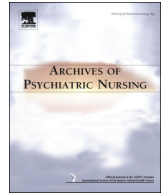




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Post-Seclusion and/or Restraint Review in Psychiatry: a Scoping Review

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A B S T R A C T

Context: It has been suggested that after an incident in which a patient has been placed in seclusion or in restraints, an intervention should be conducted after the event to ensure continuity of care and prevent recurrences. Several terms are used, and various models have been suggested for post-seclusion and/or restraint review; however, the intervention has never been precisely defined.

Objective: This article presents a scoping review on post-seclusion and/or restraint review in psychiatry to examine existing models and the theoretical foundations on which they rely.

Method: A scoping review of academic articles (CINAHL and Medline database) yielded 28 articles.

Results: Post-seclusion and/or restraint review has its origins in the concepts of debriefing in psychology and reflective practice in nursing. We propose a typology in terms of the intervention target, including the patient, the health care providers, or both.

Implications: The analysis found that the review ought to involve both the patient and the care providers using an approach that fosters reflexivity among all those involved in order to change the practice of seclusion in psychiatric settings.

Accessible summary:

- Established literature documented widely that seclusion and restraint has adverse physical and psychological consequences for patient and for health care providers.
- Post-seclusion and/or restraint review is promoted in most guidelines, but there is no scoping or systematic review yet on the subject.
- The origins of post-seclusion and/or restraint review are in the concepts of debriefing in psychology and reflective practice in nursing.
- We propose that post-seclusion and/or restraint review should focus on both patients and health care providers.
- Systematic post-seclusion and/or restraint review should be performed after each event, and its effects on patients and on mental health professionals should be rigorously assessed.

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In adult psychiatric settings, when other measures fail, aggressive in-patient behavior may result in the treatment team placing the patient in seclusion and/or restraints (SR). The Ministère de la Santé et des Services sociaux du Québec (MSSS, 2011, p. 6) defines seclusion as a “A control measure that consists in confining an individual to a location

for a specific period of time and from which the person may not leave freely,” and restraint as a “A control measure that consists in preventing or limiting a person’s freedom of movement by using human strength, any mechanical means or by depriving the person of an instrument used to offset a handicap.” However, as has been widely documented, SR has adverse physical and psychological consequences for patients. The physical consequences in particular sparked a major public debate after the *Hartford Courant* published an exposé revealing numerous adverse incidents, including more than 142 deaths linked to the application of control measures (Weiss, Altamari, Blint, & Megan, 1998). Also of concern though are the effects of SR on nurses, both on a personal and professional level (Bonner, Lowe, Rawcliffe, & Wellman, 2002; Larue, Piat, Racine, Ménard, & Goulet, 2010). Nurses who play a key role in the circumstances leading up to and in the aftermath of SR episodes must deal with emotional discomfort, including feelings of shame, fear, and distress and concern they may be abusing patients’ rights when they initiate an SR procedure.

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Mindful of these adverse outcomes, best practices in SR have thus incorporated a post-seclusion and/or restraint review (PSRR). Several SR reduction programs have been advanced (Ashcraft, Bloss, & Anthony, 2012; Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011; Huckshorn, 2004; Stewart, Van der Merwe, Bowers, Simpson, & Jones, 2010). These generally include the following components: organizational leadership, patient education on aggression management, staff training, changes to the environment, and post-seclusion and/or restraint review. For the programs that have been evaluated, the findings show a 50% to 75% reduction in the application of SR (Fisher, 2003; Huckshorn, 2004; Lewis, Taylor, & Parks, 2009; Putkonen et al., 2013; Wieman, Camacho-Gonsalves, Huckshorn, & Leff, 2013). However, the emphasis on comprehensive solutions makes it difficult to determine whether their efficacy might be due to the program as a whole or to one of its components. Moreover, despite the great interest in the development of PSRR, it seems to be the most difficult component to implement (Needham & Sands, 2010). Studies on patients' experience of seclusion (Cano et al., 2011; Kontio et al., 2012) and nurses' perceptions of SR (Bonner & Wellman, 2010; Larue et al., 2010; Secker et al., 2004) highlight the need to perform reviews of such events. As well, Mayers, Keet, Winkler, and Flisher (2010) have found that patients experience greater distress when PSRR is not conducted.

On the whole, according to the research, PSRR is highly recommended and vital to improving the care experience for both patient and staff, developing best practices, and reducing the incidence of SR (Bonner, 2008; Fisher, 2003; Huckshorn, 2004; Needham & Sands, 2010; Pollard, Yanasak, Rogers, & Tapp, 2007; Taxis, 2002; Taylor & Lewis, 2012). The practice is widely promoted in SR guidelines, although its effects have not yet been reported in a systematic review. However, the definition of PSRR and the process vary from study to study and cannot be properly tested until it has been clearly defined. The aim of this scoping review is to examine existing models and the theoretical foundations on which they rely.

