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Stories from Residential Treatment: New Pathways to Family Support

by Francine H. Rosenberg, Christopher Bellonci, Matthew Cooney, and Jennifer Bray

Who could disagree with the phrase, “Children should live in homes, not institutions”? For most children, most of the time, the evidence supports this truth. For a very small percentage of children with severe disabilities related to mental illness or trauma, however, periods of out-of-home care may play an important role in stabilization, treatment, and permanency.

In the past two decades we have seen a nationwide trend toward deinstitutionalization. This has happened across domains: Adult psychiatric hospitals have closed, schools have worked to include all students with disabilities in mainstream classrooms, and child welfare systems and community mental health systems have moved toward community- and family-based wrap-around services.

We believe, in general, this is a positive trend. Children with disabilities must remain part of their communities and maintain positive and permanent connections with kin whenever possible.

Proponents of community-based services often take their argument too far, stating that all out-of-home care represents system failure and that residential treatment is inherently not community based or family friendly. Some of these advocates argue that residential placements absorb a disproportionate amount of the systems’ resources with

few outcomes to justify the expense. They argue that at worst, residential centers retraumatize children and pull them away from families and communities.

Although we agree there is a great need for better research and outcome measurement, we challenge the prevailing notion that residential treatment represents system failure and that all children should be served in homes or families 100% of the time. A residential setting can be a rare, unique place where children and families can start to piece their lives back together; and residential treatment has an important place as part of a mature continuum of care.

This belief comes from our reading and academic study, as well as from our practice knowledge working with the residential treatment programs at the Walker School. Walker is a nonprofit agency outside Boston that provides a range of treatment and education services to troubled children and youth on two campuses and in a variety of community settings. Our residential programs serve approximately 50 children, ages 3–13, who present high-risk behaviors, major mental illnesses or neurodevelopmental disabilities, and issues resulting from abuse, trauma, and placement failure.

At Walker, our definition of *residential* is not an institutional or one-size-

fits-all definition. Our definition of *residential* means a family-friendly, developmentally enriched, homelike environment with the capacity to manage children with high-risk behaviors while using a multidisciplinary team to assess, stabilize, and teach. Our definition of *residential* means children can step up and down within our continuum of services, and we work creatively with families and funding sources to develop plans for permanency and movement toward less restrictive placement options. In fact, we believe properly defined and executed residential treatment is a critical part of a healthy continuum of care.

What does “properly defined and executed” mean? At Walker, it means a

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EMILY SHENK
EDITOR

CHRISTINE JAMES-BROWN
PRESIDENT/CEO

STEVEN S. BOEHM
ASSISTANT PUBLICATIONS DIRECTOR



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CHILD WELFARE LEAGUE OF AMERICA
HEADQUARTERS
2345 CRYSTAL DRIVE, SUITE 250
ARLINGTON, VIRGINIA 22202
703/412-2400
FAX 703/412-2401
WWW.CWLA.ORG

myriad of other options has developed from a foundation of residential treatment. Using a residential base, our agency provides short-term respite services, home-based services, school consultation and support, a hospital diversion program, and a day treatment program. Philosophically, our program is based in finding strengths and teaching skills; it is family-centered, trauma-informed, and rooted in a cycle of multidisciplinary assessment, treatment, and evaluation of outcomes.

Several circumstances exist under which one would choose a residential treatment option. We will demonstrate with some case examples.

Tom

Tom is a severely mentally ill child. He has loving parents, but when he is at home, his behavior unravels. He becomes aggressive, disorganized, and psychotic. His younger sister has developed PTSD symptoms from experiencing Tom's rages. His parents are unable to sleep.

When Tom was placed at Walker, his parents and sister experienced some relief, and Tom began to thrive. With the structure of a 24/7 milieu, Tom is more able to manage his behavior. He attends school, where he has learned to read despite many experts doubting that he ever could; plays on the basketball team; participates in the chess club; and goes on regular community outings. Tom goes home every weekend, and his family visits him frequently. They can visit the residence whenever they want and speak to him on the phone regularly.

Dalia

Dalia is a developmentally disabled youngster who experienced severe neglect and trauma in her early years. After being removed from the custody of her biological mother, she bounced through several foster homes, but none could contain her violent, self-abusive behaviors. She would run out of the house in the middle of the night and bang her head on concrete until giving herself a concussion.

Even when she was placed in the home of the regional foster parent of the year, her behaviors did not stabilize. This foster parent wanted to adopt Dalia but knew that she could not care for her full time.

After two years at Walker, Dalia is still difficult to manage; however, her

restraints have reduced, she has gained many academic and social skills, and most significantly, she has been adopted by her foster mother who is committed to her forever, even if Dalia may need periods of out-of-home care.

These two examples demonstrate our belief that for some families, in order to maintain a permanent connection, parents and children may not be able to live together full time and may require ongoing and intensive supports, including periods of time in out-of-home care.

Some children and families may need a briefer period in residential placement followed by a range of creative supports not typically found in the community. At Walker we developed these supports, enabling the following children to return home and avoid extended stays in residence or a cycle of repeated hospitalizations and expulsions. The system of care must have step-up and step-down options at all levels of intervention so rigid boundaries between home-based and out-of-home services do not interfere with continuity of care.

Sean

Sean's mother, Abby, wanted him to live at home. After several months in residential treatment, his most severe aggression had been reduced, and his mother and her helping team had a much better understanding of his underlying learning disabilities and mental health issues and how to address them.

Both Sean and Abby had been traumatized by the severe violence that had resulted from Sean's behavior before placement. Sean was using his newfound words to express he was afraid of almost everything—being alone in his house, walking around the block, encountering dogs in the neighborhood, or going to the grocery store.

