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Restraint and Seclusion in Treatment Foster Care

Using Staff Training to Decrease the Use of Restrictive Procedures at Two Facilities for Foster Care Children

Kimberly A. Crosland, Maricel Cigales, Glen Dunlap, Bryron Neff, Hewitt B. Clark, Tamela Giddings, and Alfredo Blanco

University of South Florida.

2008

Research on Social Work Practice

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info@sagepub.com

Available From: <http://www.sagepub.com>

Objective: Use of some restrictive procedures, including physical restraint, has been controversial. For children within the foster care system, who have already suffered various degrees of abuse and neglect, restrictive procedures could add to their emotional and behavioral problems. The current study was conducted to determine whether a behavioral staff training program would help reduce the use of restrictive procedures at two group facilities housing children in the foster care system. Method: Pre- and posttraining measures (incident reports) were obtained within a nonconcurrent multiple-baseline design to document the use of restrictive procedures. Results: The data revealed decreases in reports of several restrictive procedures (e.g., take downs, physical holds, and physical and pharmacological restraints) at both facilities. Conclusions: The results suggest that training direct care staff personnel, including social workers, in positive behavioral strategies might reduce staff use of restrictive procedures and result in fewer injuries to both children and staff.

Beneath the Radar: Parents' Use of Physical Interventions in Managing Their Children's Challenging Behavior in the United Kingdom

Allen, David. Hawkins, Sarah. Cooper, Viv.

2007

Residential Group Care Quarterly

8 (1) p. 4-9

Little is known about the use of physical interventions by parents of children with intellectual disability and challenging behavior; in particular, very limited data exists on their needs for training in reactive management procedures. The present exploratory study was designed to address: (1) What is the general experience of parents who manage risk behaviors? (2) To what extent do they use physical interventions as a management strategy? (3) To what extent have parents been trained in these interventions? (4) What barriers exist to them accessing training? (Author abstract)

<http://www.cwla.org/programs/groupcare/rgcqsummer2007.pdf>

Should State and Provider Agencies Completely Abandon the Use of Seclusion and Exclusively Use Physical Restraint to Intervene With Children and Youth in Emergency Situations?

Point/Counterpoint.

Masters, Kim J. Finke, Linda M.

2007

Residential Group Care Quarterly

8 (1) p. 10-14

Two views on the seclusion vs. restraint debate.

<http://www.cwla.org/programs/groupcare/rgcqsummer2007.pdf>

Legal strategies to challenge chemical restraint of children in foster care: a resource for child advocates in Florida

Jacobs, Bob.

Advocacy Center for Persons with Disabilities.

2006

National Association of Counsel for Children

1825 Marion Street, Suite 242

Denver, CO 80218

Tel: 888-828-NACC 303-864-5320

Fax: 303-864-5351

advocate@NACCchildlaw.org

Available From: <http://www.naccchildlaw.org/>

This resource is designed to help advocates educate dependency judges and protect children in foster care against rights violations, harmful drugs, and/or chemical restraint. It includes information about commonly prescribed psychotropic drugs, their side effects, and strategies for challenging harmful treatment and/or chemical restraint. A chart is provided that lists different kinds of antidepressants, mood stabilizers, stimulants, antipsychotics, anticonvulsants, antihypertensives, antihistamines, and anti-anxiety drugs and their negative physical side effects. The negative psychological effects of the medications are also noted. Legal strategies are then explained for carefully scrutinizing all requests seeking psychotropic prescriptions for a child in State custody and, where appropriate, challenging such chemical restraint as contrary to the child's well-being. Three key strategies are explained: effective cross-examination of experts,

effective school based advocacy, and illuminating the contrast between the rates of psychotropic drug use by children in the parental home vs. children in foster care. 1 chart and 65 references.
<http://www.naccchildlaw.org/training/documents/HandbookonChemicalRestraint.pdf>

Learning from tragedy: A survey of child and adolescent restraint fatalities

Nunno, Michael A. Holden, Martha J. Tollar, Amanda.

2006

Child abuse and neglect : the international journal.

