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

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 ___________________________