Abby realized that when Sean was at home she didn't set the firm limits he needed for fear of violent aggression. Abby and Sean needed a gradual return home and a change in patterns of behavior.

Walker's Family and Community Integration Service team began to work with them in the home by coaching Abby on setting appropriate limits, desensitizing Sean to being out in his neighborhood, and teaching him skills for walking around the block and going to the store. Sean gradually increased his time at home, eventually becoming a

student at Walker’s day school and spending one night per week in a “respite” bed at Walker. When Sean’s grandfather died and the resulting stress caused some behavioral regression, Abby was able to access Walker’s emergency respite for a few days, avoiding a violent incident or hospitalization.

Maria

Maria was placed in residential care after being removed from her mother’s custody and sexually molesting several younger children in her foster home.

Maria’s aunt, who was quite committed to her, visited her regularly and engaged in family therapy but was afraid to take Maria into her home. She feared Maria wouldn’t receive enough supports and that if Maria hurt a child in the community, her own competence would be in question.

After a period of treatment, Walker staff worked with the state agency to create a safety net for Maria’s aunt. Maria could come to Walker for respite every weekend, minimizing her unstructured time in the community. She could attend Walker’s therapeutic summer program and have priority status on the hospital diversion unit if her behavior deteriorated to the point of needing an inpatient stay. With these supports in place, Maria was able to live with her aunt and attend public school.

Some children’s high-risk behaviors challenge the community in a variety of ways. Often, the behaviors are so concerning that true assessment never takes place. Managing the behaviors through medication, hospitalization, and restrictive placement becomes the only goal. Efforts at diagnosis, education, or family reunification are delayed or ignored until the behavior is “stable.”

In our experience, residential placements may be uniquely well suited to manage high risk while obtaining multidisciplinary assessment and working toward permanency. The case of Tyrone is an excellent example of a residential placement that didn’t work, followed by one that did. The case of Shalekwa is one in which clinical risk was compounded by significant medical issues.

Tyrone

Tyrone was born to a drug-addicted mother. He was exposed to serious domestic violence and experienced abuse, neglect, and multiple foster care placement failures. At age 8, he was

hospitalized, and within a month was placed on six different medications, which did little to eliminate his severe aggressive outbursts.

Tyrone was then placed in residential care. He continued to be very aggressive, was restrained frequently, and did poorly in school. For 18 months he made little progress. His medications were never reassessed, no one questioned whether there was a missing diagnostic component, and little effort was made to engage his biological mother.

When Tyrone came to Walker, the multidisciplinary team carefully reviewed his history and found he had been diagnosed with a nonverbal learning disorder.

Residential placements may be uniquely well suited to manage high risk while obtaining multidisciplinary assessment and working toward permanency.

The team hypothesized that the combination of his learning disability and his past trauma led him to assume the worst of people’s intentions. He had learned to attack before being attacked. The team developed a new treatment plan based on this formulation. The plan involved much praise and positive reassurance. His restraints began to decrease. The team then decided to taper Tyrone off his medications and to more actively try to reengage his mother. A year later, Tyrone is taking only one medication, has not been restrained in months, is making academic progress, and is preparing to be reunified with his mother.

Shalekwa

Shalekwa was placed at Walker at age 9. She had been removed from her mother’s care and determined to be too severely disturbed to be placed in a foster home. At times, she looked psychotic and had severe and violent tantrums and restraints.

Her brother died of a heart condition while Shalekwa was at Walker; a few months later, Shalekwa was diag-

nosed with the same condition, and we were told she would die without a heart transplant. To meet the criteria for a transplant, however, the state agency needed to assure the hospital Shalekwa had a place to live that could meet her medical and psychiatric needs.

The state agency was unable to find a foster home able to manage this much risk. After serious consideration, Walker agreed to do so, with the promise of additional supports from the state agency, and in partnership with Casey Family Services.

As of this writing, Shalekwa is six months post-transplant. She is doing extremely well medically. Psychiatrically, she has had her ups and downs, with some very frightening moments, as restraining a child who recently has undergone cardiac surgery can be difficult. Her biological mother has reengaged, and we are working on concurrent planning with a foster parent.

In all of these examples, the residential program is part of the community continuum of care and intensively involved with families. The expertise developed in a residential treatment environment can be brought into community settings to impact a variety of children, both in order to prevent the need for more restrictive care and to enable children to return to the community more quickly and successfully. This is evidenced in our family-based work as well as in our successful collaborations with local public schools.

Residential treatment is like a powerful medicine. Careful thinking must go into the decision of when such powerful medicine is warranted, in what dose (the length of stay), and for what expected benefits. Consideration of less invasive interventions must be discussed, and the relative benefit of the intervention (medicine, residential treatment) must be weighed against its potential risks—for the individual child, the family, and the community.

The authors work at the Walker School in Needham, Massachusetts. Francine H. Rosenberg MEd is Managing Director, Christopher Bellonci MD is Medical Director and Senior Clinical Consultant, Matthew Cooney LCSW is Director of Residential Services, and Jennifer Bray is Program Director.

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

by David Allen, Sarah Hawkins, and Viv Cooper

The behavioral challenges (such as physical aggression, self-injury, and environmental destructiveness) displayed by children with intellectual and developmental disabilities pose potential risk of physical harm either to children themselves or to their caregivers. Over the last decade, there has been a considerable growth in interest in training caregivers in strategies that enable them to safely manage episodes of challenging behaviors when they occur.