METHOD

A comprehensive scoping review was carried out to answer the following question: what is known on post-seclusion and/or restraint review in psychiatry? According to a Cochrane review, this method is relevant to explore the extent of the literature in a specific domain (Armstrong, Hall, Doyle, & Waters, 2011). The following steps are included: 1) identifying the research question and relevant studies,

2) charting the data, and 3) summarizing the results. A scoping review of English and French articles was carried out using the search strategy (MH "Psychiatric Care") OR (MH "Psychiatric Nursing+") OR (MH "Mental Health Services+" AND (MH "Debriefing") OR (MH "Post seclusion") OR (MH "Post incident") OR (MH "Post event") OR (MH "Aftermath"). A date range was not used since this was an exploratory process. The result was 87 articles from the CINAHL database and 106 articles from Medline (37 were duplicates). Following discussions between the two authors, the inclusion criteria were refined, limiting the review to articles in English or French, adult psychiatry, and to articles that discussed the concept, its process, or its evaluation. Out of 156 articles, 20 were retained for further analysis. Since there are few empirical studies on PSRR, the review was broadened to include studies on debriefing by examining references cited in the articles ($n = 8$), for a total of 28 articles (Fig. 1). The results are presented according to the analysis of emerging themes.

RESULTS

Study Description

Studies identified focusing on PSRR are mostly qualitative and descriptive, with only one proposing an experimental design. They are conducted in acute psychiatric inpatient units, mainly in Australia, the UK, the US, and Canada. PSRR is discussed based on patient and staff experiences, as an intervention *per se* (Table 1) or as a component of a program (Table 2).

The Theoretical Origins of Post-Seclusion and/or Restraint Review

Psychology and Debriefing

Post-seclusion and/or restraint review, which we initially define as an intervention performed after a psychiatric patient has been placed in seclusion, traces its origins to the concept of debriefing in psychology. Psychological debriefing is generally defined as "an early intervention method for personnel groups exposed to a single task or repetitive tasks related to stressful events that carry a high potential for psychotraumatic effects" (Raphael & Wooding, 2004, p. 44). The most commonly used debriefing intervention model, Critical Incident Stress Debriefing, seeks to encourage individuals to express their emotions following a traumatic incident in order to reduce adverse psychological consequences (Mitchell, 1983). However, a Cochrane meta-analysis

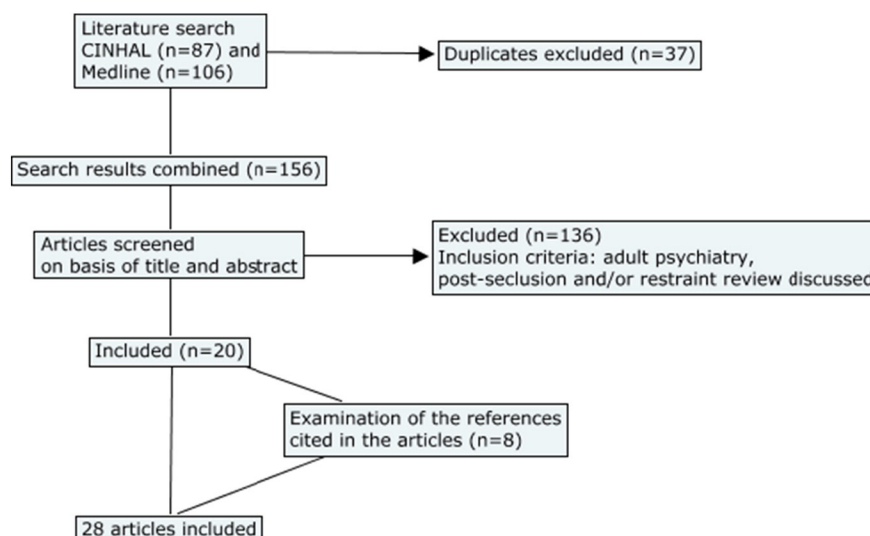


Fig. 1. Flow diagram of study selection.

Table 1
Studies Reporting Post-Seclusion and/or Restraint Review.

