Use of debriefing following restrictive practices in forensic psychiatric care

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Abstract

Purpose – *Inpatient violence is a substantial problem in psychiatric wards and de-escalation is difficult. When managing instances of violence through verbal techniques fail, mental health-care staff may use restrictive practices. The Six Core Strategies and debriefing exist for managing violence and restrictive practices in different mental health settings. Debriefing is used to get patients' views on restrictive practices, ensure proper patient care and strengthen the role of patients as experts. This study aims to provide new information on debriefing implementation and how debriefing was used among different patient groups in a forensic hospital.*

Design/methodology/approach – *Quantitative seclusion time and debriefing reports (*n *= 524) were examined with Poisson regression analysis. Fisher's exact test was used to determine the associations between debriefing and seclusion/restraint.*

Findings – *Debriefing (*n *= 524) was provided in 93% of violent episodes, which is an excellent result on an international level. There was significant variation in how often debriefing was used (*p *< 0.001) among different patient groups, i.e. dangerous, difficult-to-treat patients and criminal offenders whose sentences have been waived. Previous debriefing research has rarely specified what types of psychiatric patients have been subjected to seclusion or restraint.*

Practical implications – *The implementation of debriefing requires multiprofessional work within the organization and wards.*

Originality/value – *Debriefing seems to stimulate reflection at every level of a health-care organization, which fosters learning and can ultimately change clinical practices. The use of debriefing can strengthen the role of patients as well as professionals.*

Keywords *Debriefing, Forensic, Prevention, Restrictive practices, Seclusion, Restraint*

Paper type *Research paper*

Introduction

Inpatient violence is a significant problem in psychiatric wards (Mangaoil *et al.*, 2020); it is especially difficult to manage because violence is related to many factors, including acute and severe psychiatric disorders (Asikainen *et al.*, 2020a; Foster *et al.*, 2007; Goulet *et al.*, 2018). For this reason, the prevention and management of violence is often difficult and complex (Bowers *et al.*, 2006; Mangaoil *et al.*, 2020). In extreme and dangerous situations in which verbal de-escalation techniques fail, mental health-care staff may use coercive practices (Di Lorenzo *et al.*, 2012; Huckshorn, 2014), such as seclusion (confinement to a designated room for the short-term management of disturbed/violent behavior) or restraint (NICE, 2015). The primary motivation for seclusion is to avoid immediate harm to others, such as staff, other patients or the patient displaying violence. The decision to use seclusion is justified by the fact that it reduces the amount of stimulation that a patient experiences. It is important to stress that seclusion or restraint are only used if other means are not effective (Knox and Holloman, 2012; Riahi *et al.*, 2016). However, the use of restrictive practices during mental health-care raises certain ethical dilemmas related to patient autonomy and human rights (Kontio *et al.*, 2012). Various strategies and interventions (e.g. the Six Core

Strategies [6CS], Safewards) can prevent violence and restrictive practices (Bowers *et al.*, 2015; Huckshorn, 2005).

The 6CS have been shown to reduce restrictive practices in many countries (Goulet *et al.*, 2017; LeBel *et al.*, 2014; Putkonen *et al.*, 2013). The 6CS approach focuses on six elements:

1. organizational leadership;
2. preventive tools (assessment and risk);
3. use of data (frequency and duration of seclusion and restraints);
4. staff training;
5. patient, family or advocate involvement; and
6. debriefing (Huckshorn, 2014).

This study investigates aspect six, debriefing after coercive practices.

The recent paradigm shift in how coercive practices are viewed is largely due to the controversy, both from ethical and legal standpoints, of this issue (Bowers *et al.*, 2015; Huckshorn, 2005). At present, most health-care institutions try to avoid the use of restrictive practices; for this reason, patients should be afforded opportunities to share their perceptions of restrictive practices, e.g. use of debriefing. Based on what has been written in numerous studies (Huckshorn, 2014; Sutton *et al.*, 2014), various guidelines (NICE, 2017) and the Finnish Mental Health Act (1116/1990), patients should be debriefed by the health-care team after restrictive practices (seclusion/restraint) to ensure the continuity of care. Debriefing has been defined in this study as "supportive conversations between staff and patients who were involved in the event" (Lewis *et al.*, 2009). As such, the practice of debriefing aims to help patients and professionals recover after a traumatic event (Kenardy, 2000), and get information on patients' perceptions, e.g. violence triggers (Asikainen *et al.*, 2020a). Debriefing was also designed to develop patient awareness and help them become familiar with the internal resources they can use when facing challenges in the future (Sutton *et al.*, 2014). These experiences are critical to violence prevention in psychiatric wards (Huckshorn, 2005).