In the United Kingdom, this interest has been driven by legislative requirements to provide safe working environments, by concerns about the ethics and legality of some previously available training in this area, and by developments in the field of Positive Behavioral Support that have recognized the need to provide caregivers with proactive strategies for behavior change and reactive strategies to manage out-of-control behaviors.

The bulk of attention in this field has focused on training paid caregivers to manage such behaviors; this has included training for teachers (James, 2001). In contrast, very little has been written about the need to provide similar initiatives for parents and family members. As challenging behaviors typically develop initially within family contexts, failing to equip parents with appropriate skills may increase the risk of injuries to both child and parent, particularly if the latter has to improvise reactive management procedures.

Evidence suggests that restraint use is a fairly frequent component in interventions for children and adolescents with intellectual disability and challenging behavior. Emerson (2002) reports three separate studies that found 12%–67% of children with these needs had been subject to restraint. Adams and Allen (2001) found physical intervention by parents was the most usual response to aggressive behavior in 56% of children referred to a specialist community behavioral intervention team. In most cases, parents improvised the forms of restraint used. This study was limited however, by the fact that participants were staff members reporting on strategies used by parents, rather than parents themselves.

Although some literature exists on training staff in physical interventions (Allen, 2001), we found only two anecdotal accounts of parent training in the literature. Green and Wray (1999) described providing training in breakway techniques (procedures designed to enable caregivers to escape from grabs, pinches, bites, etc.) to the family of an 11-year-old boy with Prader-Willi syndrome. The authors suggested training contributed to the child being maintained at home, avoiding a residential placement, and improved caregiver confidence regarding the management of risk behaviors.

Shinnick and McDonnell (2003) reported on training a mother and a neighbor to manage the behavior of a 34-year-old lady with intellectual dis-

ability and challenging behavior. The training included instruction in deescalation skills and breakaway procedures. Anecdotal accounts of effective recall of procedures at an eight-month follow-up reported improvements in caregiver confidence and user behavior.

As you can see, 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:

- What is the general experience of parents who manage risk behaviors?
- To what extent do they use physical interventions as a management strategy?
- To what extent have parents been trained in these interventions?
- What barriers exist to them accessing training?

The Study

A 20-item questionnaire was devised specifically for the study, a copy of which, together with a letter explaining the purpose of the study and a prepaid reply envelope addressed to the research team, were placed in sealed envelopes. The final sample consisted of 72 parent members of the Challenging Behaviour Foundation (CBF), a national U.K. charitable organization whose mission is to disseminate information about the understanding and management of

challenging behavior to parents and caregivers.

Findings

Respondents. The average age of the respondents was 43.8 years (range 27–62); 92% were female. The average age of the child with intellectual disabilities and challenging behavior was 13 years (range 4–38). Most children (76%) were living in the family home; of the others, 10% were in 52-week residential schools, 6% were in residential schools during the week, 6% were in residential care, and 2% were in foster care.

Experience of challenging behavior. Most children (75%) in the sample presented aggressive behaviors that were rated as moderately serious or severe; the corresponding figures for self-injury were 37.5% and 67% for destructiveness toward the environment. Also, 39% presented with additional forms of challenging behavior. Increasing severity of aggression was positively correlated with increasing severity of self-injury and destructiveness; likewise, increasing severity of destructiveness was also positively correlated with increasing severity of self-injury.

Although the impact of aggression

was relatively minor for most groups, serious or major injuries usually resulted from aggression for family members in 23.7% of cases, for the child themselves in 11.1% of cases, and for significant others in 15.3% of cases. Self-injury resulted in minor injuries to the child in 50% of cases, more serious injury in 6.9% and major injury in 4.2%.

When asked to describe the most difficult behavioral incident they had ever had to manage, most respondents reported situations that resulted in a degree of injury to themselves or other family members. Although some cases resulted in relatively minor injury, other respondents described incidents of physical aggression that had resulted in cuts, sprains, broken bones, loss of consciousness, and hospital treatment:

“I was attacked by my son—punched, kicked, hair pulled—then, in the same incident, pushed against a wall. Whilst I lost consciousness and was on the ground, I was repeatedly kicked.”

“I was dragged around the floor by my hair, contact with thrown objects and prolonged and deep bit-

ing causing bleeding, bruising, infection, severe swelling, and cuts needing hospital treatment.”

“Without warning, he lunged at me and bit me on the hand/arm because I held it out to protect myself. He also bit the back of my leg. I then needed hospital treatment and skin grafts.”

Accounts of injuries to children themselves included both physical aggression and self-injury:

“My son smashed a window whilst head-banging it. A large shard of glass penetrated his shoulder and neck. He required hospital treatment (15 stitches).”

“In anger, he crushed an ornament in his hand. This wasn’t deliberate. He was frightened and wouldn’t allow his hand to be examined or dressed.”

Reports of others who had been injured during challenging behavior included teachers, other children, health professionals, and pets.

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In addition to the physical consequences of a child's behavior, respondents also recounted poignant stories about the emotional effects of coping with behavioral challenges. Some emotional responses were reported as immediate effects of challenging behavior:

"It's the most distressing thing possible to watch your child self-harming. As a mother, it kills you."

"I was bruised all over, but the emotional pain was far more to cope with."

Other emotional responses were reported as long-term effects of dealing with challenging behavior "as a way of life for all family members":

"As a family, my daughter has created massive strain and pressure over the years."

"I am so stressed. I am just living without a life."

"Things got so bad that I had to have my daughter removed by the police (several times) to stop her harming me. This has changed my life as from then on, I couldn't believe she was capable of inflicting harm to such a degree, which has left me devastated."

