Restraint Use in Residential Programs: Why Are Best Practices Ignored?

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Several states and providers have embarked on initiatives to reduce using restraint and seclusion in residential programs. Restraint and seclusion are associated with harm to youth and staff, significant costs, reduced quality of care, and less engagement of youth and families. Successful reduction/prevention strategies have been identified, implemented, and reported. Both states and residential providers have implemented prevention approaches, made significant changes, reduced restraint/seclusion use, and offered their experience and positive outcomes.

Restraint and seclusion continue to be used on children, adolescents, and youth in residential settings at higher rates than on adults in care, often with deleterious effects (LeBel, 2009b; LeBel & Goldstein, 2005; Weiss, Altimari, Blint, & Megan, 1998). These practices are traumatizing and dangerous to both children and staff; costly to agencies in terms of program operations, staff morale, and client outcomes; and inconsistent with researched best practices (e.g., youth-guided and family-driven care; Burns, Goldman, Faw, & Burchard, 1999; Courtney, Terao, & Bost, 2004; LeBel & Goldstein, 2005).

The relationship between using restraint and well-publicized deaths of children in residential care are a particular concern (Kennedy & Mohr, 2001; LeBel, Stromberg, Duckworth, Kerzner, Goldstein, Weeks, Harper, LaFlair, & Sudders, 2004; Weiss et al., 1998). The literature has documented the physical and emotional risks that commonly result from these procedures (Johnson, 2007; Mohr & Anderson, 2001; Nunno, Day & Bullard, 2008; U.S. General Accounting Office, 1999). Moreover, using restraint and seclusion impacts others involved with the youth. One parent recounted, "Seeing my son restrained in front of me was the most traumatizing event of my life; my son was crying for me and I felt helpless. We went to that program for help and we were traumatized instead" (L. Lawrence, personal communication, June 13, 2009). Despite the evidence of serious harm resulting from restraint and seclusion (restraint/seclusion) procedures, these practices continue in many child residential programs as well as other child-serving settings such as juvenile justice centers, foster care homes, and schools (National Association of State Mental Health Program Directors [NASMHPD], 2009).

Using restraint and seclusion in many residential programs is particularly disturbing given the evidence-based best practices that have effectively reduced use in an increasing number of residential programs (NASMHPD, 2009). Several states have implemented statewide practices, policies, and legislation to support restraint and seclusion reduction efforts, and the Institute of Medicine (2005) has called on providers to use practices that are evidence-based and preventative in nature.

It is time to ensure that every child-serving residential program in the United States uses the available information and tools to prevent and significantly reduce using restraint and seclusion. This paper reviews some best practices associated with this effort that lead to positive outcomes for youth and their families. The literature indicates that when restraint and seclusion are significantly reduced, a number of other positive outcomes are realized including fewer youth and staff injuries, less staff turnover, higher staff satisfaction, shorter lengths of stay, sustained success in the community after discharge, and significant costs savings (LeBel, 2009a; LeBel & Goldstein, 2005).

Overview of the National Initiative

NASMHPD represents the public mental health system in each state/territory. As part of the *National Call to Action* initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2003), NASMHPD's Office of Technical Assistance reviewed the literature and consulted with national experts on restraint and seclusion reduction. The experts identified similar patterns of practice in programs that had successfully reduced these procedures and determined that most of the change-producing strategies were implemented at low or no cost. NASMHPD published the first training curriculum on *Six Core Strategies© to Reduce the Use of Seclusion and Restraint in Inpatient Facilities* in 2002. Since then, the Six Core Strategies© have been formally evaluated, and the evidence indicates they likely meet criteria for inclusion on SAMHSA's National Registry of Evidence-Based Programs and Practices.

The public health prevention model is the foundation for the Six Core Strategies©. It focuses on identifying risk factors for conflict and violence *before they occur,* along with early intervention strategies to immediately respond to conflict before it escalates, so using restraint and seclusion can be prevented (Huckshorn, 2006). Similar strategies have been developed and promoted by American Psychiatric Association, American Psychiatric Nurses Association, American Hospital Association, National Association of Psychiatric Health Systems (2003), and Child Welfare League of America ([CWLA] 2004).