There is strong evidence about the effectiveness of the 6CS from many countries. However, there is less evidence about how successfully individual elements of this strategy have been implemented in forensic hospitals. Despite the recommendations, it seems that debriefing is only used in limited cases after coercion (Needham and Sands, 2010). Although debriefing has been studied in several countries, e.g. Australia and England, certain areas concerning debriefing remain understudied, such as the use of debriefing in the psychiatry and forensic mental health setting in Finland (Asikainen *et al.*, 2020b). According to prior research in Finland, debriefing has been poorly implemented in Finnish mental health wards.

Putkonen *et al.* (2013) previously studied the implementation of the 6CS (Huckshorn, 2005) at the same hospital that was investigated in the present study. The findings demonstrated that leadership promoted the implementation of every aspect of 6CS. However, the hospital needs more information to strengthen the role of patients as experts in their illness and rehabilitation. The study hospital is determined to develop specific interventions that will focus on peer support activities for patients and the use of debriefing after seclusion or restraint events.

There is a clear need for more information on the implementation and development of debriefing in Finnish forensic hospitals, and how debriefing can be used across different patients groups, each characterized by specific care needs.

This study produced new information about how different patient groups participate in debriefing. The presented information can serve as a blueprint for how to further improve debriefing in the mental health context.

In previous studies, use of debriefing has been divided into seclusion and restraint groups (Goulet *et al.*, 2018). This study described the debriefing implementation process in forensic hospitals in Finland and examines the use of debriefing with patients according to their legal status (2016–2020): dangerous and/or difficult-to-treat patients; and patients whose sentences have been waived. These groups of patients can experience long-term seclusion/restraint. The present study investigated differences in how debriefing was used among these two groups.

Materials and methods

Study hospital

There are two state-run forensic psychiatric hospitals in Finland. In the study hospital, patients are in involuntary care because of their psychotic illnesses, which can endanger both their safety as well as that of others. These two hospitals treat the most severely mentally ill patients in Finland.

The patients at this hospital are divided according to their legal status (2016–2020): dangerous and/or difficult-to-treat patients (59%–72%); and patients whose sentences have been waived (28%–41%) [Niuvanniemi Hospital, 2021; the Finnish Mental Health Act (1116/1990)]. The limits for seclusion time differ based on the patient's legal status. One seclusion/restraint episode can last from hours to several days, with more information provided in Table 1.

During the study period (2016–2020), the dangerous and/or difficult-to-treat patients were subjected to a total seclusion time of between 2,001 and 3,015 days, while patients whose sentences have been waived experienced total seclusion times ranging from 215 to 670 days (Niuvanniemi Hospital, 2021; Seppänen *et al.*, 2020). Seclusion time over the study period was calculated on the basis that one day includes 24 h, i.e. total hours of seclusion/24 h = total days of seclusion. The study was performed in five closed care wards, which can seclude patients.

Most of the patients have been diagnosed with schizophrenia or/and schizoaffective disorders. In addition, patients commonly have a history of substance abuse and violence (Kuivalainen *et al.*, 2017). The study hospital uses international Global Assessment of Functioning (GAF) value. The GAF describes the clinical status and patient disease diversity (APA, 2021; Luborsky, 1962). Low GAF values describe the multifaceted challenges in a patient's life that may cause him or her to become secluded. In this study, it was used to rate the social, occupational and psychological functioning of an individual, e.g. how well one manages various problems associated with everyday life. Scores range from 100 (extremely high functioning) to 1 (severely impaired). Most of the secluded patients in this study demonstrated grades at the two lowest levels. The first level includes scores between 1 and 10 and describes a patient who is constantly dangerous to himself and/or others, trying suicide and is unable to take care of hygiene. The second level (scores between 11 and 20) describes patients who show seriously impaired communication,

Table 1 Seclusion according to the legal status of the patients between 2016 and 2020

	Forensic patients		*Dangerous and difficult-to-treat patients*	
Year	*Seclusion days*	*Amount of seclusion*	*Seclusion days*	*Amount of seclusion*
2016	670	29	2,001	41
2017	729	20	2,630	37
2018	448	22	2,545	51
2019	215	15	2,479	38
2020	384	20	3,105	42

dangerous to themselves and/or others and do not take care of hygiene from time to time (APA, 2021; Luborsky, 1962).