30 (12) p. 1333-1342

Publication Information: Orlando, FL : Elsevier

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Customer Service Department 6277 Sea Harbor Drive

Orlando, FL 32887-4800

Tel: +1 (877) 839-7126

Fax: +1 (407) 363-1354

usjcs@elsevier.com

Available From: <http://www.elsevier.com/>

This study asks how 45 children and adolescents died during or after physical or mechanical restraint in a range of child welfare, corrections, and mental health residential (institutional) placements in the United States from 1993-2003. Since restraints are common and frequent safety, therapeutic, or control interventions to children's facilities, understanding the multiple causes of these facilities is essential to ensure safety and to prevent future tragedies. The study recommends that practitioner and policymaker focus on eliminating adverse environmental and organizational causes, dangerous restraint practices, and strict enforcement of standards and guidelines concerning the appropriate use of restraints, especially floor restraints, to lower risk and increase safety. (Author abstract)

Unlicensed Residential Programs: The Next Challenge in Protecting Youth

Friedman, Robert M.; Pinto, Allison; Behar, Lenore; Bush, Nicki; Chirolla, Amberly; Epstein, Monica; Green, Amy; Hawkins, Pamela.

2006

American Journal of Orthopsychiatry

77 (1) p. 67-75

American Psychological Association

750 1st St., NE

Washington, DC 20002

Tel: 800-374-2721 202-336-5500

Fax: 202-336-5502

TDD/TTY: 202-336-6123

order@apa.org

Available From: <http://www.apa.org>

Over the past decade in the United States, the number of private residential facilities for youth

has grown exponentially, and many are neither licensed as mental health programs by states, nor accredited by respected national accrediting organizations. The Alliance for the Safe, Therapeutic and Appropriate use of Residential Treatment (A START) is a multi-disciplinary group of mental health professionals and advocates that formed in response to rising concerns about reports from youth, families and journalists describing mistreatment in a number of the unregulated programs. This article summarizes the information gathered by A START regarding unregulated facilities. It provides an overview of common program features, marketing strategies and transportation options. It describes the range of mistreatment and abuse experienced by youth and families, including harsh discipline, inappropriate seclusion and restraint, substandard psychotherapeutic interventions, medical and nutritional neglect, rights violations and death. It reviews the licensing, regulatory and accrediting mechanisms associated with the protection of youth in residential programs, or the lack thereof. Finally, it outlines policy implications and provides recommendations for the protection of youth and families who pursue residential treatment.

Improving Restraint Monitoring with Pulse Oximetry

Masters, Kim J.

2006

Residential Group Care Quarterly

6 (4) p. 4-5

Discusses the use of pulse oximetry, a noninvasive procedure that offers an opportunity to measure oxygen saturation in blood, independent of anxiety or agitation, to monitor individuals subjected to physical restraints (being restrained by people) and mechanical restraints (being restrained by mechanical devices such as straps or papoose boards). (Author abstract modified)

<http://www.cwla.org/programs/groupcare/rgcqspring2006.pdf>

Wizard's Way: A Level I Intervention to Reduce Seclusion and Restraint

Alters, Dennis.

2006

Residential Group Care Quarterly

6 (3) p. 8-9

The author created Wizard's Way (WW) in 1990 to address in-patient management difficulties. The program effectively reduces the need for seclusion and restraint. This article expands on its brief description in the Practice Parameters for the Prevention and Management of Aggressive Behavior. (AACAP, 2002). (Author abstract)

<http://www.cwla.org/programs/groupcare/rgcqwinter2006.pdf>

Should Prone Restraints Be Eliminated from Practice?

Point/Counterpoint.

Holden, Martha. Leadbetter, David.

2006

Residential Group Care Quarterly

6 (3) p. 10-12

Discusses two views on the use of prone restraint in children's residential agencies.

<http://www.cwla.org/programs/groupcare/rgcqwinter2006.pdf>

Patient Characteristics and Setting Variables Related to Use of Restraint on Four Inpatient Psychiatric Units for Youths

Delaney, Kathleen R. Fogg, Louis.

