

**Commonwealth of Massachusetts
 Department of Mental Health
 Patient Debriefing and Comment Form-Revised 4/06**

Patient Name: _____
 Facility: _____ Date/time restraint or seclusion ended: _____ / _____ Med. Rec.# _____

We regret the restraint or seclusion happened. Your thoughts and suggestions are important to prevent it from happening again. If necessary, staff will help you fill out this form. Attach extra pages if necessary.

1. Was your privacy and dignity respected during this restraint or seclusion? _____

2. (a) Why do you think the restraint or seclusion happened? _____

(b) What in particular made you upset? _____

3. (a) When you got upset, what did you do? _____

(b) When you got upset, what did staff do? _____

4. (a) What could you do differently when you get upset to prevent the restraint or seclusion? _____

(b) What could staff do differently when you get upset to help you? _____

5. Did you and the staff use your Crisis Prevention Plan? _____ Do we need to change it? _____
 Y/N Y/N

6. Do you have any physical complaints or injury(s) related to the restraint or seclusion? _____ If YES, describe:

7. How did the restraint or seclusion make you feel? _____

8. Who might be helpful for you to talk with about this experience? The Human Rights Officer is available to speak with you. _____

9. While you were either restrained or secluded, is there anything else staff could have done? _____

10. Is there anything else we can do now to help you recover from this incident? _____

_____/_____
 Patient's Signature Date & Time Staff Signature Date & time

_____/_____
 *Patient's Signature Date & Time Staff Signature Date & time

To Staff: This debriefing and comment form must be offered to the patient within 24 hours of the R/S. It may be re-offered later* if the patient chooses not to comment initially. The patient may comment in writing or verbally. If verbally, the staff person will complete the form. Staff must sign and date form even if patient chooses not to comment.

FOR STAFF USE ONLY: Please check all staff follow-up actions that apply.

Medical _____ Counseling _____

Crisis Plan Revision _____ Treatment Plan Revision _____

Human Rights Officer _____ Other _____

LAR/Family has been asked to participate in debriefing _____