Authors	Aim of the study	Method	Intervention	Main results
Bonner et al. (2002) UK	To establish the feasibility of using semistructured interviews with patients and staff in the aftermath of untoward incidents involving physical restraint and to gather information on the factors patients and staff groups found helpful and unhelpful.	Descriptive Semistructured interviews with patients (n = 6) and staff (n = 12)	Postincident debriefing	<ul style="list-style-type: none"> - PSRR valued by all but not systematic. - Patients: kindness in the staff is perceived helpful, but they feel ignored and unheard particularly in the aftermath. - Staff: the aim is for reviewing the events and evaluating decisions and actions taken. Can be formal or informal. - Need to establish policies and mechanisms for after incident debriefing to all staff and patients involved.
Secker et al. (2004) UK	To take a more systemic approach by treating violent and aggressive incidents as social interactions and by seeking to understand the social contexts in which they took place.	Descriptive (n = 15 staff)	Discussion	<ul style="list-style-type: none"> - Little attempt to reflect on and learn from the incidents, either with the clients involved, or as a staff team. - Discussion in the aftermath in 7 of the 11 cases. - The aim is to correct the client's behavior, rather than exploring what had happened from the client's perspective or considering how it might have been avoided. - 3 steps required following an aggressive incident: emotional support; critical reflection and learning; pursuit of accountability.
Prescott, Madden, Dennis, Tisher, and Wingate (2007) USA	To describe the use of rapid response teams to reduce the use of mechanical restraints	Action research	Restraint rapid response team meetings	<ul style="list-style-type: none"> - On a 6-week rapid cycle change process, reduction of mechanical restraints by 36.4%. - Opportunities for real-time supervision and experiential learning. Demonstrates the organization's commitment, provide data about factors, promotes creative thinking, collaborative problem solving and the exploration of new ideas recommended by those directly involved.
Allen, de Nesnera, and Souther (2009) USA	To describe a standard meeting time and place for an executive-level review of every episode of seclusion and restraint	Descriptive Data collected for 3 years	Executive-level review (witnessing)	<ul style="list-style-type: none"> - Consumer consultants need more emotional support from debriefing to deal with negative feelings. - A range of informal and unstructured approaches is used for debriefing, but note always meet consumer consultant preferences (who, when and what). - 97% of staff and 94% of patient agreed the review was useful. - 87% of staff and 60% of patient agreed the review had allowed them to think about how the incident had been managed.
Ryan and Happell (2009) Australia	To describe current clinical practice and explore debriefing needs as expressed by consumer consultants and mental health nurses in order to consider the desirability of developing a training program to facilitate post-seclusion debriefing.	Exploratory, action research Focus group with mental health nurses (n = 31) and consumer consultants (n = 4)	Post-seclusion debriefing	<ul style="list-style-type: none"> - 58.8% had PSRR (presence of one of the five criteria) - More female consumers (70%) than males (53.5%) - Only 23.5% of males have more than one criteria - Most frequent criteria: support/reassurance" and counseling - An explicit mention of post-seclusion debriefing in 1/63 cases.
Bonner and Wellman (2010) Australia	To evaluate whether staff and inpatients had found postincident review helpful after incidents involving restraint.	Survey design with Staff (n = 30) and inpatients (n = 30)	Postincident review	<ul style="list-style-type: none"> - Only 9/24 reported to review incident with the patients. - Aim is an explication, not seeking client's experience or trying to find alternative measures - Reviews with the team only if problems have been encountered to adjust the interventions and no discussion on emotions. - 3 main elements: reflective practice
Needham and Sands (2010) Australia	To investigate the frequency and type of post-seclusion debriefing provided by nurses	Exploratory Retrospective file audit on case files (n = 63) Criteria within 3 days: support and reassurance, counseling, ventilation, physical support and psychoeducation.	Post-seclusion debriefing	<ul style="list-style-type: none"> - Only 9/24 reported to review incident with the patients. - Aim is an explication, not seeking client's experience or trying to find alternative measures - Reviews with the team only if problems have been encountered to adjust the interventions and no discussion on emotions. - 3 main elements: reflective practice
Larue et al. (2010) Canada	To explore and describe nursing interventions performed during episodes of seclusion with or without restraint in a psychiatric facility and examine the relationship between the interventions' local protocols and best-practice guidelines.	Descriptive Semistructured interviews with nurses (n = 24)	2 activities: Post-event review with the patient Post-event review with healthcare team	<ul style="list-style-type: none"> - Only 9/24 reported to review incident with the patients. - Aim is an explication, not seeking client's experience or trying to find alternative measures - Reviews with the team only if problems have been encountered to adjust the interventions and no discussion on emotions. - 3 main elements: reflective practice

(continued on next page)

Table 1 (continued)

Authors	Aim of the study	Method	Intervention	Main results
Larue et al. (2013) Canada	To understand the perception of patients regarding application of the seclusion and/or restraint protocol.	Exploratory descriptive study A survey using a Likert scale in individual face-to-face with 6 questions regarding PSRR n = 50 patients	2 activities: Post-event review with the patient Post-event review with healthcare team	focusing on the steps of the decision-making process; a discussion of emotions; and projections for future interventions in similar circumstances - Nearly all patients perceived that the health care team did not follow-up with them after seclusion - Patients agreed only "somewhat" with statements about post-seclusion follow-up (1.61, SD = 1.08), follow-up regarding feelings (1.56, SD = 0.97) and discussion to understand what had happened (1.6, SD = 0.87)
Whitecross, Seear, and Lee (2013) Australia	To identify the impacts seclusion has on an individual and measure the effectiveness of a post-seclusion counseling intervention in mitigating the experience of seclusion-related trauma and reducing time spent in seclusion.	- Before and after with a comparison group - Self-reported experience of trauma symptoms using the Impact of Events – Revised Intervention group (n = 17) Comparison group (n = 14)	Single-session post-seclusion counseling: counseling, ventilation, support and reassurance, screening physical adverse effects, psychoeducation, factors, how to avoid	- Trauma symptoms: not significant - Number of seclusion episodes: not significant (t(15.6) = 0.95, P = 0.36) - Time in seclusion: significantly fewer (t(29) = 2.70, P = 0.01)

performed in 2002 and revised in 2009 challenged the validity of findings showing a positive impact of debriefing on persons exposed to a traumatic event (Rose, Bisson, Churchill, & Wessely, 2009). A review of 15 randomized controlled studies concluded that the practice did not reduce psychological distress or prevent post-traumatic stress; debriefing was found to have a null effect as compared to the care given a control group and, in some cases, to potentially increase risk. Consequently, although the Cochrane meta-analysis has been criticized in turn (Tuckey, 2007), there is palpable discomfort over the use of this concept. Debriefing has nevertheless entered the realm of popular psychology, and its use has extended to the field of mental health.

