencing acute psychotic symptoms or elevated states
- requiring individuals to talk about the experience with people who are not trusted or known to them
- focusing on justifying staff actions or identifying who was responsible, when the person wants to express how they feel and have their experience validated
- leaving individuals feeling isolated for an extended period of time without offering an opportunity to discuss the incident with a trusted support person (i.e., more than 24hrs)
- inviting the person to discuss the experience but not allowing enough time to validate their thoughts and emotions or to discuss ways of managing their distress and getting the support they need
- opening up past traumatic experience without providing safe containment and offering further options to address the trauma.

Figure 5: Precautions Related to Post-Incident Psychological Debriefing

3.3.2 Approaches to post-incident support

Consideration is given to three approaches to post-incident support, with the advice that there are no published evaluations of effectiveness for the use of these approaches within inpatient mental health settings. Critical Incident Stress Debriefing (CISD) and Psychological First Aid (PFA) have been developed as early interventions for use following traumatic events, and the 'Screen and Treat' approach involves a period of watchful waiting, where individuals who need further specialised treatment such as Trauma-Focussed CBT may be identified.

Critical incident stress debriefing

Critical incident stress debriefing (CISD) is the most commonly used form of psychological debriefing, consisting of a standardized, structured approach to discussion of thoughts and emotions within a group setting, as outlined in Table 2 (Mitchell, Sakraida & Kameg, 2003). The approach was developed for use with emotionally healthy people experiencing acute stress reactions to abnormal traumatic events (such as emergency workers or survivors of natural disasters), rather than persons with acute psychiatric symptoms. However, even within the groups for which it was developed CISD has been found to be ineffective in preventing PTSD and potentially harmful when it exacerbates the acute stress reaction (Rose, Bisson, Churchill, & Wessely, 2002). The mixed evidence for CISD may be explained in part by the possibility that it is not always therapeutic for survivors of traumatic events to immediately discuss the events. Natural defense mechanisms such as avoidance (i.e. not engaging in talking) may be more therapeutic or individuals may be unable to participate due to emotional numbness, fatigue, or poor physical condition (Deahl, 2000; Mitchell, Sakraida, & Kameg, 2003). Bonner and Wellman (2010) have argued that any approach that requires in depth discussion of affective, cognitive and physical reactions should be avoided following seclusion or restraint incidents.

The uncertainty related to single session psychological debriefing and the recognition of the need for psychological readiness to discuss a traumatic event, have led to recommendations of a more individualised approach to post-trauma care. Clinical guidelines developed by NICE (2005) recommend that psychological debriefing which focuses on reliving the incident should not be routinely provided. Instead it is suggested that practical, social and emotional support delivered in an empathetic manner is important in promoting recovery from PTSD and that care providers should engage in watchful waiting for four weeks followed by referral for further treatment as necessary. These recommendations align with the Psychological First Aid and 'Screen and Treat' approaches.

Psychological first aid

Psychological First Aid (PFA) is a structured support process based on cognitive-behavioural principles, which aims to secure safety, provide support and proactively prepare and educate following a critical event (Devilly & Cotton, 2004). PFA was developed in response to a need for guidelines and training for first responders following natural disasters. It consists of eight core actions as outlined in Table 2, and is based on principles of facilitating a sense of safety, calmness, a sense of self efficacy, connectedness and hope (Brown, Frahm, Hyer, & Gibson, 2008). PFA is a systematic process that is adaptable to various situations and varying degrees of trauma (Szumilas, Wei, Kutcher, 2010; Yousaf, Hawthorne, Sedgwick, 2002). The approach is evidence informed, in that it supports the development of factors that research has indicated are most helpful to people's long-term recovery. These include a) Feeling safe, connected to others, calm and hopeful, b) Having access to social, physical and emotional support and c) Feeling able to help oneself, as an individual or as part of a community (Hobfoll, Watson, Bell et al., 2007). PFA is consistent with the debriefing guidelines provided within the 6CS literature, as both involve a set of helping actions aimed at reducing initial post-trauma distress and supporting adaptive functioning. Table 1 presents a comparison summary of the phases of CISD framework and PFA components.

Comparison of Post-Event Psychological Interventions	
Components of Psychological Debriefing (CISD framework)	**Components of Psychological First Aid**
Introduction: Facilitators introduce group members, encourage mutual help	*Contact and Engagement:* Initiate or respond to request for contact in a non-intrusive, helpful manner
Facts: Participants describe event from their perspective	*Safety and Comfort:* Enhance safety by providing physical / emotional comfort
Thoughts: Participants are supported to transition from 'facts' to internal perceptions of the facts	*Stabilisation (if needed):* Calm and orient overwhelmed or disoriented service users
Reaction: Participants identify the most personally traumatic aspect of the event and their reactions	*Information Gathering: Current Needs and Concerns* Identify immediate needs and tailor subsequent support to that
Symptom: Participants describe in more detail emotional, cognitive or physical reactions to the event	*Practical Assistance:* Address immediate concerns
Teaching: Focus moves away from emotional content, facilitators provide stress management strategies	*Connection with Supports:* Establish brief or ongoing contacts with natural supports in the person's own community
Re-entry: This phase closes the discussion, clarifies issues and answers questions	*Information on Coping:* Coach strategies to promote adaptive functioning and reduce distress
	Linkage with other Services: connect service users with other recovery resources, as needed

Table 1. *Comparison of CISD and PFA approaches (adapted from Mitchell et al., 2003 & Brown et al, 2008)*

The 'screen and treat' approach

The screen and treat approach to post-traumatic care involves the assessment of individual needs and early identification of people most likely to develop PTSD, in order to initiate treatment in the ensuing weeks or months (van Wyk, 2014). This aligns with the 4 week period of 'watchful waiting' recommended by NICE (2005). The approach requires the staff conducting debriefing to have relevant knowledge and skills for identifying signs of acute stress disorder or pre-existing PTSD. It also requires staff to have a range of treatment options to refer service users to or encourage colleagues to access when indicated. Recommended evidence based treatments for PTSD include *trauma focused cognitive behavioural therapy* (TF-CBT), and *eye movement desensitisation and reprocessing* (EMDR) therapy (Mabey & Servellen, 2014; NICE, 2005). Once the person at risk of developing PTSD is identified, guidelines suggest that TF-CBT intervention should be provided through outpatient services and not delivered by staff working in acute mental health settings (NICE, 2005).