2005

Psychiatric Services

57 (4) p. 493-497

American Psychiatric Association

1000 Wilson Boulevard, Suite 1825

Arlington, VA 22209-3901

Tel: 703-907-7300

apa@psych.org

Available From: <http://www.appi.org/>

OBJECTIVES: This study examined the characteristics of children and adolescents who were restrained during brief inpatient psychiatric treatment and identified whether restraint use was related to the characteristics of the youths or to the setting—time of day, day of the week, place, or programming. Incidents related to restraint use were also examined. **METHODS:** Charts were reviewed for 100 youths who were admitted to four inpatient units between December 1998 and January 2000. **RESULTS:** Thirty-one youths were not restrained, 57 were restrained once or twice, and 12 were restrained three or more times. Youths were significantly more likely to be restrained if they were male, had multiple admissions to the facility during the study period, remained in the hospital longer, had been given a diagnosis of a psychotic disorder, or had a previous psychiatric hospitalization. Youths who were restrained were also more likely to be enrolled in special education or to be in foster care or in custody of the Department of Children and Family Services. Also, these youths were more likely to have a history of voicing suicidal ideation and attempting suicide. No single setting variable was significantly related to restraint use. Incidents that prompted restraint generally involved agitation, threats, or assaults. **CONCLUSIONS:** Youths who were at greatest risk of being restrained during brief inpatient treatment shared particular characteristics related to greater use of inpatient services, guardianship arrangements, special education placement, and history of suicide attempts. Inpatient staff members should remain particularly alert to the processing and regulation problems of these groups of patients.

Are Behavior Support and Intervention Training Programs the Answer to Reducing and Eventually Eliminating Restraints and Seclusion?

Point/Counterpoint.

Mullen, Joseph K. Bailey, Keith A.

2005

Residential Group Care Quarterly

6 (2) p. 10-13

Discusses two views on behavior support/intervention and reliance on seclusion and restraint in youth services.

<http://www.cwla.org/programs/groupcare/rgcqfall2005.pdf>

Comfort Rooms: Reducing the Need for Seclusion and Restraint

Bluebird, Gayle.

National Association of State Mental Health Program Directors Research Institute.

2005

Residential Group Care Quarterly

5 (4) p. 5-6

Discusses the use of comfort rooms, rooms set up to be physically comfortable and aesthetically pleasing, to reduce the use of seclusion and restraint in children's residential facilities.

<http://www.cwla.org/programs/groupcare/rgcqspring2005.pdf>

Residential Child Care: Guidelines for Physical Techniques, Crisis Prevention, and Management

Lalemand, Kurk.

2005

Residential Group Care Quarterly

5 (3) p. 5, 7

This article discusses the selection criteria managers should consider to ensure a technique is appropriate for including in the training of direct service employees in residential child care.

<http://www.cwla.org/programs/groupcare/rgcqwinter2005.pdf>

Achieving Better Outcomes for Children and Families: Reducing the Use of Restraint and Seclusion

Johnson, Katherine.

2004

Residential Group Care Quarterly

5 (2)

This special issue provides detailed information regarding the interventions instituted by each demonstration site involved in the Best Practices in Behavior Support and Intervention Project.

<http://www.cwla.org/programs/groupcare/rgcqfall2004.pdf>

Reducing Reliance on Restrictive Techniques

Carlson, Shari.

2004

Residential Group Care Quarterly

4 (4) p. 1, 3

Chileda, a residential school in LaCrosse, Wisconsin, has committed the past 30 years to serving difficult-to-place children and young adults with developmental disabilities. The school serves 42 individuals from across the United States with diagnoses that include autism spectrum disorder,

traumatic brain injury, Down's syndrome, oppositional-defiant disorder, intermittent explosive disorder, and low-incidence neurological disorders that involve acting out. This article describes strategies that have helped make Chileda successful in the ongoing goal of reducing use of restrictive techniques. (Author abstract modified)

<http://www.cwla.org/programs/groupcare/rgcqspring2004.pdf>

Is Becoming Restraint- and Seclusion-Free a Realistic Goal for Residential Providers?

Point/Counterpoint.