Leadership Toward Organizational Change

Successful efforts to reduce using restraint and seclusion begin with strong leadership commitment, including the executive director and other administrative/clinical leaders. Leaders must take an active, consistent, visible role in implementing a comprehensive plan to prevent conflict and violence and ultimately reduce using restraint and seclusion. The plan should be developed in a continuous quality improvement framework that recognizes that culture change takes time, staff at all levels learn from each other, and mistakes will be made (Huckshorn, 2004). The plan must involve youth, family members, and advocates in all aspects of the project.

A key component of the leadership strategy is the elevation of oversight of every restraint/seclusion episode, including frequent communication and rounds by administrators to change staff's response to youth's distress (Hardenstine, 2001). Other components of the leadership strategy include developing clear mission and values statements that incorporate the commitment to restraint/seclusion prevention, identifying data-driven goals to reduce use, announcing a kick-off event, identifying restraint/seclusion reduction champions at all levels, and regularly celebrating successes.

Using Data to Inform Practice

Because national datasets on restraint/seclusion use in residential programs do not exist, agencies and programs must focus on their own practice and look to benchmark against themselves. Successful reduction initiatives use data in a nonpunitive manner to elevate the oversight of each event and to inform practice and policies (Hardenstine, 2001). This strategy uses data in a way that encourages leadership to identify staff and units that are reducing their use so effective prevention practices can be shared.

Minimally, restraint/seclusion data should be collected by unit, shift, day, and staff member involved. It is important to respond to repeated staff member involvement sensitively, recognize and

respond to staff training needs, and use only the data for disciplinary action when warranted. Data should be graphed and posted in visible areas of the program. One residential provider posts their data next to the time clock staff use to sign in, as well as in the staff restrooms, so their workforce will remain mindful of their restraint/seclusion use.

Workforce Development

Efforts to reduce restraint/seclusion are most successful when policies, procedures, and practices are based on prevention, trauma-informed care, family-driven and youth-guided care, and building resiliency. Agencies that purchase and use crisis intervention (restraint training) curriculums should request the vendor's data to ensure the efficacy of their technology and that reductions in use have resulted when that training has been implemented (NASMHPD, 2009).

Staff training should address the experiences of youth placed in restraint/seclusion, common myths, information on the impact of trauma, trauma-informed care, and crisis prevention strategies. Training should review the literature on violence attribution, and how power struggles and conflict can result from program rules and the staff's belief about their role as a "rule-enforcer" (NASMHPD, 2009). Leadership must provide guidance for staff to suspend institutional rules, when necessary, to avoid or resolve conflicts when addressing individual needs. Examples of possible rule suspension scenarios include attendance at activities, wake and sleep times, using points and level systems, and other practices that do not adequately take into account individual needs, trauma history, and emotional, behavioral, or cognitive challenges. Staff should be empowered to make decisions—in the moment—to avoid using restraint and seclusion.

Other important components of this strategy include writing explicit expectations to prevent conflict and restraint/seclusion use by new hires, through job descriptions, performance evaluations, strength-based supervision, and new staff orientation activities (NASMHPD, 2009).

Using Prevention Tools

Numerous clinical tools exist to prevent using restraint and seclusion. Assessment tools are important resources to understand each child's unique needs. Specifically, assessing for trauma, medical risk (e.g., obesity, cardiac anomalies, medication, past trauma histories), and risk for violence (e.g., previous restraint and seclusion history) are key. In addition, each child should have a crisis/safety plan, developed with the child and family, to help the youth learn how to recognize what triggers their distress, how they experience the upset, and what interventions help them calm down. Learning how to self-soothe is the essential outcome of these interventions.

Changing the physical environment to make it more attractive, normalized, and comfortable (i.e., comfort and sensory rooms) is another important prevention tool, as well as implementing a range of sensory modulation approaches and expanding meaningful, engaging activities. All of these elements should be integrated into program policies and each child's treatment plan (NASMHPD, 2009).

Full Inclusion of Consumers (Youth and Family Members) and Advocate Roles

Engaging youth and families in a treatment partnership begins with a frank discussion about the components of care and emergent practices of last resort, such as restraint, to ensure informed consent has been attained. Trust, treatment, and credibility can be compromised if restraint or other coercive measures are used without a thoughtful conversation about an organization's use of these practices and desire to prevent high risk events. Additionally, youth, family members, and external advocates should be welcomed, involved, and given meaningful roles throughout the organization (e.g., as trainers, on all committees/boards, as peer support), sending a strong message that family-driven and youth-guided care is a priority. Successful integration of youth and family members can be challenging and require refinement of organizational structures and practices (e.g., equal pay, defined training, and support; Solomon, 1998). Commitment to

implementing family-driven and youth-guided practices is essential for successfully engaging and partnering with youth and families; these practices correlate to long-term positive outcomes (Burns et al., 1999; Courtney et al., 2004).