The study setting involved five adult forensic psychiatric care wards. During the past years, these acute wards had to use seclusion on between 18% and 23% of hospital patients (Niuvanniemi Hospital, 2021). In this study, the term a secluded patient will describe any patient who experienced an episode of seclusion or restraint.

Study design and sample

The decision to subject a hospital patient to seclusion must follow the Finnish Mental Health Act (1116/1990). According to local law, a patient may be secluded due to violent behavior and/or if they pose a threat to themselves or the environment. A person who is receiving involuntary psychiatric treatment in a hospital may also be secluded if the seriously disturbing behavior prevents the treatment of other patients or endangers their safety. By law, a patient can also be secluded if he/she is likely to cause significant property damage or if there is another specific therapeutic reason for seclusion. Restraint is only allowed in connection with self-harm or harm to others (Finnish Mental Health Act [1116/1990]).

The study sample included adult forensic psychiatric inpatients who had experienced at least one episode of seclusion or restraint and who had completed a debriefing form (either with a nurse or independently). Debriefing forms were used to collect forensic psychiatric inpatients' perceptions of their violence triggers, feelings, reactions and circumstances, along with preventive means, after a compulsive or violent action had been resolved. The patient was allowed to decide whether he/she wanted to answer the form orally or in writing. If the patient decided to answer the debriefing form orally, the nurse completed the form word-by-word according to the patient. The nurse then entered the responses into the patient information system after patient approval. Although forms are offered to inpatients during the postseclusion/restraint period, the completion of the form is optional. The study hospital subjects between 62 and 66 patients to seclusion each year, with each patient potentially experiencing seclusion several times during the year. The inclusion criteria for the study were: an adult patient who had experienced a seclusion or restraint episode; and had completed a debriefing form after the seclusion episode. The exclusion criterion was a patient who had been secluded (e.g. electrotherapy) but had not received debriefing. Of the total number of analyzed forms (N = 539), 15 were rejected because they had been partially completed or were empty. A total of 524 forms were included in the study. The forms include the opinions of patients and describe the opinions of patients who had been subjected to long seclusion; the overall goal of health-care professionals was that debriefing is performed once a month with these patients.

The Coercive Prevention Group prepared a debriefing form for hospital patients according to recommendations by Sutton *et al.* (2014). The debriefing form included event description, emotional analysis and how to prevent the next violent situation. In the event description, the patient was asked to describe what had happened, along with their emotional state before seclusion. More specifically, the patient was asked how they acted in the situation leading to seclusion and how they felt that staff acted in the situation. Next, the patient was asked to describe the feelings he/she experienced during seclusion. The patient was asked to respond to several questions: was the seclusion beneficial or detrimental to the patient, and why?; while the patient was in seclusion, what could the health-care team have done to help him/her?; and how was patient privacy and dignity maintained during the seclusion? The patient was also asked to describe how the use of seclusion could have been prevented. This section included several questions: what could the patient do differently in the future to prevent such an event if he/she loses control of his/her emotions?; what are the "warning signs" that the patient's situation could escalate into violence?; and how does the patient expect the staff to react when they notice that the patient is in crisis? The patient was also asked to assess whether the situation could have been treated by some other means than seclusion. Finally, the patient was asked whether they have some additional comments or want to pose a question.