Johnson, Jermaine H. Sinclair, Jim.

2004

Residential Group Care Quarterly

4 (4) p. 10-12

Discusses two views on eliminating restraint and seclusion in residential facilities.

<http://www.cwla.org/programs/groupcare/rgcqspring2004.pdf>

The Impact of Restraint on Sexually Abused Children and Youth

Fox, Lorraine E.

2004

Residential Group Care Quarterly

4 (3) p. 1-5

This article focuses specifically on the effect of physical restraint on children who have been sexually abused, recognizing the impact is similar for adults with histories of sexual abuse.

(Author abstract)

<http://www.cwla.org/programs/groupcare/rgcqwinter2004.pdf>

Best practices in behavior support and intervention assessment

Child Welfare League of America.

2004

Publication Information: Washington, DC : CWLA Press.

Available from: Child Welfare League of America (CWLA)

2345 Crystal Drive, Suite 250

Arlington, VA 22202

Tel: 703-412-2400

Fax: 703-412-2401

order@cwla.org

Available From: <http://www.cwla.org/>

This assessment instrument is designed to help child welfare agencies improve their behavior support and intervention policies, procedures, and practices through careful self-assessment. The instrument includes 49 standards that cover five major areas agencies should review when assessing behavior support and intervention policies and practices: their ethical and legal framework; their administration and leadership; a continuum of intervention; medical issues; and professional development and support for caregivers. The assessment requires a review of

agency documentation, as well as interviews drawn from a sufficient sample of staff members, clients, and stakeholders from each unit that is being evaluated. Appendices include references for each standard in the Child Welfare League of America's best practice guidelines and an answer form. (Author abstract modified)

CWLA best practice guidelines: behavior support and intervention training

Child Welfare League of America.

2004

Publication Information: Washington, DC : Child Welfare League of America

Available from: Child Welfare League of America (CWLA)

2345 Crystal Drive, Suite 250

Arlington, VA 22202

Tel: 703-412-2400

Fax: 703-412-2401

order@cwla.org

Available From:<http://www.cwla.org/>

The use of restraint and seclusion as responses to behavior problems places children at risk of injury, death, retraumatization, and loss of trust. Agencies are advised to train workers in prevention and alternative behavior interventions to reduce intrusive practices. These guidelines developed by the Child Welfare League of America describe the components of organizational culture that discourage restraint and seclusion and review topics that should be addressed in professional training programs. The information can be used to assess the appropriateness of models proposed by external trainers. The recommended approach includes primary prevention strategies, secondary prevention, emergency safety interventions, and tertiary prevention. Suggestions focus on environmental changes that reduce aggression, as well as techniques for diverting potential problems. The proper use of restraint and seclusion is discussed. 24 references.

Reducing the use of restraint and seclusion: promising practices and successful strategies

Bullard, Lloyd. Fulmore, Darren. Johnson, Katherine.

Child Welfare League of America.

2003

Publication Information: Washington, DC : Child Welfare League of America.

Available from: Child Welfare League of America (CWLA)

2345 Crystal Drive, Suite 250

Arlington, VA 22202

Tel: 703-412-2400

Fax: 703-412-2401

order@cwla.org

Available From:<http://www.cwla.org/>

The Harvard Center for Risk Analysis has estimated that as many as 150 people die each year from injuries related to seclusion or restraint in institutions or health care facilities. Restraint and

seclusion also can cause long-term emotional trauma. This booklet was compiled to provide guidelines for the curtailment of restraint and seclusion as intended by the Children's Health Act of 2000 and similar state laws. The recommendations promote the use of alternative behavior management techniques, which have been identified in case studies, expert opinions, and research. Suggestions address leadership responsibilities, organizational culture, agency policies and procedures, staff training, and the treatment milieu. Leaders are advised to communicate the importance of reducing restraint and seclusion practices and provide the necessary resources to train and support staff. Policies such as comprehensive assessment, individualized behavior support plans, monitoring, and debriefing will help to achieve goals for alternative techniques. Facilities also should focus on safety, routines, and coping skills for children. 32 references.