Rigorous Analysis of Events

Debriefing restraint/seclusion events is essential to prevent recurrence and mitigate the adverse and potentially traumatizing effects for all directly or indirectly involved. Debriefing can be separated into two activities following an episode of restraint or seclusion. The first task is an immediate, postevent review to ensure the safety and well-being of all involved; interview those who were present and involved, and return the unit to the precrisis milieu. Using a debriefing tool with specific questions to guide this process is recommended.

The second debriefing activity is more formal and occurs later or the next day. It includes a treatment team, a representative from administration, and rigorous problem-solving methods to review and analyze the event. The purpose is to identify what can be changed to avoid a future event and to address potential trauma sequelae. The child's perspective is critical. Depending upon the age and the circumstance, this process may be conducted separately, with an advocate or favorite staff supporting the child. Information learned throughout the debriefing should be used to inform necessary changes to treatment plans and agency policies (NASMHPD, 2009).

Success Stories

Successful restraint/seclusion reduction efforts are taking place in residential programs across the country. Some initiatives resulted from the 2001 SAMHSA grant awarded to CWLA and the Federation of Families for Children's Mental Health. Grant participants included nine residential services serving youth with a range of challenges. Each program implemented a different training approach to reduce restraint/seclusion use (CWLA, 2004). Overall, the programs decreased restraint/seclusion incidents through a combination of

approaches, which are consistent with NASMHPD's Six Core Strategies©. The CWLA approach included, but was not limited to, (1) leadership commitment and raised standards; (2) enhanced workforce development through training; (3) use of prevention tools, verbal de-escalation skills, and crisis management techniques; and (4) greater youth/family involvement.

Years after the SAMHSA grant ended, some sites continue to focus on reduction. The Devereux Glenholme School in Connecticut eliminated their use of seclusion during the grant and reduced their use of restraint. Restraint is now a rare occurrence. Their grant coordinator stated,

> You don't give up on it. You keep working at it. We have researched and expanded on our activity program that youth can self-select. If youth are engaged in things that interest them—conflict and problems almost disappear. We also do not teach every staff member how to restrain. We are very careful about who uses it and when. (M. Guilfoile, personal communication, June 10, 2009)

Another CWLA grant site, the Methodist Home for Children and Youth in Georgia, has also maintained their reduction effort. This program implemented CALM (crisis, aggression, limitation, and management) training from Scotland. Now, "Restraint use is almost non-existent" (J. Myers, personal communication, June 12, 2009). Approximately two restraints occur in the program each month.

Other programs have pursued this work independently. For example, the Grafton School in Virginia created an agency-wide initiative to reduce using physical restraint with the youth and adults with autism, developmental disabilities, and psychiatric disorders served across their four campuses (Sanders, 2009). Grafton began their effort in 2004, when their executive director issued the following mandate: "Minimize restraint without compromising employee and client safety" (Sanders, 2009). The leadership made restraint reduction/elimination a key performance indicator and incorporated it into a company-wide incentive bonus program. Each campus created a program-specific action plan to reduce/eliminate restraint use and focused on several core strategies previously mentioned (Sanders,

2009). Since they began this work, Grafton reduced restraint use by 99% and staff injuries by 83% (Sanders, 2009). In addition, they realized significant operational and economic benefits including reducing the following: employee lost time and lost time expenses (97%), worker's compensation claims (50%), liability premiums (21%), and staff turnover (10%). Grafton also experienced increased staff satisfaction and was nationally recognized for their achievement (J. Gaynor, personal communication, March 13, 2009).