The available evidence indicates that there is an urgent need to develop effective post-incident support in order to mitigate distress following forced containment, as well as to identify staff and service users at risk of developing PTSD. In the absence of evidence-based debriefing interventions, services will need to develop options for support that are considered, evidence informed and flexible to suit individual needs. Many staff members and service users will manage their distress with the informal support of peers or colleagues or through external supports such as employee assistance programmes or family. However, frameworks for support such as Psychological First Aid and a Screen and Treat approach would strengthen existing informal approaches and could be embedded in service policies and procedures to ensure this aspect of care is prioritised.

4. Conclusion

Despite the limited evidence for debriefing as a standalone intervention, the available qualitative and quasi-experimental studies suggest that debriefing plays an important role in providing a psychological and operational feedback loop for individual service users and staff, as well as whole organisations. The literature indicates that debriefing needs to be delivered as part of an integrated response to seclusion and restraint use rather than a standalone intervention. The consistent implementation of debriefing requires strong leadership as well as staff commitment and adequate training.

The two functions of debriefing are to reduce distress and support a return to individual and ward 'equilibrium' in the acute phase and then to provide a feedback loop through more formal review processes. Effective debriefing provides a space for developing the reflexivity of individual service users and staff teams. It promotes a proactive response to service user distress, overwhelm and aggression, through its facilitation of regular analysis and problem solving. Ideally this should lead to positive changes in practice, ward culture and systems. Studies that used debriefing as part of a programme to reduce or eliminate coercive practices indicate that vicious cycles of fear, isolation, helplessness and reactivity for both staff and service users can be interrupted and gradually replaced with cycles of increasing hopefulness, shared responsibility, agency and trust.

While this report provides a synthesis of research and guidelines related to debriefing, services will need to adapt the given principles for the specific organisational contexts in which the intervention is delivered. The development of policies and procedures that prioritise and support debriefing practices is essential, while allowing enough flexibility for an individualised approach based on service user and staff needs and preferences. Developing a range of options for physical, emotional and social support following seclusion and restraint is also a priority, for both servicer users and staff. Improved screening for post-traumatic stress symptoms and the provision of outpatient follow-up treatment where indicated, would help to mitigate some of the longer term impact of seclusion and restraint.

Appendix A: Studies related to individual service user debriefing

First Author & Date	Study Design	Aim	Sample	Timing of Debrief	Debrief Facilitator/s	Type & Content of Debrief	Debriefing Related Outcomes
Ashcraft 2008	Quality improvement – seclusion and/or restraint reduction initiative: comparison against baseline	Describe a multi-strategy seclusion and/or restraint reduction initiative in 2 residential crisis services	Urban adult crisis centres (n=2)	Not specified	Not specified	**Individual service user debriefing:** Service users were asked what staff could have done to avoid restraining them, what they themselves could have done to avoid this, and what staff could do in the future to keep it from happening again	Feedback gained through service user debriefing was used to inform staff training for seclusion and/or restraint reduction Seclusion and restraint were successfully eliminated using debriefing as one of multiple strategies
Bonner 2002	Qualitative descriptive pilot study	Evaluate feasibility and helpfulness of a post restraint debrief	Adult Service users (n=6) Staff (n=12)	After 24 hours post-event	Research team member	**Individual service user and staff debriefing:** Semi-structured post-event interviews	Debriefing was valued by staff and service users. However, application of individual debriefing for service user and staff was typically irregular Half the service users reported reactivation of trauma following restraint and continued to fear being restrained. Service users valued attention and kindness shown in the debrief process
Bonner 2010	Qualitative survey using Likert scale to rate agreement with six statements describing review process	Identify factors to be considered when reviewing aftermath of events for staff and service users	Adult service users (n=30) Staff (n=30)	N/A	Research team member	**Individual service user and staff debriefing:** Semi-structured post-event debrief interviews	Described value of a non-threatening approach to debriefing. Debrief offers chance to identify distress & screen for individuals who need follow-up psychological support
Jonikas 2004	Quality improvement initiative: comparison against baseline	Describe a multi-strategy programme to reduce the use of physical restraint on three psychiatric units of a university hospital	One youth and two adult acute mental health units (n=3)	As soon as possible	Senior nurse not involved in event	**Individual service user debriefing:** Discussed the events precipitating the restraint, plus any needed revisions to the service user's plan. If revised, the patient's new plan was presented to all staff members during the next unit meeting. De-escalation strategies were discussed with service user both informally and after critical incidents occurred	Debriefing was one of multiple strategies used to successfully reduce restraint rates Concluded services should consider instituting comprehensive staff training that encourages adaptive patient behaviours

First Author & Date	Study Design	Aim	Sample	Timing of Debrief	Debrief Facilitator/s	Type & Content of Debrief	Debriefing Related Outcomes
Larue 2010	Case study Data collected over 1 month Structured interview with nursing staff	Describe nursing interventions during episodes of seclusion, and evaluate against best practice standards	Nurses (n=24)	Not specified	Nursing staff	**Individual service user debriefing:** At least one individual review of event with service user **Formal team debrief** in event of identified 'problems'	Nurses usually explained to service users why they had been secluded, but did not explore alternatives or strategies to prevent recurrence nor service user's feelings about the event
Needham 2010	Retrospective review of clinical records Debriefing activities categorised using audit tool	Investigate frequency and type of post seclusion debriefing provided by nurses	Not stated	Within 3 days	Nursing staff	**Individual service user debriefing:** Informal individual support, reassurance, and opportunity to vent. Nature, length, depth of debrief not clearly documented in notes	Less than 60% of service users who were secluded had a debriefing that met quality standards. Highlighted the need for development of debriefing framework & clear documentation of debriefing
Petti 2001	Retrospective content analysis of debriefing questionnaire data	Explore role of debriefing in a service user reduction activity in Young Persons inpatient facility	Questionnaire responses (both youth service users' & staff) gathered during debriefing (n=81)	As soon as service user was able to participate	Staff member not involved in event	**Individual service user debriefing:** Semi-structured post-event interview using a debriefing tool/questionnaire. Identified antecedents and alternative staff and service user responses	Debriefing supported staff and service user learning, enabled progress tracking and supported culture change. Findings highlighted need for precise use of language, accurate assessment and record keeping and use of feedback from debriefing to maintain new staff behaviours
Ryan 2009	Action research: Explored views of debriefing through interviews & focus groups	Understand post-seclusion debriefing from perspective of nurses and service users	Consumer consultants (n=4) Clinicians (n=31) all with seclusion and/or restraint experience	N/A	Nursing staff	**Individual service user debriefing**	Debriefing described as informal and unstructured. Findings highlighted the need for service user choice in who conducts the debriefing, when and what the focus is on. Nurses focused on explaining why seclusion happened and how to avoid it, but consumer consultants wanted more emotional support

