

Annotated Bibliography
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1. American Academy of Pediatrics Committee on Pediatric Emergency Medicine (1997): The Use of Physical Restraint Interventions for Children and Adolescents in the Acute Care Setting. *Pediatrics* 99 (3, March), 497-498.

This statement defines physical restraint and provides recommendations for its use in children and adolescents. Mechanical restraint and physical holding are described. The primary focus of the statement is on mechanical restraint. Recommendations: Explain the procedure to the child; physician's order is used; when intervention is used, communicate in writing to parents; physical assessment.

2. American Association of Psychiatric Technicians, Inc. (1999): *Psych Tech News Gazette*.

This is an email publication of the American Association of Psychiatric Technician, edited by George Blake, PhD. It is a source for training materials. To subscribe, send a blank email to psychtechnews-suscribe@onelist.com.

3. American Hospital Association and the National Association of Psychiatric Health Systems (1999): *Guiding Principles on Restraint and Seclusion for Behavioral Health Services*. February 25, 1999.

This statement of principles were provided to member organizations to provide the basis for a review of current policies. Restraint and seclusion are defined as emergency interventions that aim to protect patients in danger of harming themselves or others.

4. Bath, H (1994): The physical restraint of children: is it therapeutic? *The American Journal of Orthopsychiatry* 64(1, January), 40-49.

This is an overview of issues related to restraint in residential settings with children. The author draws from the classic literature of Redl, Wineman and Trieschman. He covers the functions of restraint; limit-setting, containment, and planned holding therapy. The final section covering problems with restraint is clearly stated summary of the issues facing those who provide twenty-four hour care for disturbed children. There is a section on the practical difficulties of low staff ratios, inadequate training and the increasing difficulty of the children referred for such care. The negative impact of holding on staff is discussed, including the impact on staff turnover. In conclusion, the author finds restraint a necessary, but difficult procedure with potential therapeutic benefits.

5. Berrios, Carmen D; Jacobowitz, William H (1998): Therapeutic Holding: Outcome of a Pilot Study. *Journal of Psychosocial Nursing* 36(8), 14-18.

This article addresses a study in a fifteen bed pediatric psychiatry inpatient unit. The study involved the use of therapeutic holding as an approach to decreasing the use of mechanical restraint and seclusion. The results suggested that therapeutic holding appears to be as effective as seclusion and restraint for managing aggressive behaviors. The sampling methodology limits the conclusions drawn from the study to suggestions for further study. The article expresses the opinion that the use of physical holding engenders security in the child, changing a potentially frightening experience to a comforting one.

6. Braxton, Earl T (1995): Angry Children, Frightened Staff: Implications for Training and Staff Development. In: *When Love is not Enough: The Management of Covert Dynamics in Organizations That Treat Children and Adolescents.* (Ed: Piazza, D) The Hawthorne Press, New York, NY, 13-28.

Braxton discusses the transference and countertransference issues that arise and need to be dealt with in the treatment of emotionally disturbed children. Most programs are not designed to address this issue, yet it is crucial to address staff needs in order to provide safe and effective treatment. Recommendations for training and consultation are provided.

7. Crenshaw, Wesley B; Francis, Paul S (1995): A National Survey on Seclusion and Restraint in State Psychiatric Hospitals. *Psychiatric Services* 46(10, October), 1026-1031.

A total of 101 state hospitals in 44 states were surveyed. Smaller hospitals used restraint more often than larger ones. There was a great deal of variability in the mean rates, which suggested high variability in the use of these interventions. The article includes a review of the literature that indicated: the use of seclusion had no clear impact on outcomes, though it did reduce dangerousness; the use of restraint was more likely to be related to environmental factors than intrapsychic symptoms; secluded clients tended to be younger, male, unmarried and unemployed; seclusions tend to happen early in the hospital stay; the use of one of the interventions was favored by individual therapists-even when other interventions were clearly indicated; no relationship was found between patient characteristics and the use of these interventions; great variability was found in organizational policy and practice as well as in data collection approaches.

8. Crenshaw, Wesley B; Francis, Paul S (1997): A National Survey on Seclusion and Restraint in State Psychiatric Hospitals. *Psychiatric Services* 48(3, March), 395-397.

This is a follow-up to the 1995 study. The 1995 findings were basically replicated and there were few changes noted in the rate of seclusion and restraint. There was improved consistency in data collection methodology among the hospitals surveyed.