Other programs have successfully reduced restraint use by recognizing that trauma is a central problem for many youth in residential care and created trauma initiatives. The Andrus Children's Center in New York has implemented Sandra Bloom's Sanctuary Model and become a leader in trauma-informed care (Farragher & Yanosy, 2005). Over the past 10 years, Andrus has revised their workforce development approaches, increased supervision, studied and applied their data to treatment, and approached restraint/seclusion reduction as a quality improvement effort. One of their innovative changes included deciding when staff could participate in a restraint. After analyzing their data, leaders recognized that the least experienced staff were more often involved in restraints and more likely to get injured. The program decided that staff with less than three months experience could not participate in a hands-on procedure. This reduced restraint use and injuries to staff and youth. Since they began this process, Andrus decreased their restraint use by approximately 93% (seclusion is not used), reduced restraint duration by 83%, and decreased staff turnover by 50% (B. Farragher, personal communication, May 28, 2009).

Another residential provider, the Village Network in Ohio, began restraint reduction after leaders participated in NASMHPD's Six Core Strategies© training in 2004 (Paxton, 2009). They implemented the NASMHPD curriculum, pursued resources from the National Child Traumatic Stress Network and elsewhere, and emphasized trauma education for staff:

> I was intrigued by the idea of developing "violence-free coercion-free treatment." We had a lot of restraints and violence in our program. It was not a happy place—there were

> a lot of injuries. Restraint use didn't make sense, but trauma-informed care did. We had kids with trauma histories who had different diagnoses and medications—but they weren't getting better. We had to do things differently. (D. Paxton, personal communication, January 20, 2009)

Since the Village Network began their initiative, they reduced their restraint use by approximately 94% (Paxton, 2009). Positive outcomes included reductions in staff turnover, staff injuries, worker's compensation costs, and call-offs (employees calling out sick). In addition, the number of positive discharges increased—that is, youth who were successfully discharged without returning to care. The leadership recognizes it will take years to embed this into permanent practice and sees a fundamental challenge of "continually keeping your eye on the ball and not letting up" (D. Paxton, personal communication, January 20, 2009).

Other programs have also implemented NASMHPD's Six Core Strategies© and significantly reduced their restraint and seclusion use. The Immanuel Residential Treatment Center, a 20-bed facility operated by Alegent Health Systems in Nebraska, also focused on several of the Six Core Strategies© and trauma-informed care principles and launched their initiative in 2001. Alegent created effective alternatives for youths and reduced restraint use by 62%; 99% of the remaining restraints are under one minute in duration (Hill & Martin, 2009). A cornerstone of their work has been to empower youth and families, teach problem-solving skills, and implement soothing interventions, such as comfort rooms and spirituality classes (D. Heffernan, personal communication, June 28, 2009; Hill & Martin, 2009).

Some residential providers have spearheaded statewide initiatives. Coercion-Free Nebraska (2009) is a coalition of residential providers working on a common goal of reducing treatment violence and transforming residential care. This effort was organized and led by Denis McCarville, from Uta-Hallee/Cooper Village, who eliminated seclusion and reduced restraints by 92% since 2006, with the goal of eliminating these practices in his agency. Coercion-Free Nebraska has organized conferences, strategic planning sessions, shared data, and

established the common goals of rethinking, reforming, and respecting all involved with this transformation effort. They began their efforts after leaders from programs across the state attended a Six Core Strategies© training program.

Role for Oversight Agencies

Many state agencies, including mental health, child welfare, and juvenile justice, are leaders and collaborators in restraint/seclusion reduction initiatives focused on child/adolescent residential services; examples include New York, Ohio, and Massachusetts. The Ohio Department of Mental Health (DMH) and Ohio Association of Child Caring Agencies organized a statewide effort after receiving training on NASMHPD's Six Core Strategies©. The initiative includes residential and hospital leaders and resulted in the creation of a learning community focused on reducing restraint and seclusion use (Coate-Ortiz, 2005). The group organized, mobilized, met regularly, shared data, held large statewide trainings, and obtained funding to support their work. They are now preparing to create peer-to-peer consultation so providers who have mastered certain practice change challenges can assist colleagues who may feel stuck or who need onsite assistance.