Nursing and Reflective Practice

Since disciplines interact and influence each other constantly, concepts of each other's travel too. In this regard, nurses have integrated the concept of emotional communication for health care providers. They have found that in addition to lowering their stress levels, debriefing also fosters reflective practice (Bell, 1995). It is suggested that the expression of emotions leads nurses to a critical analysis of clinical practices, an exploration of the appropriateness of the therapeutic skills used, and the promotion of safe practices (Morante, 2005). By applying the concept of debriefing to their discipline and mental health, nurses have thus added the dimension of reflective practice to the original emotional dimension of debriefing. They use the concept of debriefing in the broader sense of an emotional exchange that leads the health care providers to engage in reflective practice. As has been amply documented, incident reviews of this sort have become a vital tool of reflective practice in nursing through such strategies as debriefing and review with peers (Goulet, Larue, & Alderson, 2015). In this regard, it is a means of obtaining feedback in the context of an educational activity or a clinical experience to help nurses integrate previously acquired knowledge. Significant-event reviews foster learning that becomes meaningful when one engages in deep introspection through reflection (Dreifuerst, 2009), allowing for the verbalization and integration of experiential knowledge. As currently used, therefore, in contrast to debriefing, reflective practice is concerned less with the expression of feelings than with communication that nurtures each team member's potential. Although initially presented as a debriefing activity, we believe that PSRR can only achieve its full transformative potential if it is presented as a form of reflective practice within the context of control measures (Fig. 2).

Awareness of the two principal sources of PSRR contributes to a better understanding of how the concept emerged and how it can support

skill development in nursing staff in order to reduce SR. However, reference to the notion of debriefing in psychiatry and psychology immediately conjures up the harsh criticism leveled in this regard in the Cochrane analysis (Rose et al., 2009). This vociferous debate in the scientific community and the accretion of new dimensions are likely the reason so many and such conceptually vague terms are used to refer to the various forms of intervention conducted after the seclusion of psychiatric inpatients. The following is a non-exhaustive list of the terminology: post-event discussion (Fisher, 2003), post-seclusion debriefing (Needham & Sands, 2010; Ryan & Happell, 2009), debriefing procedures (Huckshorn, 2004; Lewis et al., 2009; Maguire et al., 2012), post-incident review (Bonner & Wellman, 2010), post-event analysis (Putkonen et al., 2013), witnessing (Allen et al., 2009; Taylor & Lewis, 2012), post-seclusion counseling intervention (Whitecross et al., 2013) and post-event review (Larue et al., 2013). We propose the term "post-seclusion and/or restraint review" not only to move away from the concept of debriefing as already described by Bonner (2008) but also to specify the incident involved: seclusion and/or restraint. We will now examine the various intervention models.

Post-Seclusion and/or Restraint Intervention Models

The authors in our literature review describe a number of post-seclusion and restraint interventions but offer no explicit typology. To compensate for this shortcoming, we suggest a PSRR typology based on the target of the intervention: the health care providers (especially nurses), the patient, or both.

Review for the Health Care Providers

Some of the suggested forms of PSRR were developed specifically for health care providers. In Canada, the Omega training program has enjoyed great popularity; it has been widely implemented in many French-language hospitals and is taught in several undergraduate nursing programs (Boyer, Guay, & Goncalves, 2014). It centers on patient pacification and developing "skills and modes of intervention to ensure the safety of the health care professional and others in aggressive situations" (ASSTSAS, 2006, p. 9 [Translation]). The Omega program sets out a two-stage intervention for reviewing disruptive events. First is *immediate feedback*, consisting of the administration of first aid and discussion, analysis, and documentation of the incident by the treatment team. This is followed by a *post-incident review* that includes one-on-one or group debriefing sessions with a support person to explore their understanding of the intervention, plan future interventions, and

Table 2
Studies Reporting Post-Seclusion and/or Restraint Review as a Part of a Program.