Te Pou
o Te Whakaaro Nui

First Author & Date	Study Design	Aim	Sample	Timing of Debrief	Debrief Facilitator/s	Type & Content of Debrief	Debriefing Related Outcomes
Whitecross 2013	Single-session debrief intervention compared to treatment as usual Measures included Trauma scores from 22-item IES-R scale; HoNOS scores; Number and duration of seclusion episodes	Evaluate effectiveness of approaches to post seclusion counselling and assess trauma symptoms associated with seclusion	Total adult service users (n=31) Intervention ward (n=17) Comparison ward (n=14)	Five days to one month post event	Research team member	**Individual service user debriefing:** Included counselling, ventilation, support, screening for physical adverse effects, education and exploration of antecedents and alternative strategies	Overall, time spent in seclusion was significantly less for the intervention group. In service users who had more than one seclusion the mean number of seclusion episodes was far lower for those who received the debriefing intervention When group scores were combined, 47% of service users' IES-R scores indicated 'probable PTSD.' However, no change in intervention group trauma scores following debrief

Appendix B: Studies reporting staff debriefing practices

First Author & Date	Study Type or Design	Purpose and Outcome of Study	Type and Content of Debrief	Service User Input	Timing	Debrief Facilitator/s
Allen 2009	Descriptive case example of quality improvement strategy	Described the impact of using executive level review in an adult acute service Executive review provided visible administrative and clinical support, promoted creative thinking and problem solving to minimize use of seclusion and/or restraint	**Executive Level Review**: A forum for "witnessing" of seclusion and/or restraint incidents & performance improvement for seclusion and/or restraint reduction. Focused on creative & collaborative problem-solving	No	Every weekday - all episodes from previous 24 hrs or weekend reviewed	Administrative leaders with input from clinical educators. Held in medical director's office
Azeem 2011	Quality improvement-seclusion and/or restraint reduction initiative: comparison against baseline	Described the use of the Six Core Strategies based on trauma informed care in reducing the use of seclusion and/or restraint with hospitalised youth Debriefing was one of multiple strategies used to reduce seclusion and/or restraint	**Immediate post-event analysis:** Reviewed emotional support needed for the service user and staff involved and immediate changes required in the treatment plan **Formal team debrief:** Root cause analysis to identify what went wrong, what could have been done differently, and how to avoid similar incidents in the future	Yes	Immediate: directly after seclusion and/or restraint Formal: within 48-72hrs	Facilitator not stated – included staff members involved in incident
Belanger 2001	Quality improvement-seclusion and/or restraint reduction initiative: comparison against baseline	Described a systematic approach to identifying the root causes of the seclusion and/or restraint problem and developing solutions to identified causes at a public MH institute Successfully reduced the number and length of seclusion and/or restraint episodes, improved the quality of seclusion and/or restraint documentation in the medical record	**Immediate post-event analysis:** Review service user status and use of seclusion and/or restraint **Formal team debrief:** Review of event for staff using structured root cause analysis. Aimed to examine the need for seclusion and improve quality processes and documentation	No	Immediately post-event Follow-up not specified	Immediate: Nurse supervisor Formal: Quality director
Donat 1998	Quality improvement initiative: comparison against baseline	Described a seclusion and/or restraint reduction programme, which included behavioural analysis and review of treatment plans for frequently secluded or restrained adult service users Debriefing was one of multiple strategies used to reduce seclusion and/or restraint	**Executive level review:** A Behaviour Management Committee (BMC) reviewed incidents and developed behavioural plans for the most frequently contained service users. Provided extra administrative overview and clinical expertise to treatment team	No	Review committee met within two weeks of identifying service user at risk of further seclusion and/or restraint	Review committee: a social worker, psychiatric nurse, patients' rights advocate & five clinical psychologists

Te Pou
o Te Whakaaro Nui

First Author & Date	Study Type or Design	Purpose and Outcome of Study	Type and Content of Debrief	Service User Input	Timing	Debrief Facilitator/s
Donat 2003	Quality improvement initiative: comparison against baseline	Described a seclusion and/or restraint reduction programme Changing criteria for: administrative review, composition of the case review committee and development of a behavioral consultation team led to seclusion and/or restraint reduction and reduced reliance on PRN medication	**Executive level review**: Implemented Donat's (1998) executive review procedure as above, but lowered threshold for review, increased frequency of reviews and added departmental heads, psychopharmacological and behavioural consultants to review committee	No	Weekly review of data by psychology director who prompted a review when indicated	Review committee plus departmental heads, pharmacy and behavioural consultants
Fisher 2003	Quality improvement initiative: comparison against baseline	Described the successful application of the 6CS restraint reduction program at a large, urban, state psychiatric hospital for adult service users Combined restraint and seclusion rates reduced by 67% over a period of two years	**Immediate post-event analysis:** Staff involved reviewed the event and identify causes, errors, etc **Formal team debrief:** Treatment team and service user reviewed event and developed improved responses to distress as well as providing emotional support	Yes	Immediate: directly after seclusion and/or restraint Formal: once service user able to provide thoughtful input	Facilitator not specified but immediate debrief involved treatment team Formal: Included team and service user
Foxlewin 2012	Qualitative consumer-led research Content analysis of focus group and narrative data	Explored what occurred during seclusion and restraint review meetings that led to significant seclusion reduction **The presence of consumer representation in seclusion review meetings was a key factor in supporting attitude and cultural change within the service**	**Executive Level Review**: Seclusion and restraint review team closely examined every seclusion and restraint incident and 'near misses' to find out what happened, what could have been done differently and what worked to prevent seclusion	Yes	Met weekly. All seclusions and restraints in the preceding week reviewed	Facilitator not specified Review panel consisted of four consumers, the unit team leader, nurses, ward services and allied health staff and doctors
Lewis 2009	Quality improvement initiative with comparison against baseline Retrospective review of clinical records	Described an evidenced-based seclusion and/or restraint reduction programme in five adult inpatient units Achieved a 75% reduction in the use of seclusion and restraint with no increase in patient or staff injuries	**Immediate post-event analysis:** To gather information related to triggers & contributory factors plus initial identification of support to avoid future events **Formal team debrief**: To develop staff practices and improve treatment plans	No	Immediate debrief: directly following seclusion and/or restraint event Formal: Day after seclusion and/or restraint event	Immediate: Experienced nurse not involved with event Formal: Clinical nurse expert