9. Fassler, D; Cotton, N (1992): A National Survey on the Use of Seclusion in the Psychiatric Hospitalization of Children. *Hospital and Community Psychiatry* 43(4, April), 370-374.

This paper summarizes the findings of a study of state policies, procedures and regulations in the psychiatric treatment of children. Only six states had regulations that specifically address seclusion. The authors summarized the state regulations that they identified. The regulations covered: duration and frequency, ordering and who may order seclusion, documentation, termination of the procedure, breaks during episodes, design of seclusion rooms and staff training. Included is a model policy addressing the use of seclusion. The authors also discussed a clinical/developmental model for seclusion.

10. Fisher, William (1994): Restraint and Seclusion: A Review of the Literature. *Am. J. Psychiatry* 151(11, November), 1584-1591.

The author reviewed the literature since 1972 on restraint and seclusion. The author summarized the findings: 1) Seclusion and restraint are basically efficacious in preventing injury and reducing agitation. 2) It is nearly impossible to provide care for severely ill individuals without these procedures. 3) Restraint and seclusion have negative effects on patients and staff 4) Demographic and clinical factors have little influence on the rate of use of these procedures 5) Cultural, leadership attitudes and staff role perceptions have a greater influence on the use of restraint and seclusion 6) Training in prediction, prevention of violence, self defense and implementation are valuable in reducing rates and increasing safety. 7) Studies comparing well defined training programs have potential usefulness.

11. Forquer, Sandra L; Earle, Kathleen A; Way, Bruce B; Banks, Steven M (1996): Predictors of the Use of Restraint and Seclusion in Public Psychiatric Hospitals. *Administration and Policy in Mental Health* 25(6, July), 527-532.

This article describes a study of restraint and seclusion in psychiatric hospitals operated by the New York State Office of Mental Health. The study found that after age, the hospital where the patient was served was the greatest predictor of the use of these interventions. Patient characteristics were controlled in analysis. The logistic regression model was used to calculate the relative effects of variables on the use of restraint and seclusion.

12. Goren, S; Singh, N; Best, A (1993): The Aggression-Coercion Cycle: Use of Seclusion and Restraint in a Child Psychiatric Hospital. *Journal of Child and Family Studies* 2(1), 61-73.

This is a study of the use of seclusion and restraint in a public child psychiatric hospital over a three year period. The study of 1670 events indicated that there was a stable rate of seclusion among children with five or less events. There was an increase in the duration of seclusion among those who were secluded more than five times. The authors felt that this indicated that the procedure was not effective in decreasing undesirable behavior. The increasing length of restraint or seclusion for those who were secluded or held frequently was interpreted as evidence of repetitive cycles of aggression and coercion. The authors believe that the environment and culture of the institution were a major factor in these seclusion and restraint events. Interpreting these events without understanding the interaction between the child and the environment misses a crucial causal factor. Further, the authors speculated that the aggression/coercion cycles that many of the children experienced at home were reinforced due the organizational reliance on restraint and

seclusion for addressing behavioral issues. The authors recommend reworking organizational procedures to avoid reinforcing aggressive behavior and maximizing child and parent participation in decision-making.

13. Goren, Suzanne; Abraham, Issac; Doyle, Nancy (1996): Reducing violence in a child psychiatric hospital through planned organizational change. *JCAPN* 9(2, April-June), 27-38.

This article summarizes a project in a fifty bed urban public child psychiatric hospital. The authors believe that the use of coercion is determined more by the mind set of the organization than by clinical necessity and that the use of coercion can be significantly reduced through organizational intervention. A summary of the strategies used: A study of the actual usage of restraint and seclusion; providing this information to staff; assessment of organizational climate; assessment of staff communication across disciplinary and team boundaries; creation of a task force to reduce aggression; changing the mind-set about the use of seclusion and restraint; revision and standardization of the behavior modification program; revision of policy and procedures related to crisis episodes; development of a family-focused approach. As a result of the changes made, restraint was reduced by a factor of 98%. The rate of seclusion is down 50%

14. Goren, Suzanne; Curtis, John (1996): Staff Members' Beliefs About Seclusion and Restraint in Child Psychiatric Hospitals. *Journal of Child and Adolescent Psychiatric Nursing* 9(4, October-December), 7-14.