Authors	Aim of the study	Method	PSRR of the program	Main results
Fisher (2003) USA	To describe elements of a successful restraint reduction program and their application.	Descriptive Seclusion rate (expressed in physicians orders per 1000 recipients days)	2 types of post-event discussions. - Post-event analysis - Debriefing with the recipient and his regular treatment team	- Reduced SR rate by 67% over a period of 2 years. - Both staff and recipients (>90%) endorsed the value of post-restraint debriefings in preventing repeat occurrences.
Huckshorn (2004) USA	To present core strategies for reduction of seclusion and restraint use in mental health settings based on a prevention approach.	<i>Not described</i>	Debriefing procedures: - immediate post-incident review - formal analysis of the incident - patient debriefing	6 core strategies: 1) leadership, 2) use of data, 3) workforce development, 4) assessment and prevention tools, 5) involvement of consumers/family members, 6) event-debriefing procedures.
Ashcraft et al. (2012) USA	To describe the implementation and the evaluation of a "no force first" policy, an active program to avoid and eliminate the use of force, including seclusion, mechanical restraint, and pharmacological restraint and forced medication.	Descriptive, pre and post Over a 58-month follow-up Number of seclusion and restraint episodes	Debriefing with the consumer Critical incident review	- Larger crisis center took 10 months until a month registered 0 seclusions and 31 months until 0 restraints. - Smaller crisis center took 2 months and 15 months. - Staff learned to listen closely to people and to give them what they were asking for whenever possible. - Informed new crisis intervention and deescalation training manual.
Putkonen et al. (2013) Finland	To study the feasibility of preventing coercive measures without violence for males with schizophrenia in applying six core strategies.	Cluster-randomized controlled trial 2 intervention wards 2 control wards	Postevent analysis	- Patient-Days with SR or room observation: declined from 30% to 15% for intervention wards vs 25% to 19% for control wards. - SR time decreased from 110 to 56 h per 100 bed patient-days vs an increase of 133 to 150 h for control wards
Lewis et al. (2009) USA	To describe an evidenced-based performance improvement program that resulted in a decrease in the use of SR.	Descriptive pre/post Hours of seclusion Hours of restraint	Witnessing program: immediate post event debriefing formal and rigorous interview	- 75% reduction in the use of SR. - Decrease of restraint ranging from 20–97%. - Decrease of seclusion of 30–63%. - No increase in patient or staff injuries.
Maguire, Young, and Martin (2012) Australia	To present the initiatives that were introduced during a seclusion reduction project based on the six core strategies that were undertaken.	Descriptive pre/post Number of seclusion events and patients secluded Hours of seclusion/month	- Post-seclusion debriefing - Seclusion review process	- A reduction of seclusion events and the hours of seclusion. - A lesser reduction in the number of patients that was secluded.
Donat (2003) USA	To review and evaluate a variety of interventions that were considered to have contributed to the successful reduction of reliance on the use of SR in a public psychiatric hospital for adult patients with severe and persistent psychiatric impairments.	Multiple regression analysis to monthly SR on 5 years. Program's component: criteria for review, case review committee, behavioral consultation team, standards for behavioral assessments, staff-patient ratio	Case review committee	- Reduction of 75% in the use of seclusion and restraint - The only variable that was significantly associated with reduction in the use of SR was changes in the process for identifying critical cases and initiating a clinical and administrative case review.
Qurashi, Johnson, Shaw, and Johnson (2010) UK	To report changes in patterns of seclusion use and adverse incidents over a 5-year period (information and transparency, audit and peer reviews, risk management, patient involvement, training and leadership)	Descriptive pre/post Number of seclusion episodes Number of incidents recorded	Seclusion peer group review meeting	- A reduction of 67% of the number of seclusion episodes per month - A decrease of the incidents recorded
Wieman et al. (2013) USA	To examine implementation and outcomes of the Six Core Strategies for Reduction of Seclusion and Restraint.	Descriptive pre/post n = 43 psychiatric facilities	Debriefing	- Reduction of the % secluded by 17% (p = .002) - Reduction of the seclusion hours by 19% (p = .001) - Reduction of the proportion restrained by 30% (p = .03). - No significant reduction reduction in restraint hours
McCue, Urcuyo, Lili, Tobias, and Chambers (2004) USA	To describe a program to reduce the use of restraint (better identification of patients, stress/anger management group, staff training on crisis intervention, crisis response team, daily review of restraints, incentive system for staff).	Prospective study pre/post Unpaired t-tailed t test Rate of restraint use: number of restraints/1000 patient-days	Daily review of all restraints.	- Individual facility effect sizes varied; - Significant decrease in the rate of restraint use: (mean SD: before = 7.99, after = 3.70; p < .0001) - No sustained increase in incidents of assault, suicidal behavior, or self-injury.

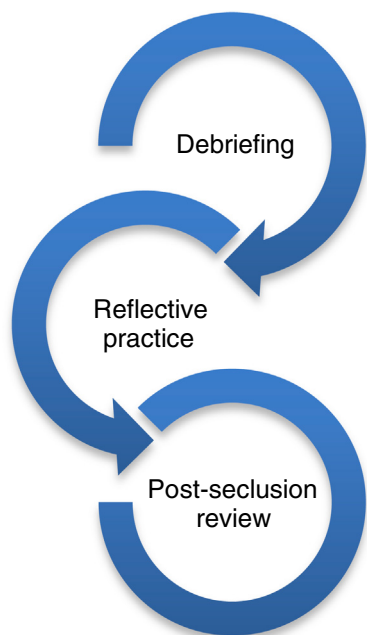


Fig. 2. The theoretical origins of post-seclusion and/or restraint review.

meet with the patient if necessary. This part of the program has never been evaluated empirically. Such analysis is similar to the psychiatric rapid response team described by Prescott et al. (2007), which primarily aims to develop a hypothesis on the cause of SR to make appropriate changes in the treatment plan. A PSRR on a more executive level is also suggested (Allen et al., 2009). It takes the form of a daily meeting with the medical director and immediate staff and provides a narrative description of the incident as well as an opportunity to share perceptions and emotions.