Te Pou
o Te Whakaaro Nui

First Author & Date	Study Type or Design	Purpose and Outcome of Study	Type and Content of Debrief	Service User Input	Timing	Debrief Facilitator/s
McCue 2004	Quality improvement initiative with comparison against baseline	Described the use of six interventions for restraint reduction that involved changing staff behaviour within an adult psychiatric inpatient service There was a significant decrease in the use of restraint after the initiatives were implemented, with no increase in assault, suicidal behaviour, or self-injury	**Formal team debrief**: Daily review of all restraints, conducted within the morning rounds. Each incident was discussed to review the events leading to the restraint, alternative actions that could have been taken, and strategies to prevent future restraints	No	Within 24 hours of event	Chair of the morning rounds
Pollard 2007	Quality improvement initiative: comparison against baseline	Examined whether the introduction of new policy standards and related procedures for the use of seclusion and/or restraint had a statistically significant impact on seclusion and/or restraint use in adult secure inpatient unit Results showed a notable decrease in seclusion and/or restraint use, which maintained statistical significance even after controlling for changes in unit environmental variables	**Executive Review:** Administrative and nursing leadership reviewed all episodes of restraint for appropriateness and for meeting specified documentation requirements. Also identified opportunities for improvement of care	No	"Ongoing basis"	Not specified
Prescott 2007	Quality improvement initiative: comparison against baseline	Described the successful use of a 'rapid cycle' change process to reduce the use of mechanical restraints in an adult inpatient service	**Formal Team Debrief:** Multidisciplinary rapid response team reviewed each event to answer the question: what can be done to prevent further restraints of the individual service user?	No	Within 24 hours	Multidisciplinary team: Medical, nursing, admin
Putkonen 2013	Randomised Controlled Trial	Examined whether seclusion and/or restraint could be prevented in four high security units for adults with schizophrenia without an increase in violence Debriefing one of multiple strategies used to reduce seclusion and/or restraint without increasing violence	**Formal Team Debrief:** Staff reviewed all violent incidents that occurred and reported on the practices, restrictions, and alternative methods used, according to a post-event analysis sheet. Successful interventions were identified and praised and other practices analysed for improvement. Individual crisis plans were also revised and developed following incidents	Yes	Incidents from previous 24 hours were reviewed every morning	Treatment team with senior nurse and senior psychotherapist/counsellor

First Author & Date	Study Type or Design	Purpose and Outcome of Study	Type and Content of Debrief	Service User Input	Timing	Debrief Facilitator/s
Qurashi 2010	Quality improvement initiative: comparison against baseline	Examined the impact of a seclusion reduction programme in an adult forensic unit Debriefing one of multiple strategies used to reduce seclusion and/or restraint without increasing violence	**Executive level review and external peer review**: Seclusion review committee of senior clinicians met to review seclusion incidents. Practices were compared across clinical teams to improve clinical care and standardise clinical practice. External consultation also used as needed	No	Monthly	Lead psychiatrist
Sclafini 2008	Case study of external consultation for frequently restrained service users	Examined impact of consultation process in which a university-based team provided support to review seclusion and/or restraint incidences for adults with developmental disabilities and mental illness. Eliminated restraint use and changed unit culture	**External consultation:** Ongoing case consultations provided by external behavioural experts working with treatment team. Used service user perspective, behavioural analysis and CBT approach to help staff modify their approach and treatment plans	Yes	Immediate and ongoing	External academic consultants
Sullivan 2005	Quality improvement initiative: comparison against baseline	Described the violence safety program instituted at the adult inpatient services at a public hospital. Significantly reduced the use of restraints and seclusion department-wide, while providing a safe and therapeutic environment for recovery	**Type not specified:** Events were carefully reviewed by staff and service users to determine what might have been done differently	Yes	Not specified	Not specified - involved treatment staff

References

Adamson, C. E. (2006). *Complexity and context: Staff support systems in mental health after critical incidents and traumatic events* (PhD). Massey University, Massey University, Wellington. Retrieved from http://hdl.handle.net/2292/10318

Adriaenssens, J., de Gucht, V., & Maes, S. (2012). The impact of traumatic events on emergency room nurses: Findings from a questionnaire survey. *International Journal of Nursing Studies, 49*(11), 1411-1422. doi:10.1016/j.ijnurstu.2012.07.003

Allen, D. E., de Nesnera, A., & Souther, J. W. (2009). Executive-level reviews of seclusion and restraint promote interdisciplinary collaboration and innovation. *Journal of the American Psychiatric Nurses Association, 15*(4), 260-264. doi:10.1177/1078390309342749

Allen, M. H., Carpenter, D., Sheets, J. L., Miccio, S., & Ross, R. (2003). What do consumers say they want and need during a psychiatric emergency. *Journal of Psychiatric Practice, 9*(1), 39-58. Retrieved from http://www.practicalpsychiatry.com

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders.* Arlington, VA: American Psychiatric Publishing.

Antai-Otong, D. (2001). Critical incident stress debriefing: A health promotion model for workplace violence. *Perspectives in Psychiatric Care, 37*(4), 125-132.

Ashcraft, L., & Anthony, W. (2008). Eliminating seclusion and restraint in recovery-oriented crisis services. *Psychiatric Services, 59*(10), 1198-1202. doi:10.1176/appi.ps.59.10.1198

Azeem, M. W., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R. B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing, 24*(1), 11-15. doi:10.1111/j.1744-6171.2010.00262.x

Barton, S. A., Johnson, M. R., & Price, L. V. (2009). Achieving restraint-free on an inpatient behavioral health unit. *Journal of Psychosocial Nursing and Mental Health Services, 47*(1), 34-40. doi:10.3928/02793695-20090101-01

Beck, C. T. (2011). Secondary traumatic stress in nurses: A systematic review. *Archives of Psychiatric Nursing, 25*(1), 1-10. doi:10.1016/j.apnu.2010.05.005

Belanger, S. (2001). The S & R challenge: Reducing the use of seclusion and restraint in a state psychiatric hospital. *Journal for Healthcare Quality, 23*(1), 19-24. Retrieved from http://www.wiley.com/bw/journal.asp?ref=1062-2551

Bjorck, J., & Klewicki, L. (1997). The effects of stressor type on projected coping. *Journal of Traumatic Stress, 10*(3), 481-497.