Use of Physical Interventions

Most respondents (87.5%) reported using physical interventions; 20.8% used them frequently. Personal restraint—one person being held by others—was much more common than mechanical restraint, such as the use of ties or harnesses (85.9% vs. 26%).

Increasing frequency of physical intervention was positively correlated with increasing severity of injury arising from aggression for the child, but not for the family or significant others. It was also positively correlated with increasing severity of other challenging behaviors and negatively correlated with parent age.

Respondents used a range of strategies—which varied according to level of restrictiveness—to deal with their chil-

dren's challenging behaviors. As an initial and least restrictive response, many respondents described attempting to defuse the situation by talking to the child or distracting her in some way:

"I try to explain that the behavior is inappropriate and try to calm her."

Physical removal often was detailed as a means of confining the behavioral incident to a safer area. With small children, this removal tended to involve lifting or carrying the child:

"We had to carry him home screaming—two people, one at either end—like a log."

In other instances, respondents reported removing the child by walking with him, usually with the assistance of another person:

"We tried to walk him, standing either side holding his hands (one each), to a quiet area."

Some respondents described restrictive physical intervention, via both personal and mechanical restraint. Personal

restraint took a variety of forms, including one person holding the child's hand:

"I took hold of his hand firmly so he could not break free";

one person holding the child around the body from behind, in a seated or standing position:

"He sat between my knees and I held him round the chest and held onto his arms"

"I managed to put my arms around her upper body and held her really tight until she calmed down (about 15 minutes)";

two or more people holding the child in some way:

"He became so aggressive, it took 3–4 adults to hold him down."

Adverse outcomes as consequences of the personal restraint for those carrying it out included injury and emotional and physical exhaustion. Reports frequently indicated factors that prevented the possibility of personal restraint use.

DISCUSSION POINTS

- The data showed most parents in the sample had been exposed to physical aggression and destructive, self-injurious behavior from their children. Physical aggression usually resulted in serious injuries to caregivers in almost one-quarter of the sample, and self-injury was serious or major in 11%.
- The severity of the behavioral incidents parents faced was clear from the study results. Not surprisingly, a number of parents indicated that repeated exposure to such behaviors was a significant stressor.
- Most parents had used physical interventions, with over one-fifth employing them on a frequent basis. A variety of restraints, both personal and mechanical, were employed. We found few correlates of physical intervention, although older parents were less likely to use restraint.
- Despite the high proportion of parents using physical intervention, only one-quarter of the sample had received any training in these procedures. As a result, many of the interventions were designed by the parents themselves.
- Although most of those who had received training viewed it positively, some limitations were also reported. Those who had not cited a number of impediments to their doing so.
- It is very clear from the present study that, regardless of whether or not caregivers are actually trained in physical interventions, they are going to use them out of necessity.
- Failing to train natural caregivers is hard to justify on ethical grounds, and will be hard to defend on legal grounds should serious injury or fatality arise from a failure to provide a potentially effective intervention.
- Reactive training should only take place within the context of an overall Positive Behavioral Support Intervention.

The most common of these barriers was the size and strength of the child, which appeared to be exacerbated by parents attempting to deal with situations on their own:

“He was too strong for me to hold.”

“She is tall and I couldn’t regain control on my own.”

Accounts of mechanical restraint included:

“We tied her shoelaces together to prevent her from kicking out.”

“If really necessary, he has to be put in his pushchair and restrained in it with the reigns on.”

“We did not know what to do so we tried wrapping him in a duvet to protect us and him.”

Training in Physical Interventions

Despite high rates of restraint, only 25.4% of respondents had actually received training in how to restrain safely. Any training that had been provided had been made available through National Health Service providers in 28.6% of cases, education in 21.4%, and social services in 7.1%.

Arrangements for training often appeared ad hoc. Sometimes, for example, parents had received training as part of their jobs and were then applying the training at home. Ninety-three percent of those who had received training rated it useful or very useful.

Although a relatively small percentage of respondents had received formal physical intervention training, the comments of those who were using their own techniques made clear that this did not reflect the perceived need for training among this group. A few people said they felt confident continuing without training, but the rest outlined three main reasons for needing to be trained in physical interventions.

First was a desire to get techniques right to avoid injury to themselves and their children and to avoid accusations of mistreatment from others:

“I am desperate for training since I heard a child in America died as a result of parents using incorrect techniques when restraining their child.”

“We feel absolutely desperate. In public we’re afraid of being reported for not handling him properly.”

The second reason was a recognition that, although many respondents felt confident using physical interventions with their children when they were small, difficulties would ensue as their children grew up:

“Training is becoming more of an issue now that he is getting older, bigger, and stronger.”

A substantial proportion of respondents said they had either not been aware of physical intervention training, or it had never been offered to them, but many had actively pursued training to no avail.

Third, a number of respondents whose children were in residential schools/care felt they could no longer have their children home for visits as a result of not being trained:

“Physical intervention is far from desirable but, without training, home visits by our son may be curtailed.”

In addition to training in physical intervention techniques, a few respondents identified a need for broader behavioral information to prevent the likelihood of challenging behavior occurring in the first place:

“Training is needed, but also knowledge and information that is relevant to back training up. It is no use simply providing restraint training if a parent has no idea

how to possibly work on behaviors and try to improve things.”

Although the vast majority of respondents who had been trained rated their training positively, the qualitative data highlighted a number of perceived limitations of the training: the training was too basic, only a couple of techniques were taught, the training was too short, training consisted of a one-off session with no refresher session, there was no advice on how to prevent behavior from escalating, the techniques taught were difficult to apply in the home setting, techniques taught required two people when often only one was present, and techniques taught could not be used in the community.