The authors note a lack of research on the perceptions of children who have experienced seclusion and restraint. Thus, psychiatric care is being provided without a research-based understanding of the impact of these interventions on children. There are no studies in the literature comparing beliefs and practices related to seclusion and restraint among child psychiatric hospitals. Thus, there is a gap in our understanding of aggression management in child psychiatric facilities. Studies of restraint and seclusion practice in the adult arena demonstrates that institutional variables-values, standards of practice, rules, social norms, etc., exert significant influence on the management of aggression. The purpose of this study was to shed light on the belief of staff members regarding seclusion and restraint. The findings indicate that the 320 staff surveyed from thirteen institutions had low to moderate confidence that restraint and seclusion would result in a positive patient response. The fact that interventions were still used in spite of the low level of confidence in them suggests that there are persistent, unexamined traditional practices. The authors discussed the paradox of the desire to maintain a quiet, controlled unit while developing a therapeutic alliance with children most likely to disrupt it. The study confirmed what is reported in the literature, that physical violence is the most frequent antecedent to seclusion and/or restraint. The child's initial refusal to comply rarely results in seclusion or restraint. But, an escalating pattern of increased noncompliance leads to verbal threats/physical aggression, which is then given as a rationale for coercive intervention. Aggression and hostility lead to avoidant behavior and coercive behavior by the staff.

15. Harrell, S; Orem, R (1980): Preventing Child Abuse and Neglect: A Guide for Staff in Residential Institutions. DHHS Publication No. OHDS 80-30255 ed. US Government Printing Office, Washington, DC.

This guide, though dated, is a useful overview of ideas that can assist organizations in developing systems to minimize the use of restraint and seclusion. The idea that staff become institutionalized is discussed. That is, the status quo of the institution is seen as normative, "They could not possibly understand the issues unless they worked here." The concepts of ombudspersons and institutional advocacy programs are discussed.

16. Hunter, Richard H (1999): Reducing Aggression and the Use of Restrictive Procedures in Psychiatric Care. Presented to the JCAHO Restraint Use Task Force Public Hearing, April 13, 1999. (Submitted for Publication; 34 pages)

This article describes assessment and case formulation strategies staff use to understand and treat aggressive behavior. It also addresses milieu management incentive systems, treating cognitive dysfunction, data collection and outcome measurement. The author can be reached at rhunter@midwest.net.

17. JKM Training (1999): Liability: A formula to prevent successful litigation against your agency and your staff in matters related to the Physical Restraint of youth in care. Unpublished manuscript.

This material was developed by JKM Training, based on litigation information provided by the Juvenile Law Center of San Francisco. The types of litigation related to physical restraint are described: Negligence and Failure to Train/Supervise. Organizational actions are described in relation to policy, training, and documentation.

18. Joint Commission on Accreditation of Healthcare Organizations (1999): Synthesis of Oral and Written Testimony Received by the Joint Commission on the Use of Restraints for Psychiatric Patients. May 26, 1999.

This is a summary of the testimony received by the Joint Commission in San Francisco, Atlanta and Washington DC during the spring of 1999. The testimony was provided by providers of behavioral healthcare, training organizations, professional organizations, consumers and family members. The summary is divided into eleven categories: Philosophical issues/general observations; leadership; staff training and competence; assessment; orders for restraint; non-physical interventions; application of restraints and use of therapeutic holds; monitoring of patients in restraint or seclusion; post restraint issues; documentation, data collection and reporting; and survey related issues.

19. Kalogjera, Ikar, et al (1989): Impact of Therapeutic Management on the Use of Seclusion and Restraint with Disruptive Adolescent Inpatients. *Hospital and Community Psychiatry* 40(3), 280-285.

The use of seclusion and restraint was reduced by 64% after the introduction of a therapeutic management protocol. The protocol classified disruptive behavior into four stages and standardized stage-specific interventions were implemented. A new policy on restraint and seclusion provided specific interventions as well as specified release criteria. A system of post-release follow-up between staff and patients was established. The stages of aggressive behavior

were defined as: Verbal, Motor, Property-damage, Attack. This is a very useful article that defines clinical approaches. Aggression is seen as an acting out of inner conflict. Disruptive behavior is seen as a form of communication.

20. Long, Nicholas (1995): Why Adults Strike Back: Learned Behavior or Genetic Code. *Journal of Emotional and Behavioral Problems* (1).