CWLA Best Practice Guidelines: Behavior Management

Child Welfare League of America, Inc., Washington, DC.

2002

Publication Information: Child Welfare League of America, Inc., Washington, DC.

Available from: CWLA c/o PMDS

PO Box 2019

Annapolis Junction, MD 20701-2019

Tel: 800-407-6273

Fax: 301-206-9789

cwla@pmds.com

Available From: <http://www.cwla.org>

Developed by the National Task Force on Behavioral Management of the Child Welfare League of America, these guidelines outline the best practices for serving children and youth with challenging behaviors. The recommendations for administration, intervention, and professional development are based on an ethical and legal framework that emphasizes the rights of children and families and compliance with established regulations. The text addresses topics such as placement and contract policies, licensing regulations, external monitoring, incident reporting, organizational culture, and the role of governing and advisory boards. Intervention and medical issues include individualized service planning, the selection of behavior intervention models, preventive planning, de-escalation, restraint usage, and medical or psychiatric assessments. Staff recruitment and hiring, orientation, and in-service training considerations also are discussed. A glossary is included. 29 references and 3 tables.

Practice Parameter for the Prevention and Management of Aggressive Behavior in Child and Adolescent Psychiatric Institutions, With Special Reference to Seclusion and Restraint

American Academy of Child and Adolescent Psychiatry, Washington, DC.

2002

Journal of the American Academy of Child and Adolescent Psychiatry

41 4S-25S

Publication Information: Lippincott Williams and Wilkins, Hagerstown, MD.

Available from: American Academy of Child and Adolescent Psychiatry

3615 Wisconsin Ave. NW
Washington, DC 20016
Tel: (202) 966-7300
Fax: (202) 966-2891

Available From: <http://www.aacap.org>

This parameter reviews the current state of the prevention and management of child and adolescent aggressive behavior in psychiatric institutions, with particular reference to the indications and use of seclusion and restraint. It also presents guidelines that have been developed in response to professional, regulatory, and public concern about the use of restrictive interventions with aggressive patients with regard to personal safety and patient rights. The literature on the use of seclusion, physical restraint, mechanical restraint, and chemical restraint is reviewed, and procedures for carrying out each of these interventions are described. Clinical and regulatory agency perspectives on these interventions are presented. Minimal standards identified by clinical consensus based on empirical evidence promote the use of intake and assessment, treatment planning, and staff training to prevent aggressive behavior. In crisis situations, clinical guidelines and minimal standards recommend de-escalation strategies, such as anger management and stress reduction. Seclusion or restraint should be used only when the patient is at risk of dangerous behavior toward self or others. However, minimal standards require that the autonomy of the patient be considered when deciding on a course of action. The strategy should be selected in cooperation with a physician and the patient should be monitored. Although the Joint Commission on Accreditation of Healthcare Organizations permits qualified registered nurses to implement the restraint, the Health Care Financial Administration mandates that an independent practitioner examine the patient within one hour. Physical and mechanical techniques that include airway obstruction must not be used. Effectiveness, indications, contraindications, complications, and adverse effects of seclusion and restraint procedures are addressed. The Joint Commission on Accreditation of Healthcare Organizations also promotes the use of performance/process improvement teams and projects to identify problems in the restraint procedures endorsed by institutions. (Author abstract modified) 120 references.

Annotated Bibliography of Selected Empirical Studies [Restraint and Seclusion: An Annotated Bibliography]

Child Welfare League of America.
2002

This annotated bibliography is an effort to address the need to care safely for children and youth, by establishing what is known in the research literature about the use of restraint and seclusion, identifying gaps in the research, and widely disseminating the findings. CWLA will continuously add to the bibliography as more research findings are released.

<http://www.cwla.org/programs/behavior/SAMSHAbib.pdf>

A Prolegomenon on Restraint of Children: Implicating Constitutional Rights

Kennedy, S. S. Mohr, W. K.

Indiana Univ., Indianapolis. School of Nursing.
2001

American Journal of Orthopsychiatry
71 26-37

Publication Information: American Orthopsychiatric Association, New York, NY.