“The training received was only one two-hour session. It seemed to focus on removing the child from the situation, which may have been helpful in school, but at home there is nowhere to remove them to.”

“It should have been more ongoing as he is not little anymore...so techniques have to change.”

“The course was too basic and didn’t solve our problems or restore our confidence.”

A substantial proportion of respondents said they had either not been aware of physical intervention training, or it had never been offered to them, but many had actively pursued training to no avail. Respondents identified a number of barriers to obtaining training: a lack of resources in the geographical area, not meeting the criteria for referral, not knowing where to access training, inability to afford training costs, a lack of support from local agencies, and organizational concerns about parental accountability. Frustration at the general lack of acknowledgement of a need for parents to be trained was evident:

“It has always amazed me that care staff are trained in many aspects of disability, but parents/caregivers are left to deal with it on their own.”

“It seems to be assumed that, as parents, we don’t have the same restrictions as professionals (for example, if we want to ‘sit’ on him, we can), whereas a professional requires something more ‘acceptable’ (and probably more effective).”

Those parents who had actually received training as parents (for example, not via their jobs) tended to recount a far from easy process to obtaining it:

“It took over three years of searching! The majority of agencies stated that they could only help with children of adolescent age and above. I had to reach my breaking point (a stay in a psychiatric unit) before receiving any advice and very limited training (one session).”

Conclusions

The main findings of the study are highlighted in the text box on page 6. Most parents in the sample had been exposed to physical aggression and destructive, self-injurious behavior from their children. Most parents had used physical interventions: More than one-fifth had employed them frequently, and in a variety of forms of both personal and mechanical restraint. We found few correlates of physical intervention, although older parents were less likely to use restraint.

Despite the high proportion of parents using physical intervention, only a quarter of the sample had received any training in these procedures. As a result, many of the interventions were designed by the parents themselves. Seventeen percent of respondents reported physical interventions known to be associated with high risk of injury or fatality.

It is important to emphasise that, in the absence of both training and appropriate professional supports, no blame can be attached to parents for either the use of these dangerous procedures or some of the questionable containment strategies reported.

It goes without saying that any training in physical intervention should only take place within the context of a clear positive behavioral support approach. Fortunately, there are clear,

positive examples of how parent training in these wider support strategies can be effectively provided (Bambara et al., 2004), take account of caregivers’ existing strengths and needs, and be successfully accommodated into families’ existing daily routines (Albin et al., 1996).

It is clear, however, that access to professional help within the present sample was comparatively and unacceptably low. One could logically conclude that better and more effective therapeutic support to families would reduce the use of reactive strategies. In this selected sample, though, where the children’s behaviors were often very severe, it is doubtful whether their use could be completely eliminated.

This being the case, the reasons parents in the United Kingdom seem unable to access reactive training need further consideration. The principle reason is probably that the legislative drivers that are at the forefront of improving training for staff clearly are not in place for natural caregivers. Although this is a critical variable, a number of other factors also appear to militate against parent training being delivered.

In addition to the anxieties regarding vicarious liability discussed earlier, concerns exist about perceived conflicts with child legislation, such as whether teaching parents physical interventions may lead to an increase in abusive practice, whether training can be effectively controlled or monitored in family homes, and whether caregivers have the physical competencies to be able to properly implement taught strategies.

The issue of why physical intervention training causes so much concern over liability is of interest, particularly when one considers that National Health Service provider trusts, for example, may train caregivers to conduct other intrusive and risky procedures (for example, administering complex and risky medications) that do not appear to provoke the same level of concern or result in the same impasse.

The present study makes very clear that, regardless of whether caregivers are actually trained in physical interventions, they are going to use them out of necessity. The general health risks arising from inappropriate physical inter-

ventions have already been alluded to, but it also seems possible the risk of abuse may increase, rather than diminish, if parents do not receive training.

Although issues of monitoring and quality control may be higher in family settings, these worries apply to staffed situations also. Trainers in physical intervention are familiar with concerns that technical fidelity may decrease rapidly after training, and that staff records of physical intervention may be unreliable. Agencies therefore must be concerned about the consequences of acts of omission, not just of acts of commission.

Although the evidence for the effectiveness of physical intervention training is somewhat equivocal (Allen, 2001), the significant financial investment this training attracts both in the United Kingdom and the United States presumably means agencies feel it to be of some value. If this is the case, then failing to train natural caregivers is hard to justify on ethical grounds and will be hard to defend on legal grounds should serious injury or fatality arise from a failure to provide a potentially effective intervention. Several practical suggestions have been made regarding how parent training could be provided in a manner that protects all parties (Green & Wray, 1999; Shinnick & McDonnell, 2003).

The present study is limited by its restricted sample. As is typically the case with postal surveys, the response rate was only around 30%. Furthermore, as the sample was self-selecting, we can make no claims that it was at all representative of the total population of natural caregivers supporting family members with intellectual and developmental disabilities and challenging behaviors. If anything, the sample was likely to be highly skewed in that parent members of this organization were perhaps more likely to be supporting individuals with more severe challenges.

Future research needs to address these limitations by including a much broader sample of children and parents. This will enable the true rate of physical intervention within family contexts to be established. Future studies should also examine the relative frequency of

restraint use among different family members (i.e., parents and siblings); this is important, as mothers were the primary respondents in the present study.

Finally, more evidence of the effectiveness of parent training in physical interventions needs to be collected to match the equivalent, developing literature regarding the effectiveness of training for paid caregivers.