Bluebird, G. (2004). Redefining consumer roles: Changing culture and practice in mental health settings. *Journal of Psychosocial Nursing and Mental Health Services, 42*(9), 46-53.

Bonner, G., Lowe, T., Rawcliffe, D., & Wellman, N. (2002). Trauma for all: A pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing, 9*(4), 465-473. doi:10.1046/j.1365-2850.2002.00504.x

Bonner, G., & Wellman, N. (2010). Postincident review of aggression and violence in mental health settings. *Journal of Psychosocial Nursing and Mental Health Services, 48*(7), 35-40. doi:10.3928/02793695-20100701-02.

Boon-Chuan, E. (2010). A systematic literature review: Managing the aftermath effects of patients' aggression and violence towards nurses. *Singapore Nursing Journal, 37*(4), 18-24.

Te Pou
o Te Whakaaro Nui

Bowers, L., Van Der Merwe, M., Nijman, H., Hamilton, B., Noorthorn, E., Stewart, D., & Muir-Cochrane, E. (2010). The practice of seclusion and time-out on English acute psychiatric wards: The city-128 study. *Archives of Psychiatric Nursing, 24*(4), 275-286. doi:10.1016/j.apnu.2009.09.003

Brown, L.M., Frahm, K.A., Hyer, K., & Gibson, M. (2008). *Psychological first aid: Guide for nursing homes.* Available at: http://agingstudies.cbcs.usf.edu/pdf_files/PFA_for_ Older_Adults_2ndEd.pdf.

Brunet, A., Weiss, D. S., Metzler, T. J., Best, S. R., Neylan, T. C., Rogers, C., . . . Marmar, C. R. (2001). The Peritraumatic Distress Inventory: A proposed measure of PTSD Criterion A2. *American Journal of Psychiatry, 158*, 1480-1485.

Bryant, R., & Harvey, A. (1996). Posttraumatic stress reaction in volunteer fire fighters. *Journal of Traumatic Stress, 9*(1), 51-62. doi:10.1002/jts.2490090106

Butler, K., & Martin, R. (2012). Gaining patient perspective after incidents of restraint or seclusion. Retrieved from http://www.champ.org.nz/index.php/innovation/2012-awards

Caldwell, B. (2005). Elevating oversight. On *Creating violence free and coercion free mental health treatment environments: Video training for the reduction of seclusion and restraint.* USA: NASMHPD.

Chen, W. C., Hwu, H. G., Kung, S. M., Chiu, H. J., & Wang, J. D. (2008). Prevalence and determinants of workplace violence of health care workers in a psychiatric hospital in Taiwan. *Journal of Occupational Health Psychology, 50*(3), 288-293. doi:10.1539/joh.L7132

Collins, S., & Long, A. (2003). The psychological effects of working with trauma. *Journal of Psychiatric and Mental Health Nursing, 10*(1), 17-27. doi:10.1046/j.1365-2850.2003.00526.x

Cusack, K. J., Frueh, B. C., Hiers, T. G., Suffoletta-Maierlc, S., & Bennett, S. (2003). Trauma within the psychiatric setting: A preliminary empirical report. *Administration and Policy in Mental Health, 30*(5), 453-460.

Deahl, M. (2000). Psychological debriefing: Controversy and challenge. *Australian and New Zealand Journal of Psychiatry, 34*(6), 929-939. Retrieved from http://www.sagepub.com.ezproxy.aut.ac.nz/

Delaney, K. R. (2006). Evidence base for practice: reduction of restraint and seclusion use during child and adolescent psychiatric inpatient treatment [Review]. *Worldviews on evidence-based nursing / Sigma Theta Tau International, Honor Society of Nursing, 3*(1), 19-30. doi:10.1111/j.1741-6787.2006.00043.x

Donat, D. C. (2003). An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. *Psychiatric Services, 54*(8), 1119-1123. doi:10.1176/appi.ps.54.8.1119

Donat, D. C. (2005). Encouraging alternatives to seclusion, restraint, and reliance on PRN drugs in a public psychiatric hospital. *Psychiatric Services, 56*(9), 1105-1108. doi:10.1176/appi.ps.56.9.1105

El-Badri, S. M., & Mellsop, G. (2002). A study of the use of seclusion in an acute psychiatric service. *Australian and New Zealand Journal of Psychiatry, 36*(3), 399-403. doi:10.1046/j.1440-1614.2002.01003.x

Faschingbauer, K. M., Peden-McAlpine, C., & Tempel, W. (2013). Use of seclusion: Finding the voice of the patient to influence practice. *Journal of Psychosocial Nursing and Mental Health Services, 51*(7), 32-38. doi:10.3928/02793695-20130503-01

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers, and educators* (pp. 3-28). Lutherville, MD: Sidran Press.

Fisher, W. A. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. *Journal of Psychiatric Practice, 9*(1), 7-15. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15985912

Fluttert, F. A. J., Van Meijel, B., Nijman, H., Bjørkly, S., & Grypdonck, M. (2010). Preventing aggressive incidents and seclusions in forensic care by means of the 'Early Recognition Method'. *Journal of Clinical Nursing, 19*(11/12), 1529–1537. doi:10.1111/j.1365-2702.2009.02986.x.

Foxlewin, B. (2012). What is happening at the seclusion review that makes a difference: A consumer led research study. Retrieved from http://www.ourcommunity.com.au/files/OCP/Nov2012.pdf

Fralick, S. (2007). A restraint utilization project. *Nursing Administration Quarterly, 31*(3), 219-225. doi:10.1097/01.NAQ.0000278935.11374.b0

Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., . . . Hiers, T. G. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services, 56*(9), 1123-1133. doi:10.1176/appi.ps.56.9.1123

Gaskin, C. J., Elsom, S. J., & Happell, B. (2007). Interventions for reducing the use of seclusion in psychiatric facilities: Review of the literature. *The British Journal of Psychiatry, 191*, 298-303. doi:10.1192/bjp.bp.106.034538

Gentry, J. E., Baranowsky, A. B., & Dunning, K. (2002). ARP: The Accelerated recovery program (ARP) for compassion fatigue. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 123-137). NY, New York: Brunner-Rutledge.