In Massachusetts, the commissioners of child-serving agencies (i.e., mental health, child welfare, public schools, early education, and juvenile justice) initiated a statewide effort to prevent restraint/seclusion use across agencies and levels of care in 2009. State leaders were alarmed at the extent of restraint use in community-based residential programs and private residential schools serving youth with special education needs (Garinger, 2009). In 2008, more than 65,000 episodes of restraint occurred in these settings and resulted in more than 2,300 injuries to youth and approximately 1,900 injuries to staff (Garinger, 2009). The interagency effort is building on the DMH's successful, 10-year restraint/seclusion reduction initiative, which started in all child/adolescent psychiatric hospitals and intensive residential treatment facilities in the state. DMH's effort led to an 88% reduction in restraint/seclusion use statewide

and included developing new standards and practices such as crisis prevention planning and trauma assessment for all in care, prohibiting prone restraint, eliminating mechanical restraint with children, and reducing the maximum duration of restraint/seclusion episodes (NASMHPD, 2009).

New York has focused on restraint/seclusion reduction, too. The Office of Mental Health has been working with residential treatment providers and also developed new regulations to promote restraint and seclusion reduction. Like Massachusetts, New York has offered training programs, consultation, statewide forums, and a range of other activities to promote provider's prevention/reduction efforts.

State, county, and local oversight agencies representing child- and family-serving systems must support programs' effort to prevent, reduce, and sustain restraint/seclusion reductions. In addition to revising regulations and licensing requirements to clarify and delineate best practices, oversight agencies should use training programs, conferences, newsletters, consultation opportunities, and other resources to support these efforts. Establishing statewide or county or city workgroups, task forces, or learning communities toward these efforts have proven to be successful and should be part of defined plans by oversight agencies. Finally, champions for this work are needed in all constituent groups; indeed, it has been individuals and small groups of leadership who have transformed residential programs, as well as entire states.

Next Steps

It is clear from national, statewide, and individual program initiatives that significant and sustained restraint/seclusion reduction is possible. Recommendations for state agency and residential leaders who have not yet begun this process or who have not sustained their efforts include:

- The Six Core Strategies© have met evidence-based criteria for reducing restraint/seclusion use. Probably the most important follow-up for both state agency and residential program leadership is obtaining this public-domain curriculum, which is available at no cost, to gain an in-depth understanding of

these strategies and develop strategic plans for implementing the strategies.

- Every state and residential program leader who has embarked on this effort has reported that it has been one of the most difficult of their careers. Each successful leader has shared the need to maintain a strong commitment and long-term focus on the goal to prevent and reduce restraint/seclusion, or gains will be lost. Pennsylvania has been working on the goal of elimination of restraint/seclusion in their adult hospitals for more than 17 years. They have achieved better outcomes than any other state in the country because their leadership remains committed to the goal of restraint/seclusion elimination.
- Form relationships with other successful state and residential leaders to troubleshoot and problem solve when "the going gets rough."
- Form statewide groups. The results of these types of groups have resulted in significantly more than restraint/seclusion reduction, as mutual learning occurs about best practices different programs have implemented. After attending a two-day training program on the Six Core Strategies©, Elizabeth Childs MD, the former commissioner for the Massachusetts DMH, stated, "This initiative isn't really about reducing the use of restraint and seclusion. This is about implementing best practices to support better outcomes for the people we serve" (personal communication, July 15, 2005).
- Encourage professional associations to focus on best practices for preventing and reducing restraint and seclusion use. For example, both the American Association of Children's Residential Centers and the National Association for Children's Behavioral Health have featured best practices in reducing restraint/seclusion at their national conferences.
- Contract with national experts to conduct onsite reviews and consultation, using standardized review instruments based on the Six Core Strategies©. Regular onsite reviews have proven to be invaluable in achieving significant and sustained reductions. Outcome data from the Massachusetts 2004–2007

State Infrastructure Grant (funded by SAMHSA) demonstrated a 65% reduction in restraint/seclusion use across 11 adult inpatient programs. Only 2 of the 11 programs received onsite reviews during the three-year initiative; these two programs reduced restraint/seclusion use by 93.5% and 96.9%, respectively, during this same time (Huckshorn, Caldwell, & LeBel, 2008).