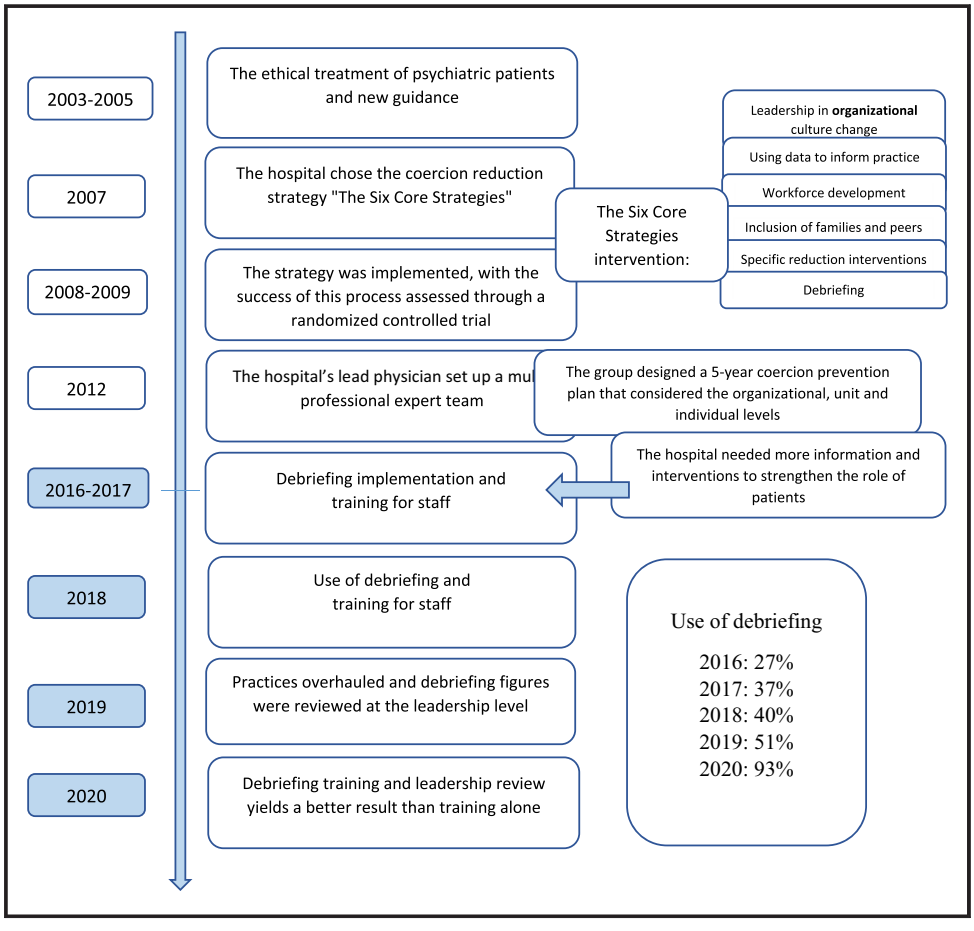
Data collection and analysis

The debriefing forms were printed from the patient information system and processed manually. The data were collected retrospectively from debriefing forms (N = 524) filled out between 2016 and 2020, as well as various phases of the debriefing implementation process at the study hospital (Figure 1). Descriptive statistics were calculated. Reports of seclusion time and use of debriefing statistics were examined with Poisson regression analysis to determine whether there were differences among groups of patients classified by legal status (categorical variables) in terms of the annual amount of debriefings (implementation years) and frequency of seclusion or restraint incidents per 1,000 patient-days (dependent variables) (Dunteman and Ho, 2006). Fisher's exact test was used to determine the nonrandom associations between two categorical variables, i.e. debriefing and S/R. The data were processed using the SPSS 27.0 software package (SPSS Inc., Chicago, IL). We applied thematic analysis to analyze the patient responses concerning their experiences of seclusion (Braun and Clarke, 2006).

Ethical issues

The study received ethical approval (448/2015) from the Research Ethics Committee, Hospital District Northern Savo, Finland and Niuvanniemi Hospital. Ethical approval was granted for the use of anonymous debriefing form data in the research. The study used the Finnish National Advisory Board's Social Welfare and Health-Care Ethics research

Figure 1 Process of coercion reduction strategy implementation



guidelines for vulnerable subjects, which includes psychiatric patients. The debriefing forms were coded so that the information they contained could not be linked with patient data. All of the analyzed data were protected, and only the researchers could access the collected information.

Findings

This study described the implementation and use of debriefing among different patient groups in a Finnish forensic hospital. A former study indicated that the 6CS, especially debriefing, were poorly implemented in Finnish mental health hospitals (Asikainen *et al.*, 2020b). The presented results describe which factors enhance the debriefing implementation process, with an emphasis on seclusion-related debriefing from 2016 to 2020. Previous studies do not explain which factors are missing from the process because debriefing is scarcely offered to patients. Debriefing was used after seclusion or restraint due to a violent situation (n = 4–28 monthly). Violent situations are caused by, among other things, social aspects, environmental factors and the patient's illness (low GAF scores). Patients in the study were divided into two GAF levels. The study used the international GAF value to describe why these patients were often secluded (see GAF criteria). Low GAF values describe multiple, and multifaceted challenges within the mental health community.

The first GAF level (scores between 1 and 10) included 32%–36% of the studied patients (between 2016 and 2020); these groups involved longer seclusion times than the second group. The second GAF level (scores between 11 and 20) included 41%–49% of the studied patients (between 2016 and 2020), who usually had more than one psychological condition.