David Allen and Sarah Hawkins are clinical psychologists with the National Health Service in South Wales, UK. Viv Cooper is the founder of the Challenging Behaviour Foundation, Rochester, England.

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Q: *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: Seclusion has been determined to be much safer than physical restraint in preventing deaths. Numerous deaths can be attributed to the use of physical restraint. States and provider agencies that have decided to discontinue the use of seclusion should reevaluate their decision.

by Kim J. Masters

For at least 300 years, seclusion and restraint have been the most restrictive interventions in preventing and managing aggressive behavior. Residential treatment facilities have favored restraint, particularly for children, whereas psychiatric hospitals have not had a clear preference for either. Attempts to ban seclusion, however, have resulted in an increase in the use of restraint (Swett, Michaels, & Cole, 1989).

Differences between residential facility and psychiatric hospital practice are sometimes baffling. For example, the use of prone restraint is a favored intervention taught by a widely used aggression management training program for residential treatment facilities (TCI 1980, 1999). Oddly enough, this organization is located in New York, a state that bans the use of prone restraint in psychiatric hospitals (New York State Office of Mental Health, 1997).

The governing cultures of residential treatment appear to have been influenced by therapeutic philosophies emerging from *The Other 23 Hours* (Treischman, Whittaker, & Brendtro, 1969), which sees physical restraint as a corrective emotional experience and seclusion as abandonment. This approach is supported in some states that prohibit the use of seclusion in these facilities, because of the risk for posttraumatic stress disorder (PTSD) associated with prolonged isolation and neglect, and the possibility that a room may become a firetrap.

A rekindling of the seclusion vs. restraint debate occurred when it was discovered that both children and adolescents have died during restraints. Fatalities occurred with prone restraint, the basket hold, and supine restraint. During a restraint, staff may unintentionally compress patients' airways, restrict circula-

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COUNTERPOINT: When a child or youth is placed in seclusion, the staff must generally escort or transport the child to the seclusion room. So even when the decision is to simply seclude, the child often experiences both a physical intervention and seclusion. In addition, physical interventions such as escort and transport have a much higher rate of injuries to both children and staff than do physical restraints.

by Linda M. Finke

In ancient Greece, those who behaved in an inappropriate manner were exiled from society. This form of sanction was viewed as such a horrible punishment that Socrates chose to drink poison rather than suffer such banishment, a form of isolation or seclusion.

The same conclusion can be drawn from the use of solitary confinement in the penal system. Throughout history, the worst punishment deemed possible in prisons is seclusion or solitary confinement. In psychiatric care, patients who behave inappropriately are placed in seclusion. Perhaps the only difference is that in psychiatric care we call seclusion "therapeutic."

The use of seclusion remains common practice in psychiatric care (Lendemeijer & Shortridge-Baggett, 1997). The purpose of this article is not to repeat the numerous reviews of the literature (Brown & Tooke, 1992; Fisher, 1994; Lendemeijer & Shortridge-Baggett, 1997; Sailas & Fenton, 2000) but to present the case that the use of seclusion in the psychiatric care of children is not an evidence-based practice. This article further documents that research has found seclusion to be harmful to patients and not related to positive patient outcomes.

Discussions of restraints and seclusion frequently pair the two interventions as though they are closely linked. Moreover, the literature often speaks of both as if they are the same intervention. The use of restraints in psychiatric settings has received wide discussion, and there has been some reluctant change in practice. The use of seclusion as an intervention has received less attention but requires the same scrutiny. This is especially true when seclusion is implemented with children, a particularly vulnerable population.

see COUNTERPOINT, page 12

tion, decrease oxygenation, and promote the development of fatal arrhythmias (see “Restraint Asphyxia: Silent Killer,” *Residential Group Care Quarterly*, Summer 2001).

Medications that may also contribute to the development of these fatal arrhythmias include those with anticholinergic side effects, such as tricyclic antidepressants; possibly alpha adrenergic agents like clonidine, which may affect blood pressure and pulse; thioridazine [mellaril] and other drugs that may prolong qt/qtc intervals (the length of time for the depolarization and repolarization of the ventricles of the heart); and stimulants that may increase heart rate.

What can be said of the medical dangers of seclusion? Screaming, yelling, and pacing all promote compensatory cardiovascular mechanisms, including increased breathing in response to the need for more oxygen. This, in turn, decreases the risk for arrhythmias.

Restraint, on the other hand, inhibits these compensatory responses, because it decreases the child’s mobility while at the same time increasing heart rate and hampering blood flow, often without permitting a child to breathe adequately to meet increased oxygen needs. This would explain a common occurrence—children who are restrained demanding, “Let me go, I can’t breathe!”

What exactly causes death from seclusion? The only case I am aware of resulted from a child being put in seclusion after a restraint. But there is always a risk of a medical crisis from medication reactions, or self-induced trauma if patients are not continuously observed during these times. Because children are sometimes put in seclusion on these occasions, it may be assumed incorrectly that seclusion is the culprit if a fatality occurs.

A risk of self-injury during seclusion exists, however, particularly in inadequately padded rooms. Similar risks exist for patient injury during the initiation and premature termination of restraint. The damage occasionally reported in severely psychotic adults—genital or eye mutilation—has not been reported in the child and adolescent literature I have reviewed.

There is a risk of injury during

transport of a patient to seclusion as well. But if children are taught the role of brief seclusion in regaining self-control, they may choose seclusion rather than restraint and go to the room willingly. As an added inducement, children may have the freedom of unlocked seclusion, if they can keep their anger within the confines of the room.