- Partner with statewide protection and advocacy groups and family and youth advocacy/support groups. Transparency and partnerships with experts in family-driven and youth-guided care are critical to implementing practices that will significantly impact positive culture change.
- Clarify values and develop new leaders. Ultimately, any practice improvement initiative requires strong leadership commitment to clear values. As emphasized by Anthony and Huckshorn (2008), effective leaders create an organizational culture that identifies and tries to live by key values. Every successful and sustained prevention/reduction initiative has had strong leadership with a clear commitment to best practice values and the ability to motivate staff to action (Anthony & Huckshorn, 2008; NASMHPD, 2009). Brian Carroll (personal communication, June 22, 2009), the CEO of Secret Harbor and Foster Care Resources, Washington, described his multiyear residential transformation effort, which resulted in significantly reducing restraint use and implementing several family-driven and youth-guided practices: "This is 100% being driven by me, the leader. Staff were open, but I had to say this is the way train is moving—get on or get off. We reviewed every residential practice against our core values. Some staff chose to get off, most stayed."

Conclusion

Children continue to die, and staff and children continue to receive serious physical injuries and experience trauma and retraumatization, due to restraint/seclusion use. There can be no more compelling rationale

than to prevent these outcomes. Reducing restraint/seclusion use does more than decrease the number of episodes—it creates better, quantifiable outcomes for youth, families, staff, and organizations (LeBel, 2009a, 2009b; LeBel & Goldstein, 2005). Best practices that correlate to significant and sustained reductions, as well as national experts, are available to support state and residential leaders throughout the country. By making restraint/seclusion reduction a priority, programs can provide more opportunities for children to learn, succeed, and continue on their paths toward resilience and a return to community life.

Resources

Program and Contact	Capacity (beds)	Ages	Youth Population	Restraints Reduced
Immanuel Residential Treatment Center, NE Daniel Martin, Unit Coordinator daniel.martin@alegent.org	20	6–18	Child welfare/ mental health	62%
Andrus Children's Center, NY Brian Farragher, LMSW, MBA, Chief Operating Officer www.andruschildren.org/	73 80 day slots	7–14	Child welfare/ special education	93%
The Village Network, OH Dave Paxton, LISW-S, Regional Director www.thevillagenetwork.org/	20	10–18	Mental health/ child welfare	94%
The Grafton School, VA James Gaynor, Ph.D., Chief Executive Officer www.grafton.org/	400	7–68	Youth/adults with autism spectrum disorders,a developmental disabilities, and psychiatric diagnoses	99.8%

State and National Efforts

Six Core Strategies©
National Association of State Mental Health Program Directors
c/o Pat Shea, Deputy Director of the Office of Technical Assistance
pat.shea@nasmhpd.org
www.nasmhpd.org

Coercion-Free Nebraska
Denis McCarville, President/CEO
Uta-Halee/Cooper Village
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Ohio Children's Residential Learning Community
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References

Anthony, A. A., & Huckshorn, K. A. (2008) *Principled leadership in mental health systems and programs.* Boston: Boston University Center for Psychiatric Rehabilitation.

Burns, B. J., Goldman, S. K., Faw, L., & Burchard, J. D. (1999). The wraparound evidence base. In B. J. Burns & S. K. Goldman (Eds.), *Promising practices in wraparound for children with serious emotional disturbance and their families. Systems of care: Promising practices in children's mental health,* 1998 series, Vol. IV. (pp. 77–100). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Child Welfare League of America. (2004). *Achieving better outcomes for children and families: Reducing restraint and seclusion.* Washington, DC: Author.

Coate-Ortiz, K. (2005). Learning communities are launched: Focus on reduction of seclusion and restraint in Ohio's mental health system. *Quality Matters Newsletter.* Columbus: Ohio Department of Mental Health. Retrieved February 16, 2009, from http://dmhext01.mh.state.oh.us/dmh/newsletter/qualitymatters.nsf/onlinecontent/0BC642E3AAC193AD85256F8D0073C500#3.

Coercion-Free Nebraska. (2009). *Coercion-free Nebraska website.* Retrieved February 16, 2009, from www.cfnebraska.org.

Courtney, M. E., Terao, M. E., & Bost, N. (2004). *Midwest evaluation of the adult functioning of former foster youth: Conditions of youth preparing to leave state care. Executive Summary.* Chicago: Chapin Hall Center for Children at the University of Chicago.

Farragher, B., & Yanosy, S. (2005). Creating a trauma-sensitive culture in residential treatment. *Therapeutic Communities, 26*(1), 93–109.

Garinger, G. (2009). *Annual report 2008.* Boston: Office of the Child Advocate. Retrieved August 11, 2009, from www.mass.gov/childadvocate/about/annual_report.pdf.