Available from: Wanda K. Mohr

Indiana Univ. School of Nursing 1111 Middle Dr., NU 489
Indianapolis, IN 46202-5107

wkmohr@iupui.edu

Thirty-seven children died within a ten-year period of injuries sustained while being physically restrained in psychiatric facilities in the United States. Although research has demonstrated that the practice is not beneficial and can result in harm to the child, many facilities continue to utilize seclusion and restraint as methods for protecting a child from injuring himself or others.

Restraint can be harmful particularly for conduct-disordered children who have cognitive and emotional impairments caused by maltreatment. These children often are hypervigilant and quick to react with angry and aggressive behavior that can provoke hospital staff into restraining them. However, abused children may experience restraint as a reminder of previous trauma and react with an elevated stimulus stress response. The stress response involves chemical changes in the brain and body that can be harmful if repeated or continued for a long period. In addition to the dangers of prolonged stress response, children can be harmed by the physical discomfort of restraint, the emotional impact of isolation and shame, and other injuries that can occur during restraint, such as asphyxia. Despite these consequences, seclusion and restraint are commonly used by hospital workers who have little training in psychiatric care and the prevention of aggression. Standards issued by the Health Care Financing Administration, the Joint Commission on Accreditation of Healthcare Organizations, and the American Academy of Child and Adolescent Psychiatry discourage the use of seclusion and restraints but do not provide guidelines for when it can be used, authorization procedures, time limits, and physician supervision. The Supreme Court has ruled that patients in a psychiatric institution have the right to reasonably safe methods of confinement and protection from unreasonable restraint. The definition of "reasonable" needs to be clarified by further research and the development of specific standards. 92 references.

**Massachusetts Department of Mental Health Task Force on the Restraint and Seclusion of
Persons Who Have Been Physically or Sexually Abused: Report and Recommendations**

Carmen, E. Crane, B. Dunnicliff, M. Holochuck, S. et al.

Boston Univ. School of Medicine, MA. Brockton Multi-Services Center.

1996

Publication Information: Massachusetts State Dept. of Mental Health, Boston

Available from: Massachusetts State Dept. of Mental Health
25 Staniford St.

Boston, MA 02114-2575

Tel: (617) 727-5500

This report presents recommendations for preventing the revictimization of mentally ill individuals with a history of physical or sexual abuse. The Task Force on the Restraint and Seclusion of Persons Who Have Been Physically or Sexually Abused recommends that the Massachusetts Department of Mental Health (DMH) take actions to address problems concerning assessment procedures, the use of restraints, the DMH-DMA draft purchasing specification, emergency services, a pilot project for all-women units, the Office of Internal Affairs, and training. The task force recommends the use of the Trauma Assessment Form and the Restraint Reduction Form in the assessment of clients; proposes changes in DMH restraint and seclusion regulations; suggests language additions concerning special needs, cultural competency, assessment and treatment planning, restraint and seclusion in emergency programs, and all-women units; and recommends hiring and investigative practices in the Office of Internal Affairs. Appendixes present forms, correspondence, and a list of task force members. 19 references.

The Physical Restraint of Children: Is It Therapeutic?

Bath, H.

Marymead Children's Centre, Canberra (Australia).

1994

American Journal of Orthopsychiatry

64 40-49

Publication Information: American Orthopsychiatric Association, New York, NY

Available from: AOA Publications Sales Office

49 Sheridan Ave.

Albany, NY 12201-1413

Tel: (212) 564-5930

Fax: (212) 564-6180

amerortho@aol.com

Available From: <http://www.amerortho.org>

This article discusses the use of physical restraint with children under 13 years of age. The pros and cons are examined, and physical restraint is addressed as a reactive action and as a therapeutic treatment. The functions of limit setting and containment are addressed as part of therapeutic intent. Restraint and seclusion are compared as responses to dangerous aggression, and a number of theoretical warrants for the use of physical restraint with children are reviewed, with a primary focus on its attachment-promoting possibilities. Parallels are drawn between sound physical restraint procedures and the temporal phases upon which the holding therapies are based. Numerous references. (Author abstract modified)