Generally, for patient safety, seclusion is clearly favored as a restrictive intervention over any type of restraint because of decreased physiologic stress on the child or adolescent and a far lower mortality associated with its use.

The stresses and risk for staff injury in carrying out a seclusion also should be less than those generated by a physical or mechanical restraint, because the procedure requires less time in direct contact with the patient.

What of the oft-cited psychological damage from seclusion? The literature about the development of PTSD from the seclusion room experience dates from Wadson and Carpenter’s (1976) report, which described patients isolated for prolonged periods—up to a day or more, akin to solitary confinement in a prison.

I am not aware of literature demonstrating PTSD from a 5- to 15- minute seclusion, the expected length when active prevention and management strategies for aggression control are practiced by children and taught by staff. In most cases, this time presents a benign opportunity for a child or adolescent to regain self-control.

Critics of the use of seclusion often place it in a 300-year-old procrustean bed, unchanged since its description by Phillipe Pinel in his work at the Bicetre Hospital in Paris in 1794. Today’s seclusion times should be brief, and the rooms well-ventilated, of adequate size, attractively colored, and well padded, with doors that unlock in case of fire. The rooms can have calming music and visual inputs as well. The role of seclusion should be to distract a person from his anger until he can calm himself. With audio and visual inputs, we may even be able to accelerate this process, resulting in 5- to 10-minute seclusions. When part of a comprehensive preventive aggression management program,

locked seclusion offers more opportunities for children and adolescents to regain self-control and avoid injury and death.

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Suggested Reading

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Kim J. Masters is the Medical Director at Focus by the Sea, St. Simons Island, Georgia.

Defining Terms

Seclusion. The definition of seclusion can vary but usually refers to some form of isolation. The isolation may occur in a locked, bare room, or it may take place within the confines of a patient's room. A secluded individual may be required to sit in a chair or serve a time-out (Miller, 1986).

Seclusion also involves some form of involuntary or voluntary confinement (Lendemeijer & Shortridge-Baggett, 1997). Most authors consider time-out rooms as seclusion (Landau & MacLeish, 1988). Landau and MacLeish also state that the legal definition of seclusion in most states equates with isolation. This paper uses a broad definition of isolation to include all forms of isolation, including being sent to one's room or time-out.

Evidence-based practice. According to Brown (1999), evidenced-based practice involves the critical review of research findings to evaluate their usefulness in patient care. Ingersoll (2000) further contends that evidenced-based nursing practice is theory-driven, research-informed decision making. It follows that the use of seclusion in psychiatric care would need to be theory-based and supported by research findings to be deemed evidence-based practice.

Seclusion and Research Findings

Numerous articles in the literature theorize and present philosophies about the need for seclusion with psychiatric patients. Most are not supported by research, however, and most of the research that does not exist on the use of seclusion has been chart reviews that record the demographics of patients or count the documented use of seclusion. Few studies incorporate a rigorous methodology able to support generalized conclusions, such as control groups or even measured patient outcomes.

Sailas and Fenton (2000) reviewed 2,155 citations from 1974 to 1999 and found not one controlled study of seclusion. The published research has no theoretical foundation either. No attempt has been made to connect theory with search methodology when studying seclusion.

Child-Related Research

To add to the concern about methodology, most of the research examining the use of seclusion in the psychiatric setting has been done with adult patients. Little research has examined the use of seclusion with children; therefore, clinicians are left in part to draw conclusions from studies of adult patients.

Miller (1986) is one of the few researchers who have examined the use of seclusion specifically with children. His definition of seclusion ranged from

Investigators found that children who were secluded in a child psychiatric inpatient unit in a general hospital were more likely to have histories of physical abuse, neurological impairment, lower verbal skills, and suicide attempts than those who were not secluded.

use of a locked isolation room, to sitting on a chair, to being sent to one's room. The 40 children in the study, ranging in age from 5 to 13, were asked to draw and comment about seclusion or time-out. The illustrations that portrayed people did not seem to convey the concept of children gaining self-control while in seclusion, but rather conveyed punishment, where the child was crying and pleading for help. The children's descriptions of seclusion also included feelings of fear and abandonment.

Millstein and Cotton (1990) also conducted a study specifically exploring the use of seclusion with 102 children. These investigators found that children who were secluded in a child psychiatric inpatient unit in a general hospital were more likely to have histories of physical abuse, neurological impairment, lower verbal skills, and suicide attempts than those who were not secluded. They found that seclusion was used more frequently on Mondays and Wednesdays,

when staff members were the busiest, and during the most stimulating and demanding times in the unit.

Millstein and Cotton further found the use of seclusion did not differentiate among the children in their ability to cope with the environment using the Adaptive Behavior Index. They also found an increase in time a child spent in seclusion with each occurrence, rather than the decrease in time one might expect if children were learning new behaviors from the experience.

Irwin (1987) approached seclusion with a different strategy by exploring the effect of avoiding the use of seclusion on a child psychiatric unit with 21 patients in Providence, Rhode Island. Interventions such as negotiation, avoidance of power struggles, deescalation, relaxation techniques, and the teaching of positive coping strategies replaced seclusion. Conducted over eight months, the study concluded that a safe, therapeutic milieu could be organized to care for children without the use of seclusion.

Tsemberis and Sullivan (1988) studied the introduction of a seclusion room to reduce the use of a straitjacket on a children's unit in a large municipal hospital. They found the use of seclusion did not decrease the use of restraints, and isolating children from staff and peers had a negative psychological effect on children.

Adult-Related Research

Mattson and Sacks (1978) studied the use of seclusion in a private psychiatric hospital and found that staff tended to view seclusion as a strategy to control the therapeutic milieu rather than an intensive care environment in which patients should be carefully monitored.