Although patients are mentioned in this type of program, the intervention is rooted in a philosophy that is more organizational than clinical in nature. It focuses less on patient-centered humanistic care than on staff safety, although it could be directed at both. Moreover, the Omega program suggests meeting with patients if necessary and, if appropriate, having them take responsibility for their behavior (e.g. asking for an apology or taking legal action).

In a Finnish exploratory study on training requirements for aggression management, nurses ($n = 22$) and physicians ($n = 5$) indicated in focus group that in addition to a need for peer support in order to engage in a learning experience through post-seclusion debriefing, they also required professional support after an especially trying SR incident (Kontio et al., 2009). The study thus implicitly brings to light the reflective dimension of PSRR. Although the need for staff to take part in an organized review is expressed, no definition or model is provided for the review. Indeed, in an action research developing a rapid response team to reduce the use of SR (Prescott et al., 2007), meetings after each incident are an opportunity for real-time supervision and experiential learning.

The primary feature of these types of PSRR for health care providers is a concern for the safety of both the staff and the patient; yet the latter does not figure extensively in the process. One might think, from the literature, that PSRR would offer an excellent opportunity for reflexivity; however, only few studies (Kontio et al., 2009; Prescott et al., 2007) raised the possibility of using the review as a form of staff learning within Schön's (1983) meaning of "reflection on action."

Review for Patients

Some of the interventions in the literature are aimed exclusively at patients. However, these studies are still in the early stages. Bonner and Wellman (2010) and Needham and Sands (2010) maintain that

the models developed in the field of psychology cannot be applied to patients in the context of SR. Needham and Sands (2010, p. 230) therefore recommend developing a post-seclusion debriefing model that clearly lays out the conditions of the intervention: "This model needs to include the most appropriate timing to provide debriefing, who should provide the intervention, the consumers' response to debriefing, and guidelines and framework for communication and consistency." Bonner (2008), however, does present a framework for a patient review; the *Thames Valley University Post-Incident Review Framework* is aimed at helping patients manage their feelings and explore the reasons for their negative emotions. The model comprises 14 questions to guide the nurse in carrying out a patient review on the triggering events, factors the patient deems important, and issues to be considered in future situations in which there is a risk of violence. For their part, Whitecross et al. (2013, p. 513) define post-seclusion debriefing as "an intervention that potentially supports patients' natural recovery mechanisms after a seclusion event. It can be described as a talking therapy that offers the patient the opportunity to make sense of their experience and bring about emotional resolution and healing." The content of the intervention was developed based on the five PSRR-related interventions (counseling, venting, support and reassurance, screening for physical adverse effects, and psychoeducation) identified by Needham and Sands (2010). Through this discussion, the treatment team and the patient identify triggers and signs of escalating aggression as well as the type of preventive intervention preferred by the patient (Whitecross et al., 2013).

In a review with patients, the objective is thus to help them manage their feelings and find out what caused them to lose control of their emotions and behave as they did. This objective is consistent with the concept of psychological debriefing in the literature.

Review for Patients and Health Care Providers

A PSRR that involves activities directed at both the patient and the care providers also exists. Fisher (2003) was the first to put forward a two-stage intervention: an immediate analysis with staff to quickly reconstruct the incident between the parties involved and to draw up a short-term plan, and a debriefing 24 to 48 hours later to undertake a detailed analysis that draws on the perspectives of both the patient and the treatment team in order to plan the next steps and avoid a repetition of seclusion.

In 2004, as head of the National Coordinating Center for Seclusion and Restraint Reduction in the United States, Huckshorn drew on Fisher's work to develop a model for preventing violence and the utilization of SR: *Six Core Strategies for Reducing Seclusion and Restraint Use*. The proposed strategies involve: (a) organizational leadership, (b) analysis of SR data, (c) staff training and education, (d) prevention tools, (e) patient involvement, and (f) debriefing tools. The SR reduction program is founded on the deconstruction of myths and assumptions, trauma-informed care, recovery and the public health prevention model. Debriefing activities are integrated into tertiary prevention with the aim of diminishing the adverse effects of SR on patient and staff and preventing recurrences. Huckshorn (2004, 2005) operationalized the activities outlined by Fisher (2003) and underscored the importance of the patient's perspective in the practice review. More specifically, Huckshorn (2005) outlined three debriefing activities: First, an immediate post-incident review is carried out with the care providers involved to restore the environment to a pre-crisis level and physical and emotional security and to document the episode. Then, a formal analysis of the incident is conducted 24 to 48 hours after the seclusion episode by a senior manager who was not involved in the incident. The treatment team—with the patient when possible—is asked to analyze the incident following an 11-step, 67-question protocol (Huckshorn, 2005). The goal is to produce an individualized treatment plan and recommendations. Lastly, patient debriefing by a person not involved in the event should be conducted as soon as the patient's condition permits to minimize the adverse effects of SR, share responsibility

for the incident, and restore the relationship of trust between patient and staff. Reviews that involve both the patient and the care providers therefore have multiple components that target both of them. The authors do not discuss PSRR in terms of team reflexivity; however, it seems to us that the formal review offers the team an excellent opportunity to grow from the experience by questioning its practices. Indeed, in a study examining violent and aggressive incidents as social interactions, Secker et al. (2004) revealed that these incidents were rarely seen as an opportunity to reflect and learn, either with the patient or as a team.