Georgieva, I., Mulder, C. L., & Whittington, R. (2012). Evaluation of behavioral changes and subjective distress after exposure to coercive inpatient interventions. *BMC Psychiatry 12*(54), 1-11. doi:10.1186/1471-244X-12-54

Giddens, J. B. (2008). *Critical incident stress debriefing/psychological debriefing: A critical review of the literature* (Thesis). ProQuest Information & Learning, US. Retrieved from https://http://www.zotero.org/groups/trauma_and_ptsd/items/itemKey/P3FP57DV

Glassheim, B. (2008). A guide to evidence-based practices for psychiatric hospitalization: Adults with mental illnesses and co-occurring substance use disorders 1-65. Retrieved from https://http://www.sccmha.org/

Grubaugh, A. L., Zinzow, H. M., Paul, L., Egede, L. E., & Frueh, B. C. (2011). Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review, 31*(6), 883-899. doi:10.1016/j.cpr.2011.04.003

Happell, B., & Gaskin, C. J. (2011). Exploring patterns of seclusion use in Australian mental health services. *Archives of Psychiatric Nursing, 25*(5), 1-8. doi:http://dx.doi.org.ezproxy.aut.ac.nz/10.1016/j.apnu.2011.04.001

Hendryx, M., Trusevich, Y., Coyle, F., Short, R., & Roll, J. (2010). The distribution and frequency of seclusion and/or restraint among psychiatric inpatients. *The Journal of Behavioral Health Services and Research 37*(2), 272-281. Retrieved from http://www.springer.com/public+health/journal/11414

Hobfoll SE, Watson P, Bell CC. (2007). Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. *Psychiatry* (70), 283–315

Horsfall, J., & Cleary, M. (2003). Patient concerns about seclusion: Developing a leaflet. *Issues in Mental Health Nursing, 24*(1), 575-585. doi:10.1080/01612840390207999

Huckshorn, K. A. (2004). Reducing seclusion & restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services, 42*(9), 22. Retrieved from http://www.jpnonline.com

Huckshorn, K. A. (2005). Six core strategies to reduce the use of seclusion and restraint planning tool. Retrieved from http://www.nasmhpd.org

Huckshorn, K. A. (2006). Six core strategies for reducing seclusion and restraint use: A snapshot of six core strategies for the reduction of S/R (revised 2006). Retrieved from http://www.nasmhpd.org/

Huckshorn, K. A. (2007). Trauma informed care: Six core strategies to reduce the use of restraint planning tool. Retrieved from http://www.ddamaryland.org

Huckshorn, K. A. (2008). Six core strategies for reducing seclusion and restraint use: Policy and procedure on debriefing for seclusion and restraint reduction projects (revised 2008). Retrieved from http://www.NASMHPD.org

Huckshorn, K. A. (2010). *Preventing violence, trauma, and the use of seclusion and restraint in mental health settings: Preventing seclusion/restraint in recovery oriented systems of care* [Power point presentation]. Retrieved from http://www.iusmm.ca/documents/pdf/Hopital/Colloques/Kevin_Ann_Huckshorn.pdf

Huckshorn, K. A. (n.d.). Six core strategies for reducing seclusion and restraint use: Policy and procedure on debriefing for seclusion and restraint reduction projects. Retrieved from http://www.nasmhpd.org

Jacobowitz, W. (2013). PTSD in psychiatric nurses and other mental health providers: A review of the literature. *Issues in Mental Health Nursing, 34*(11), 787-795. doi:10.3109/01612840.2013.824053.

Johnson, M. E. (2010). Violence and restraint reduction efforts on inpatient psychiatric units. *Issues in Mental Health Nursing, 31*(3), 181-197. doi:10.3109/01612840903276704

Jonikas, J. A., Cook, J. A., Rosen, C., Laris, A., & Kim, J.-B. (2004). Brief reports: A program to reduce use of physical restraint in psychiatric inpatient facilities. *Psychiatric Services, 55*(7), 818-820. doi:10.1176/appi.ps.55.7.818

Keski-Valkama, A., Sailas, E., Eronen, M., Koivisto, A. M., Lonnqvist, J., & Kaltiala-Heino, R. (2010). Who are the restrained and secluded patients: a 15-year nationwide study. *Social Psychiatry and Psychiatric Epidemiology, 45*(11), 1087-1093. doi:10.1007/s00127-009-0150-1

Khangura, S., Konnyu, K., Cushman, R., Grimshaw, J., & Moher, D. (2012). Evidence summaries: The evolution of a rapid review approach. *Syst Rev, 1*(10). doi:10.1186/2046-4053-1-10.

Kontio, R., Valimaki, M., Putkonen, H., Kuosmanen, L., Scott, A., & Joffe, G. (2010). Patient restrictions: Are there ethical alternatives to seclusion and restraint. *Nursing Ethics, 17*(1), 65-76. doi:10.1177/0969733009350140

Larue, C., Piat, M., Racine, H., Menard, G., & Goulet, M. H. (2010). Nursing decision making process in seclusion episodes in a psychiatric facility. *Issues in Mental Health Nursing, 31*(1), 208-215. doi:10.3109/01612840903131800

LeBel, J., Huckshorn, K. A., & Caldwell, B. (2010). Restraint use in residential programs: Why are best practices ignored. *Child Welfare, 89*(2), 169-187. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/20857886

Lewis, M., Taylor, K., & Parks, J. (2009). Crisis prevention management: A program to reduce the use of seclusion and restraint in an inpatient mental health setting. *Issues in Mental Health Nursing, 30*(3), 159-164. doi:10.1080/01612840802694171

Lind, M., Kaltiala-Heino, R., Suominen, T., Leino-Kilpi, H., & Valimaki, M. (2004). Nurses' ethical perceptions about coercion. *Journal of Psychiatric and Mental Health Nursing, 11*(4), 379-385. doi:10.1111/j.1365-2850.2004.00715.x

Litz, B. T. (2008). Early intervention for trauma: Where are we and where do we need to go. *Journal of Traumatic Stress, 21*(6), 503-506. doi:10.1002/jts.20373

Mabey, L., & van Servellen, G. (2014). Treatment of post-traumatic stress disorder in patients with severe mental illness: A review. *International Journal of Mental Health Nursing, 23*(1), 42-50. doi:10.1111/inm.12007

Maguire, T., Young, R., & Martin, T. (2012). Seclusion reduction in a forensic mental health setting. *Journal of Psychiatric and Mental Health Nursing*. doi:10.1111/j.1365-2850.2011.01753.x

Martin, A., Krieg, H., Esposito, F., Stubbe, D., & Cardona, L. (2008). Reduction of restraint and seclusion through collaborative problem solving: A five-year prospective inpatient study. *Psychiatric Services, 59*(12), 1406-1412. doi:10.1176/appi.ps.59.12.1406

Martinez, R. J., Grimm, M., & Adamson, M. (1999). From the other side of the door: Patient views of seclusion. *Journal of Psychosocial Nursing and Mental Health Services, 37*(3), 13-22. Retrieved from http://ezproxy.aut.ac.nz/login

McBeth, S. (2004). Get a firmer grasp on restraints. *Nursing Management, 35*(10), 20, 22.