Schwab and Lahmeyer (1979) conducted a six-month study of a busy inpatient psychiatric unit in Chicago with 300 patients ages 13–78. Thirty-six percent of the patients were placed in seclusion during their hospitalization. The reasons staff offered for using seclusion were “dissimulation, agitation, and poor impulse control,” but investigators found seclusion was used most often at night (10:00 P.M. to 2:00

A.M.), when the unit census was high and staffing was low. Patients who were placed in seclusion were younger, hospitalized longer, more manic, and on more medications.

In a study of adult patients in a large, community mental health center, Convertino, Pinto, and Fiester (1980) also found a relationship between the use of seclusion and staffing patterns. They called for national standards concerning the use of seclusion to ensure the intervention was safe and humane. Phillips and Nasr (1983) drew similar conclusions from their study of an inpatient state psychiatric hospital.

Soloff and Turner (1981) studied patterns of seclusion and found no relationship between seclusion and the mental status and diagnosis of patients. Rather, seclusion was generally used to contain possible threats of assault on staff, and a strong cultural bias meant that seclusion was more often used with committed, chronically ill, and African American patients.

Brown and Tooke (1992) reached similar conclusions, finding the data available on the use of seclusion did not distinguish between its use as a treatment and its use as a tool of social control. Again, although staff said patients were placed in seclusion due to agitation and violence, the data pointed to staff and unit factors more than to patients' violent or agitated behavior.

The authors also brought attention to the fact that patients were often secluded on admission when there was no possibility of appropriate assessment and intervention beforehand. Based on their review, Brown and Tooke stated no systematic or controlled evaluations have been undertaken of the effectiveness of seclusion relative to other strategies in achieving its intended goals, whether to avert violence and prevent injury, maintain a therapeutic milieu, or benefit the secluded patient (p. 717).

Fisher (1994) reviewed the research literature that reinforced the previous findings. He concluded the use of seclusion, although widespread, was harmful to patients. He also said cultural biases, staff role perception, and administrator attitudes had a greater influence on the use of seclusion than did patient demo-

graphics or clinical factors.

LeGris, Walters, and Browne (1999) conducted a chart review of a patient sample of 85 adults in a Canadian inpatient psychiatric setting. They found no difference in mental status at discharge after the use of seclusion, but did find a 12-day increase in length of hospital stay. These researchers also found, as did previous researchers, that patients who were younger and on more medication tended to be secluded more. Patient gender, diagnosis, and number of previous admissions did not differ between the secluded group of patients and those not secluded.

Seclusion was generally used to contain possible threats of assault on staff, and a strong cultural bias meant that seclusion was more often used with committed, chronically ill, and African American patients.

The Patient's View of Seclusion

Studies that examined the patient view of being in seclusion consistently found seclusion is a very negative experience and is seen as punishment (Binder & McCoy, 1983; Brown & Tooke, 1992; Fisher, 1994; Heyman, 1987; LeGris et al., 1999; Martinez, Grimm, & Adamson, 1999; Meehan, Vermeer, & Windsor, 2000).

LeGris et al. found, as did previous researchers, that patients perceived seclusion to be very uncomfortable and nontherapeutic. The patients also felt that the negative experience produced negative behavior. Patients saw the use of seclusion as a reaction to poor staffing and the lack of a therapeutic milieu. One patient described her experience in seclusion as being led "naked and without armor" to seclusion to think about the "lie they have given me to live" (Fisher, p. 1585).

Martinez et al. (1999) conducted a study specifically examining seclusion

from the patient's perspective. The population included 15 children, 13 adolescents, and 41 adults in a Denver psychiatric setting. As in other studies, patients said they experienced vulnerability, neglect, and a sense of punishment while in seclusion.

Both patient groups—those secluded and those not secluded—expressed concern that seclusion was used too much. Patients who were secluded also stated that anger and agitation were a result of being placed in seclusion. Secluded patients expressed feelings of fear, rejection, boredom, and claustrophobia.

Mann, Wise, and Shay (1993) studied the views of 50 patients shortly after they were released from seclusion and found similar conclusions.

The literature reveals the use of seclusion on a child psychiatric unit is not evidenced-based practice.

Nursing Implications

Allen (2000) conducted a literature search of nurses' attitudes about the therapeutics of seclusion. He found nurses still have a positive view of seclusion despite the lack of supportive scientific evidence.

Practice must begin to match the evidence. The use of seclusion in psychiatric care must be replaced with researched interventions that have been found to be helpful in the progression of patients' mental health. Children are very vulnerable, and the continued use of techniques that are traumatic and harmful cannot be tolerated.

Future studies must explore therapeutic interventions using methodological rigor and theoretical foundations. We must look at the measured effects of interventions over time, especially when interventions are used with children. The psychological and biological outcomes are important to measure and monitor over time. Psychiatric nursing practice cannot be evidence based until research connects theory to findings.

Conclusion

The research on the use of seclusion with children or adults reveals the experience may actually cause additional trauma and harm. No research supports

a theoretical foundation for the use of seclusion with children. Evidence has been building for more than 30 years that seclusion does not add to therapeutic goals and is in fact a method to control the environment rather than a therapeutic intervention.

The literature contains no study that examines the physical effects of the use of seclusion. With the mounting evidence of the dangerous physical aspects of restraints, that the physical effects of seclusion have received no attention is a major oversight.

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Linda M. Finke is Director of Professional Development Services, Sigma Theta Tau International, Indianapolis, Indiana.

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