Thus, some types of seclusion reviews are patient centered, others focus on the health care providers, while others consider both. Given that SR has been found to adversely affect both patients and staff, it seems appropriate that an intervention should take both into account. This type of complex intervention would not only respond to the needs of the individuals involved but also improve SR practices, particularly by fostering team reflexivity. For example, to facilitate the reflective practice of a team, Maguire et al. (2012) suggested that a senior nurse should take leadership of the seclusion review process and make recommendations for practice. According to Secker et al. (2004) and Larue et al. (2010), critical reflection and learning should be a core component of PSRR.

Evaluation of Post-Seclusion Review: The Current State of Knowledge

Evaluation studies involving seclusion and restraint have usually dealt with SR reduction programs, which include PSRR. Since PSRR is fully integrated into these programs, it is hard to determine its specific impact on SR reduction. The following is an overview of studies that have evaluated PSRR in clinical settings and considered its utility and efficacy.

Frequency

Although most SR protocols contain a PSRR component, the literature offers little information on its practice in clinical settings (MSSS, 2011). In a 2010 Australian retrospective study, Needham et al. examined case-file notes to document five nursing interventions (consultation, ventilation, support and reassurance, physical interventions, and psychoeducation) for measuring post-seclusion debriefing. The interventions were identified through the literature, but it is difficult to pinpoint the process that led to their selection or their specific link to PSRR. The authors found that 58.8% of the case files in 63 seclusion events mentioned at least one of the interventions, but only one file contained a note dealing explicitly with the patient's experience of seclusion. These findings corroborate those of other studies that showed, in fact, that many patients believed that no SR review was conducted in their presence (Bonner et al., 2002; Larue et al., 2013; Ryan & Happell, 2009). Moreover, according to staff, PSRR is not discussed as a systematic intervention. In a Canadian study on nursing interventions pre-, per-, and post-SR, only 9 nurses out of 24 reported reviewing the incident with the patients (Larue et al., 2010).

Utility

Although PSRR is not systematically conducted in clinical settings, an exploratory study of the utility of post-incident review assessed how it is perceived in an acute psychiatric unit in England (Bonner & Wellman, 2010). It was deemed helpful by 97% of staff ($n = 30$) and 94% of patients ($n = 30$). The utility of PSRR is also highlighted in an exploratory study of six psychiatric units in two Finnish hospitals (Kontio et al., 2009). Nurses and psychiatrists identified a need for training in post-SR that would take the form of "debriefing of the situations afterward within a peer group as a learning experience" (Kontio et al., 2009, p. 203). The participants thus envisioned training occurring through PSRR.

Efficacy

The review of the literature revealed only one quantitative study that dealt exclusively with an evaluation of a post-seclusion intervention.

Using an experimental study design, Whitecross et al. (2013) compared 31 patients who had been placed in seclusion in an acute psychiatric unit and subsequently received an intervention of post-seclusion counseling with a control group that received the usual care (review at the patient's request or if the health care provider determined the need). Over 9 months, more than 47% of the sample reported PTSD-like symptoms; there was no significant difference between the groups. However, the members of the experimental group were subjected to significantly fewer hours of seclusion than the control group ($t(29) = 2.70, p = 0.01$). According to Whitecross et al. (2013), a single debriefing session is probably not enough to reduce symptoms of PTSD. However, given the reduction in SR, they suggest that the implementation of an SR intervention may have made the treatment team more aware of the issues involved to the point that they changed their practices.

The SR reduction program based on the *Six Core Strategies* clinical model, which includes a PSRR component, has been the subject of several evaluations, and the results seem promising. The program has been implemented at 43 American sites, and pre- and post-introduction information is available for eight states. The data reveal mean reductions of 17% in the number of patients in seclusion ($p = .002$), 19% in hours of seclusion ($p = .001$), and 30% in patients placed in restraints ($p = .03$) (Wieman et al., 2013). The program has also been introduced in Ontario; preliminary data comparing results to those for a control group are encouraging (Anderson & Waldman, 2012). The introduction of the program in a psychiatric hospital in New York State has led to a 75% reduction in the use of SR in 4 years with no increase in injuries to patients or staff (Lewis et al., 2009; Taylor & Lewis, 2012). Moreover, in a cluster-randomized controlled study that implemented this model with men with schizophrenia, the proportion of patient-days with SR or room observation declined from 30% to 15% for intervention wards, and SR time decreased from 110 to 56 hour per 100 bed patient-days (Putkonen et al., 2013).