The ethical debate (Mental Health Legislation and Human Rights, 2003) and new guidance (NICE guidance, 2015, 2017) concerning the treatment of psychiatric patients have highlighted the need to evaluate how forensic psychiatric hospitals use coercion, especially seclusion and restraint. The study hospital had previously chosen to apply the coercion reduction strategy "The Six Core Strategies" developed by Huckshorn (2005). The success of this implementation was previously examined in a randomized controlled trial between 2008 and 2009 (Putkonen *et al.*, 2013).

A debriefing implementation study was conducted from 2016 to 2020. Hospital staff were trained on how to use debriefing during one debriefing session, violence prevention training and staff negotiations between 2016 and 2018. In addition, nurses were provided with individual counseling. The use of debriefing in one pilot ward improved from 34% to 100% following training.

The operational practices of the hospital were overhauled, and the leadership of the hospital reviewed debriefing figures from the fall of 2019. Furthermore, the importance of debriefing was discussed in conjunction with the reduction of restrictive practices during meetings with nurses and physicians. Based on assessments by the hospital leadership, the use of debriefing increased significantly at the ward level. Moreover, the combination of debriefing training and leadership review (year 2020) yielded better results (93% implementation of debriefing) than training alone. The hospital has achieved better systematic outcomes than what has been reported on an international level (Krieger *et al.*, 2021; Needham and Sands, 2010). A Poisson regression revealed that debriefing use has increased annually between 2016 and 2020 by 37.1% (95% CI: 28.4%–46.5%; $p < 0.001$). The relationship between the use of debriefing and the use of seclusion or restraint was tested by cross-tabulation and Fisher's test. Debriefing explained 98.3% of the variance in the seclusion group and 76.9% of the variance in the seclusion/restraint group. This difference was almost statistically significant ($p = 0.055$).

From 2017 on, debriefing was mainly performed among dangerous and difficult-to-treat patients (85%), with a minority of the debriefing sessions performed for patients whose

sentences have been waived. Some patients (N = 15) refused to respond to the debriefing form. Of these, 67% were patients whose sentences have been waived. The reasons for not responding were that there was no need to clarify or repeat the matter and that debriefing was of no interest.

Perceptions among groups of patients that were subjected to long seclusion

The study hospital has patients (dangerous and/or difficult-to-treat patients and patients whose sentences have been waived) who have been secluded/restrained for long periods (months to years). This type of action is defined as "long seclusion." It is challenging to define this type of seclusion, and health-care professionals should first review why a patient is being subjected to seclusion. In cases of challenging patient behavior, a combination of various medications is commonly used to balance the patient's well-being. It is well known that different psychiatric medications have different effects. For example, the effect of a particular medication may only begin two weeks after the medication is started (Moncrieff *et al.*, 2013). As such, the patient may be secluded until the condition subsides and the medication begins to take effect. Some patients do not benefit from treatment interventions or any medication. These patients may be secluded for long periods. In this study, "long seclusion" is defined as seclusion lasting more than two weeks. At the study hospital, between 51% and 66% of all secluded patients experienced long seclusion. Debriefing with dangerous and difficult-to-treat patients who had been subjected to long seclusion (range 48%–96%) was more common than debriefing with patients whose sentences have been waived (range 21%–50%). Answers to the debriefing forms revealed that patients felt various actions could improve their quality of life during seclusion. Most of the patients wanted more time to discuss the situation with their nurse or have a short period of seclusion. Several patients who experienced long seclusion reported that they get some treatment for their condition during the day. Moreover, many patients have access to a telephone, computer, magazines or other relaxing activities in their seclusion room.

The use of seclusion is the last way to protect a patient or others from harm. When seclusion is used, the patient needs a treatment plan designed by a multiprofessional team. The use of debriefing after restrictive practices was not found in any of the secluded patients' treatment plans.

Discussion

This study presented new information about the extent to which debriefing was used after restrictive practices among different patient groups; this knowledge will help researchers, practitioners and decision-makers better understand the impact of this practice, and how it can improve psychiatric care. In Finland (Asikainen *et al.*, 2020b), debriefing was previously found to be only poorly implemented for the purpose of preventing the use of restrictive practices in psychiatric settings. The present study was performed to assess the current implementation of debriefing in Finnish psychiatric care and provide evidence of how debriefing can improve the care of forensic psychiatric patients. It is possible that the presented results will encourage other mental health hospitals to work harder to implement debriefing practices in a bid to improve care quality and dramatically reduce restrictive practices.