McCue, R. E., Urcuyo, L., Lilu, Y., Tobias, T., & Chambers, M. J. (2004). Reducing restraint use in a public psychiatric inpatient service. *The Journal of Behavioral Health Services & Research, 31*(2), 217-224. doi:10.1007/bf02287384

McKinnon, B., & Cross, W. (2008). Occupational violence and assault in mental health nursing: A scoping project for a Victorian mental health service. *International Journal of Mental Health, 17*(1), 9-17. Retrieved from http://www.wiley.com/WileyCDA/WileyTitle/productCd-INM,subjectCd-HE70.html

Meehan, T., Bergen, H., & Fjeldsoe, K. (2004). Staff and patient perceptions of seclusion: Has anything changed? *Journal of Advanced Nursing, 47*(1), 33-38. Retrieved from http://eu.wiley.com/WileyCDA/WileyTitle/productCd-JAN.html

Meehan, T., Vermeer, C., & Windsor, C. (2000). Patients' perceptions of seclusion: A qualitative investigation. *Journal of Advanced Nursing, 31*(2), 370-377. doi:10.1046/j.1365-2648.2000.01289.x

Ministry of Health. (2010). Seclusion under the mental health (Compulsory Assessment and Treatment) Act 1992. Retrieved from http://www.moh.govt.nz

Mitchell, A., Sakraida, T. J., & Kameg, K. (2003). Critical incident stress debriefing: Implications for best practice. *Disaster Management and Response, 1*(2), 46-51. Retrieved from http://www.elsevier.com/locate/dmr

Morales, E., & Duphorne, P. L. (1995). Least restrictive measures: Alternatives to four-point restraints and seclusion. *Journal of Psychosocial Nursing and Mental Health Services, 33*(10), 13-16. Retrieved from http://www.jpnonline.com

National Association of State Mental Health Program Directors. (1999). Position Statement on Seclusion and Restraint. Retrieved from http://www.nasmhpd.org/Policy/position_statement-posses1.aspx

National Association of State Mental Health Program Directors. (2005). NASMHPD position statement on services and supports to trauma survivors. Retrieved from http://www.nasmhpd.org/

National Association of State Mental Health Program Directors [NASMHPD]. (2006). Training curriculum for the reduction of seclusion and restraint. Retrieved from http://www.nasmhpd.org/

National Executive Training Institute [NETI]. (2005). Training curriculum for reduction of seclusion and restraint: Draft curriculum manual. Retrieved from http://www.health.vic.gov.au/

National Institute for Clinical Excellence [NICE] (2005). Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care. Retrieved from http://www.nice.org.uk

Needham, H., & Sands, N. (2010). Post-seclusion debriefing: A core nursing intervention. *Perspectives in Psychiatric Care, 46*(3), 221-233. doi:10.1111/j.1744-6163.2010.00256.x

Needham, I. (2006). Psychological responses following exposure to violence. In D. Richter & R. Whittington (Eds.), *Violence in mental health settings: Causes, consequences, management* (pp. 295-318). Retrieved from link.springer.com/chapter/10.1007%2F978-0-387-33965-8_15

Norris, M. K., & Kennedy, C. W. (1992). The view from within: How patients perceive the seclusion process. *Journal of Psychosocial Nursing and Mental Health Services, 30*(3), 7-13. Retrieved from http://www.jpnonline.com

O'Hagan, M., Divis, M., & Long, J. (2008). Best practice in the reduction and elimination of seclusion and restraint: Seclusion time for change. Retrieved from http://www.tepou.co.nz

Petti, T. A., Mohr, W. K., Somers, J. W., & Sims, L. (2001). Perceptions of seclusion and restraint by patients and staff in an intermediate-term care facility. *Journal of Child and Adolescent Psychiatric Nursing, 14*(3), 115-127. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11814078

Pollard, R., Yanasak, E. V., Rogers, S. A., & Tapp, A. (2007). Organizational and unit factors contributing to reduction in the use of seclusion and restraint procedures on an acute psychiatric inpatient unit. *The Psychiatric quarterly, 78*(1), 73-81. doi:10.1007/s11126-006-9028-5

Te Pou
o Te Whakaaro Nui

Prescott, D. L., Madden, L. M., Dennis, M., Tisher, P., & Wingate, C. (2007). Reducing mechanical restraints in acute psychiatric care settings using rapid response teams. *The Journal of Behavioral Health Services and Research, 34*(1), 96-105.

Putkonen, A., Kuivalainen, S., Louheranta, O., Repo-Tiihonen, E., Ryynänen, O. P., Kautiainen, H., & Tiihonen, J. (2013). Cluster-randomized controlled trial of reducing seclusion and restraint in secured care of men with schizophrenia. *Psychiatric Services, 64*(9), 850-855.

Qurashi, I., Johnson, D., Shaw, J., & Johnson, B. (2010). Reduction in the use of seclusion in a high secure hospital: A retrospective analysis. *Journal of Psychiatric Intensive Care, 6*(2), 109-115. doi:10.1017/S174264640999015X

Richter, D., & Berger, K. (2006). Post-traumatic stress disorder following patient assaults among staff members of mental health hospitals: A prospective longitudinal study. *BMC Psychiatry, 6*(15), 15-24. doi:10.1186/1471-244X-6-15

Rose, S., Bisson, J., Churchill, R., & Wessely, S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD) (Intervention Review). *Cochrane Database of Systematic Reviews*, 1-49. doi:10.1002/14651858.CD000560

Russell, J. P. (2005). Quality improvement tools. In *The ASQ auditing handbook: Principles, implementation, and use* (3rd ed., pp. 235-250). Retrieved from http://books.google.co.nz/books

Ryan, E. P., Aaron, J., Burnette, M. L., Warren, J., Burket, B., & Aaron, T. (2008). Emotional responses of staff to assault in a pediatric state hospital. *Journal of the American Academy of Psychiatry and the Law, 36*(3), 360-368.

Ryan, R., & Happell, B. (2009). Learning from experience: Using action research to discover consumer needs in post-seclusion debriefing. *International Journal of Mental Health Nursing, 18*, 100-107. doi:10.1111/j.1447-0349.2008.00579.x

Sailas, E. E. S., & Fenton, M. (2012). Seclusion and restraint for people with serious mental illnesses. *Cochrane Database of Systematic Reviews 2000, 1*(6), 1-18. doi:10.1002/14651858.CD001163.