An SR reduction program of this type has also been implemented in Australia in a forensic hospital, where managing aggressive behavior is especially challenging given the prison culture and the fact that it houses a population at high risk of aggression (Maguire et al., 2012). A few individual PSRR initiatives have been introduced in this setting, but the authors stress the value of strengthening the program so that it can be an opportunity for learning and discussion about the treatment being applied—in other words, a reflective practice. Over 2 years, there has been a reduction in the frequency (occurrences per patient) and duration of seclusion events but little change in the number of patients in SR as a proportion of inpatients (Maguire et al., 2012).

To sum up, although to date only one study has been conducted that specifically addresses the efficacy of PSRR, programs with a PSRR component show a 50% to 75% reduction in SR events (Fisher, 2003; Huckshorn, 2004; Lewis et al., 2009; Putkonen et al., 2013; Wieman et al., 2013). This leads to the question of what the relative weight of the various components, including PSRR, might be. So far, only the study of Whitecross et al. (2013) has attempted to answer this question.

DISCUSSION

An examination of the origins, theoretical foundations, models, and evaluation of PSRR has helped clarify the intervention.

Models and Reflective Practice

The scoping review revealed that there are numerous forms of PSRR. We have proposed a typology based on the target of the intervention, that is, whether it is focused on the patient, the treatment team, or both. By way of clinical vignettes, Boumans, Egger, Souren, Mann-Poll, and Hutschemaekers (2012) established that team reflexivity is inversely related to its tendency to seclude. Knowing that the use of SR is less determined by the individual characteristics of patients and staff than by the team's characteristics (Boumans et al., 2012), it is

relevant to propose an intervention that initiates collective reflecting. These findings are consistent with those of Huckshorn's (2014) study of leaders and staff who were involved in projects that were successful in reducing the use of SR. Although, initially, the use of SR was the organizational standard and was not questioned in the settings studied, SR reduction projects have changed team perspectives toward a much more flexible practice. Huckshorn (2014) discusses this change in connection with the concept of team learning in Senge's (2006) organizational change model, which stresses the importance for treatment teams to be able to change their beliefs and behaviors and hence move toward a new shared vision. According to Lewis et al. (2009), developing different PSRR activities in a non-punitive environment, where everyone is encouraged to express themselves freely, becomes a learning opportunity for all.

If the interaction between patients and their care providers is considered central to the decision of whether to resort to SR, and if the goal is to produce meaningful learning for patients and improve staff ability to manage aggressive behavior, the most appropriate course is to select an intervention model that can impact all the levels involved. Although, to our knowledge, PSRR has rarely been presented as a therapeutic intervention, we believe it could help patients develop their capacity for mentalization, an ability which is often diminished in mental health populations. Such an intervention would thus also offer patients an opportunity for reflection and give them a greater sense of empowerment in situations involving aggressive escalation.

Post-seclusion and/or restraint review involves reflexivity on the part of the patient, the treatment team, and the organization. This reflexivity should ideally contribute to changing the culture of the unit and lead to the adoption of a more comprehensive, holistic perspective and preventive interventions that promote patient recovery. As a form of reflective practice that embraces both the treatment team and the patient, PSRR seeks to encourage emotional communication, analysis of the steps that led to the decision to resort to SR, and planning of future interventions (Fisher, 2003; Huckshorn, 2004). Post-seclusion and/or restraint review is therefore a method of stimulating critical reflection about seclusion, which is essential to enhancing SR prevention and improving SR interventions when they are applied. The retrospective facet is crucial: analyzing the clinical decision after the event enables staff to approach future situations without falling into emergency mode or submitting to automatic reflexes or strict protocols, thereby improving decision making (Le Coz, 2007). With this in mind, we propose the following definition of PSRR: a complex intervention taking place after an SR episode targeting the patient and the health care providers in order to enhance the care experience and result in meaningful learning for the patient, team, and organization.

Study Limitations

The study's limitations revolve mostly around the methodology. First, because of the multitude of expressions used in discussions on the concept of PSRR, it is therefore possible that some relevant papers were overlooked despite the fact that many keywords were used. This also explains why the concept of "review" was not used in the initial search; it was only added after some of the texts were read. Second, the analysis would have been more rigorous had each author conducted his or her own literature review and then obtained inter-rater agreement.

CONCLUSION

The proposed typology of PSRR clarifies the concept in terms of the intervention target: the patient, the care providers, or both. When the issue of SR is approached in a holistic fashion, when the interaction between clinician and patient is placed at the centre of therapeutic care, it is evident that any proposed solutions must involve both patients and care providers, especially nurses. Thus clarified and rooted firmly in a nursing and reflective practice perspective, an intervention of this

type is sure to reduce the risk of aggression and the need to resort to control measures. In addition to improving the patient and nurse experience when SR is involved, PSRR will also help to continually enhance the quality and safety of patient care when managing aggressive behavior. The review of the literature reveals a paucity of PSRR evaluation studies; this topic merits further research.

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