Hardenstine, B. (2001). *Leading the way toward a seclusion and restraint-free environment: Pennsylvania's success story.* Harrisburg: Office of Mental Health and Substance Abuse Services, Pennsylvania Department of Public Welfare.

Hill, E., & Martin, D. (2009). *Immanuel residential treatment center restraint/seclusion initiative: Overview and data report.* Omaha, NE: Alegent Health Systems.

Huckshorn, K. A. (2004). Reducing the use of seclusion and restraint in mental health systems: A public health prevention approach with interventions. *Journal of Psychosocial Nursing and Mental Health Services, 42*(9), 22–33.

Huckshorn, K. A. (2006). Re-designing state mental health policy to prevent the use of seclusion and restraint. *Administration and Policy in Mental Health, 33*(4), 482–491.

Huckshorn, K., Caldwell, B., & LeBel, J. (2008, August 4). *Status report of the national initiative.* Paper presented at the Substance Abuse and Mental Health Services Administration Seclusion and Restraint Matrix Group Planning Meeting, Rockville, MD.

Institute of Medicine. (2005). *Improving the quality of health care for mental and substance-use conditions: Quality chasm series*. Washington, DC: National Academies Press.

Johnson, T. D. (2007). Respiratory assessment in child and adolescent residential treatment settings: Reducing restraint-associated risks. *Journal of Child and Adolescent Psychiatric Nursing, 20*(3), 176–183.

Kennedy, S. S., & Mohr, W. K. (2001). A prolegomenon on restraint of children: Implicating constitutional rights. *American Journal of Orthopsychiatry, 71,* 26–37.

LeBel, J. (2009a). *The business case for preventing and reducing restraint and seclusion use.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

LeBel, J. (2009b, May). *The Massachusetts department of mental health statewide restraint and seclusion prevention initiative.* Paper presented at the Interagency Leadership Forum to Prevent the Use of Restraint in Residential Settings, Shrewsbury, MA.

LeBel, J., & Goldstein, R. (2005). The economic cost of using restraint and the value added by restraint reduction or elimination. *Psychiatric Services, 56*(9), 1109–1114.

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., Harper, G., LaFlair, L., & Sudders, M. (2004). Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care. *Journal of the American Academy of Child and Adolescent Psychiatry, 43,* 37–45.

Mohr, W., & Anderson, J. A. (2001). Faulty assumptions associated with the use of restraints with children. *Journal of Child and Adolescent Psychiatric Nursing, 14*(3), 141–151.

National Association of State Mental Health Program Directors. (2009). *National executive training institute: A training curriculum for the reduction of seclusion and restraint* (7th ed.). Alexandria, VA. National Association of State Mental Health Program Directors, Office of Technical Assistance.

National Association of Psychiatric Health Systems (NAPHS). (2003). *Learning from each other: Success stories and ideas for reducing restraint/seclusion in behavioral health*. Retrieved February 27, 2003, from www.naphs.org/rscampaign/index.html.

Nunno, M. A., Day, D. M., & Bullard, L. B. (Eds.). (2008). *For our own safety: Examining the safety of high-risk interventions for children and young people.* Arlington, VA: Child Welfare League of America.

Paxton, D. (2009, January 9). *The Village Network's experience creating and supporting coercion-free and violence-free treatment environments.* Paper presented at the Ohio Department of Mental Health and the Ohio Association of Child Caring Agencies conference, Proactive Positive Interventions, Columbus, OH.

Sanders, K. (2009). The effects of an action plan, staff training, management support and monitoring on restraint use and costs of work-related injuries. *Journal of Applied Research in Intellectual Disabilities, 22*(2), 216–220.

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2003). *A national call to action: Eliminating the use of seclusion and restraint.* Rockville, MD: Author. Retrieved February 16, 2009, from www.samhsa.gov/seclusion/sr_report_may08.pdf.

Solomon, M. L. (1998). *Positive partnerships: How consumers and nonconsumers can work together as service providers.* Chicago: University of Illinois at Chicago.

U.S. General Accounting Office. (1999, September 7). *Mental health: Improper restraint or seclusion use places people at risk* (GAO/HES-99-176). Washington, DC: Author.

Weiss, E. M., Altimari, D., Blint, D. F., & Megan, K. (1998, October 11–15). Deadly restraints: A nationwide pattern of death. *The Hartford Courant*.