The study hospital had previously aimed to reduce the use of restrictive practices during treatment through the 6CS, and achieved significant results, as described by Putkonen *et al.* (2013). Furthermore, multiple studies have researched how patients' compulsive actions can be reduced through the development of new ways of working (Kuivalainen *et al.*, 2017). NICE (2015) provides guidance on how organizations should consider patient rights in restrictive practices, e.g. seclusion, through the report "Violence and aggression: short-term management." This guidance emphasizes the use of debriefing. Debriefing was

implemented at the study hospital between 2016 and 2020, with the presented results clarifying how well debriefing has been implemented in this time period. The results demonstrate that it is necessary to engage leadership in the implementation process for debriefing to succeed. This study illustrated that the involvement of management, monitoring clinical practices and discussing statistics all improve the use of debriefing. Earlier studies have illustrated that core components of any new approach should be incorporated into the organization's policies, practice guidelines and training modules to ensure consistent conceptualization and implementation of the debriefing process (Huckshorn, 2004; Mangaoil *et al.*, 2020). The 6CS, along with other studies, e.g. Sutton *et al.* (2014), recommend integrating the use of debriefing into patient care plans. However, the use of debriefing was not mentioned in the studied patients' treatment plans. This may be because there is a lack of separate guidance from the hospital. Since 2017, debriefing was mostly provided to dangerous and difficult-to-treat patients (85%), with less debriefing provided to patients whose sentences have been waived (15%). This small share of patients whose sentences have been waived in the debriefing volumes was explained by patients' refusal of debriefing. Notably, the patients felt that there was no need to clarify or repeat the matter and that debriefing was of "no interest." Patients who have committed a crime appear to have the most negative stance toward debriefing; this is a clear developmental challenge for the use of debriefing. The largest group of patients who received debriefing was the dangerous and difficult-to-treat patients. They have the lowest GAF scores, which reflect wide-ranging challenges in many different areas of life. Problems in these areas cause conflict and violence. In the future, the development of debriefing can be used to solve individual problems and find different ways for how patients cope with difficult situations. A patient who experiences considerable problems with the social environment is often subjected to long seclusion. At the study hospital, between 51% and 66% of the patients who experienced seclusion were also subjected to long seclusion due to the severity of their mental illness or disrupting behavior. Kuivalainen *et al.* (2017) illustrated the same kind result.

The underlying goal of debriefing following long seclusion is gathering patients' perceptions to improve the quality of life and conditions during the seclusion. The presented results agreed with previous findings (Ling *et al.*, 2015) in that patients reported experiencing a variety of negative emotional states and reactions as a consequence of restrictive practices. In other words, patients wanted access to different activities during restrictive practices. There is a clear need to develop a specific debriefing form for patients who have experienced long seclusion because the current instructions are not detailed enough to lay the grounds for longer seclusion periods. Debriefing can improve patients' quality of life and reduce the use of coercive measures by considering patient perceptions.

The strengths and limitations of this study were mainly related to the research process and debriefing. The rigor of the study was ensured by respecting the scientific criteria. Moreover, the statistical analyses were validated by an independent biostatistician. Although the study population was representative of individuals who are treated or examined in forensic psychiatric hospitals in Finland, some limitations hinder the generalizability of the results to general psychiatry. The limitations of this study are related to the sample size, the fact that only one forensic hospital was involved in the research, and the heterogeneity of the debriefings. Although patient files are well regulated in Finland, the quality of the data analyzed in the present study depended on how detailed the staff were when entering their notes into the patient register. The debriefing form limits the extent to which certain issues and questions related to seclusion can be discussed.

Conclusions

The results of this study will allow researchers to develop and evaluate debriefing tools in conjunction with organization, staff and patients. Debriefing offers the possibility to use patient

and staff perceptions to improve the quality of care as well as ward safety. The study produced new information about the extent to which debriefing was used among different patient groups (categorized based on legal status). The largest group of patients who received debriefing was the dangerous and difficult-to-treat patients. A specific model should be developed to further use the information obtained from the debriefing forms. Previous research has focused on seclusion or restraint rather than considering both as restrictive practices in assessments of psychiatric care. In addition, the presented study examined debriefing after long seclusion. The results demonstrated that the current debriefing model is inappropriate for patients who have experienced long seclusion. This requires a separate debriefing form that takes into account the patient's quality of life during restrictive practices.

More research about how organizations can make better use of debriefing information to meet specific goals will be needed in the future.

Implications for forensic nursing practice

- Debriefing seems to stimulate reflection at every level of a health-care organization, within the ward and among patient; this can foster learning and change clinical practices.
- More research into how often psychiatric patients who have been subjected to restrictive practices are debriefed is recommended.

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