This article describes “The Student’s Conflict Cycle” that moves from irrational beliefs to incident, emotional response, behavior, and adult reactions. Based on this cycle, Long describes the concept of counter aggression as a reaction to being caught in the student’s conflict cycle. There is further discussion about counteraggression as a result of a violation of values, bad mood, not meeting professional expectations, rejection and helplessness, and unfinished psychological business. Long’s writing is pragmatic, coming from a depth of experience in treating disturbed youth.

21. Long, Nicholas J; Fecser, Frank A; Brendtro, Larry K (1998): Life Space Crisis Intervention: new skills for reclaiming students showing patterns of self-defeating behavior. *Healing* 3(2, Fall/Winter), 2-24.

Long, Brendtro, and Fecser present a model of intervening with children and youth. Life space crisis intervention grew from the work of Redl and Wineman's Life Space Interviewing. This approach uses crisis intervention as a part of a treatment program. This approach defines the conflict cycle, six stages of intervention and staff competencies in each of the intervention stages. This model has been applied in public school and treatment settings.

22. Miller, Derek; Walker, Mark C; Friedman, Diane (1989): Use of a Holding Technique to Control the Violent Behavior of Seriously Disturbed Adolescents. *Hospital and Community Psychiatry* 40(5, May), 520-524.

Therapeutic holding was studied in an inpatient adolescent psychiatric unit over an eighteen month period. Therapeutic holding was seen as a way of avoiding mechanical restraint and seclusion. The procedure and setting were described. The procedure for auditing the documentation of each hold was described. Results: 40% of the population were held; the mean length was 21.2 minutes; younger patients were more likely to be held; males were held more than females; diagnosis was unrelated to the use of the procedure; long stay patients were more likely to be held even after correction for days in the hospital; the mean length of holds were dramatically shorter than the mean length of mechanical restraint. The authors recommend that the procedure be evaluated as means of reducing the length of time in restraining procedures.

23. Mohr, Wanda K; Mahon, Margaret M; Noone, Megan J (1998): A Restraint on Restraints: The Need to Reconsider Restrictive Interventions. *Archives of Psychiatric Nursing* XII (2, April), 95-106.

This article focuses on how children and adolescents describe their experience of restraint. Three themes developed during the study: vicarious trauma (everyone present is affected by the

restraint), staff alienation (an experience of distance from the staff and not being understood), and direct trauma (physical and psychological trauma resulting from restraint).

24. Morales, E; Duphorne, P (1995): Least Restrictive Measures: Alternatives to Four Point Restraints and Seclusion. *Journal of Psychosocial Nursing and Mental Health Services* 33(10), 13-16.

This article describes a three month study in an acute psychiatric hospital unit. The staff were provided with bimonthly inservices on using least restrictive measures in working with aggressive patients. The staff were encouraged to offer the patients choices when they showed signs of agitation. Choices included such things as one-to-one verbal interactions, warm milk, and beating on a pillow, e.g. By the end of the project, the time spent in restraint was estimated to have been reduced by 50%. The staff felt that verbal interaction, limit-setting, quiet time and as-needed medication were the most effective interventions.

25. Morrison, Eileen F (1990): The Tradition of Toughness: Psychiatric Nursing Care by Non-Professional Staff in Institutional Settings. *Image:Journal of Nursing Scholarship* 22(1, Spring), 32-38.

This article addresses the informal social systems that developed among direct care staff in one facility. These social norms defined how and when physical control is utilized. Subtle coercion was used by the staff toward the staff, for example, staff who used verbal techniques to deal with an aggressive situation were likely to be ignored when physical violence did break out. The study was conducted using participant observation and in-depth interviews to collect data. The study found that a focus on control results in more violence. Also discussed is the interactive nature of the environment. For example, rules around access to cigarettes were the focus of numerous violent episodes. The study found major themes in the informal culture of direct care staff: blaming the system for rules that are designed to control the patient; the role of leadership among physical enforcers; and putting on a show of formal values in order to avoid negative sanctions for following the informal values. In conclusion, the author suggested that the awareness of such cultural norms as the tradition of toughness is necessary for leaders who want to emphasize norms such as cooperation and persuasion.

26. Joseph K. Mullen, MSW (1996): Passive Restraint (Nonviolent Crisis Intervention): Current Issues in Training and Policy. *Juvenile Justice Update* Volume 2(Number 1, February/March, 1996), 1,2,11-13,15.

This article defines a model for matching the level of staff intervention with the behavior of the individual so that excessive levels of intervention may be avoided.