Scanlan, J. N. (2010). Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: What we know so far a review of the literature. *The International Journal of Social Psychiatry, 56*(4), 412-423. doi:10.1177/0020764009106630

Scholtes, P. R., Joiner, B. L., & Streibel, B. J. (2003). *The team handbook* (3rd ed.). Retrieved from http://www.amazon.com/The-Team-Handbook-Third-Edition/dp/1884731260

Sclafani, M. J., Humphrey, F. J., Repko, S., Ko, H. S., Wallen, M. C., & Digiacomo, A. (2008). Reducing patient restraints: A pilot approach using clinical case review. *Perspectives in Psychiatric Care, 44*(1), 32-39. doi:10.1111/j.1744-6163.2008.00145.x

Sequeira, H., & Halstead, S. (2004). The psychological effects on nursing staff of administering physical restraint in a secure psychiatric hospital: When I go home, it's then that I think about it. *British Journal of Forensic Practice, 6*(1), 3-15. doi:10.1108/14636646200400002

Singh, N. N., Subhashini, D., Davis, C. M., Latham, L. L., & Ayers, J. G. (1999). Reconsidering the use of seclusion and restraints in inpatient child and adult psychiatry. *Journal of Child and Family Studies, 8*(1), 243-253. Retrieved from http://www.springer.com.ezproxy.aut.ac.nz/

Smith, G. M. (2005). Special Section on Seclusion and Restraint: Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program. *Psychiatric Services, 56*(9), 1115-1122. doi:10.1176/appi.ps.56.9.1115

Soloff, P. H., Gutheil, T. G., & Wexler, D. B. (1985). Seclusion and restraint in 1985: a review and update. *Hospital and Community Psychiatry, 36*(6), 652-657. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/4007819

Substance Abuse and Mental Health Services Administration. (2012). *A public health approach to prevention of behavioural health conditions* [Power point presentation]. Retrieved from http://store.samhsa.gov/

Sullivan, A. M., Bezmen, J., Barron, C. T., Rivera, J., Curley-Casey, L., & Marino, D. (2005). Reducing restraints: alternatives to restraints on an inpatient psychiatric service - utilizing safe and effective methods to evaluate and treat the violent patient. *The Psychiatric quarterly, 76*(1), 51-65.

Suveg, C. (2007). Implications of the debriefing debate for research and clinical practice. *Clinical Psychology: Science and Practice, 14*(2), 117-120. doi:10.1111/j.1468-2850.2007.00070.

Szumilas, M., Wei, Y., Kutcher, S. (2010). Psychological debriefing in schools (Commentary). Canadian Medical Association Journal (182), 9.

Taxis, J. C. (2002). Ethics and praxis: Alternative strategies to physical restraint and seclusion in a psychiatric setting. *Issues in Mental Health Nursing, 23*(2), 157-157. doi:10.1080/016128402753542785

Te Pou o Te Whakaaro Nui. (2013). *Reducing Māori seclusion: A summary report with recommendations for managers and leaders of mental health services.* Auckland, NZ: Te Pou o Te Whakaaro Nui.

Tyrer, S., Beckley, J., Goel, D., Dennis, B., & Martin, B. (2012). Factors affecting the practice of seclusion in an acute mental health service in Southland, New Zealand. *The Psychiatrist, 36*(6), 214-218. doi:10.1192/pb.bp.111.035790

Valenkamp, M., Delaney, K., & Verheij, F. (2014). Reducing seclusion and restraint during child and adolescent inpatient treatment: Still an underdeveloped area of research. *Journal of Child and Adolescent Psychiatric Nursing.* doi: 10.1111/jcap.12084

van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (1996). *Traumatic stress.* NY, New York: Guilford Press.

Van Der Merwe, M., Muir-Cochrane, E., Jones, J., Tziggili, M., & Bowers, L. (2012). Improving seclusion practice: Implications of a review of staff and patient views. *Journal of Psychiatric and Mental Health Nursing.* doi:10.1111/j.1365-2850.2012.01903.x

van Wyk, G. (2014). Update on early intervention following trauma: Facilitation of trauma recovery. Retrieved from http://www.traumatrainingonline.com

Visalli, H., & McNasser, G. (2000). Reducing seclusion and restraint: Meeting the organizational challenge. *Journal of Nursing Care Quality, 14*(4), 35-44. doi:10.1097/00001786-200007000-00007

Weiss, E., Altimari, D., D, B., & Megan, K. (1998). Deadly restraint: A Hartford Courant investigative report. Day one: A nationwide pattern of death. Retrieved from http://www.charlydmiller.com/LIB05/ 1998hartfordcourant11.html

Wessely, S., & Deahl, M. (2003). Psychological debriefing is a waste of time. *The British Journal of Psychiatry, 183*(1), 12-14. doi:10.1192/bjp.Jundeb

Wharewera-Mika, J. (2012). *Ahakoa te momo mate, whakanuia tāngata mental health inpatient services: Māori needs when extremely distressed* (Masters Thesis). University of Auckland. Retrieved from http://researchspace.auckland.ac.nz

Wharewera-Mika, J., Cooper, E., McKenna, B., Wiki, N., Field, T., Haitana, J., . . . Edwards, E. (2013). Strategies to reduce the use of seclusion and restraint with tāngata whai i te ora. Retrieved from http://www.tepou.co.nz

Whitecross, F., Seeary, A., & Lee, S. (2013). Measuring the impacts of seclusion on psychiatry inpatients and the effectiveness of a pilot single-session post-seclusion counselling intervention. *International Journal of Mental Health Nursing, 22*, 512-521. doi:10.1111/inm.12023

Williams, P. M. (2001). Techniques for root cause analysis. *Baylor University Medical Center Proceedings 14*(2), 154-157. Retrieved from http://www.baylorhealth.edu/Proceedings/

Woodward, S., Rejman, M., & Hill, K. (2004). Root cause analysis and mental health incidents. *The Mental Health Review, 9*(3), 17-20. Retrieved from http://www.emeraldinsight.com/journals.htm?issn=1361-9322

Yousaf, F., Hawthorne, M., Sedgwick, P., (2002). Impact of patient suicide on psychiatric trainees. The Psychiatric Bulletin (26) 53-55

www.tepou.co.nz

Part of the Wise Group

Te Pou
o Te Whakaaro Nui