27. National Association of State Mental Health Program Directors Medical Directors Council (1999): Reducing the Use of Seclusion and Restraint (Draft). Draft dated March, 1999.

Seclusion and restraint are: almost always experienced by the individuals involved as traumatic, put staff and patients at risk and can seriously jeopardize treatment. The procedures should be used for safety only and then only if less restrictive procedures have failed. The most

effective model when considering restraint and seclusion is the public health model: primary, secondary and tertiary prevention. The paper also addresses factors that contribute to a safe environment; what does not work; and recommendations

28. Ray, Nancy K; Myers, Karen J; Rappaport, Mark E (1996): Patient Perspectives on Restraint and Seclusion Experiences: A Survey of Former Patients of New York State Psychiatric Facilities. *Psychiatric Rehabilitation Journal* 20(1, Summer), 11-18.

This article reports the findings of a mail survey of 1,040 individuals who received care at psychiatric facilities in New York State. Approximately half of the respondents reported being subject to restraint or seclusion during their stay and 94% reported at least one complaint about the appropriateness of the use of restraint and seclusion and/or their care or monitoring during the procedure. The use of restraint and seclusion is associated with a more negative patient assessment of their overall hospital stay. Responses also indicate an affirmation of the importance that patients attach to attempts to avoid these more restrictive interventions. The authors note that the literature on the patient's perspective is limited and work on patients view on restraint are nonexistent. The literature that does exist on restraint suggests: that the staff underestimated time in seclusion; that seclusion events were clearly influential and were remembered even a year after discharge; that staff and patients believed that the other patients benefited more from the seclusion than the patient who was secluded; that patients believe that seclusion should be shorter (one hour, not four hours); that there was a disparity between patient and staff views toward seclusion. Findings of this study: 73% of respondents indicated that they were not a danger to self or other at the time of restraint; that restraints or seclusion were used as punishment, and that they had been provoked to an angry outburst by staff or other patients; 78% indicated that their care in restraint were not compliant with at least one state standard. There were numerous other negative findings, e.g., that they were not protected from harm; that they were ridiculed; that unnecessary force was used; physical injury and sexual abuse.

29. Ray, Nancy K; Rappaport, Mark E (1995): Use of Restraint and Seclusion in Psychiatric Settings in New York State. *Psychiatric Services* 46(10, October), 1032-1036.

This study was conducted in 125 psychiatric settings in New York State. The study measured the percent of patients restrained, percent of patients secluded, the rate of restraint orders and the rate of seclusion orders. Variations in the use of restraint and seclusion were found to be dramatic and are difficult to correlate with differences in patient populations. The authors suggest that the variations are likely due to the disparate perspectives on the advisability of restraint and seclusion and the limited comparative monitoring of the procedures. This is also supported by the finding that patients appear to be treated successfully with no restraint or seclusion in many psychiatric settings.

30. Sanson-Fisher, RW; Poole, D; Thompson, V (1979): Behaviour patterns within a general hospital psychiatric unit: An observational study. *Behavior Research and Therapy* 17, 317-332.

This study utilized naturalistic observation methodology to collect data about staff and patient interaction in a forty bed inpatient psychiatric unit. The study was designed to provide a factual base for planned interventions. Observations were coded into seven categories: individual task

behavior, egocentric behavior, group task formal, group task informal, group interaction. The findings: Staff spent little time interacting with patients. A majority of staff time was spent interacting with peers. Patients spent one half of their time in non-interactive behavior. Staff and patients occupied spatially segregated areas of the unit. The therapeutic potential of the unit was underutilized. The next step in the study was to evaluate the content of the interactions between staff and clients to guide program redesign. The methodology of this study should be considered for evaluating unit behaviors relating to restraint and seclusion.

31. Soloff, P H; Guthell, T G; Wexler, D B (1985): Seclusion and restraint in 1985: A review and update. *Hospital and Community Psychiatry* 36(6, June), 652-657.

The incidence of violence in psychiatric facilities is significant and greatly underestimated. For example, in a twelve year period, more than 12,000 cases of assault, primarily between staff and patients were reported within Veterans Administration hospitals. The authors outline factors that have increased the risk of violence, for example, drug use and the treatment of impulsive character disorders and borderline personalities in inpatient psychiatric settings. Court rulings that have impacted the use of seclusion and restraint are outlined. Eleven empirical studies are summarized. Findings: incidence of restraint and seclusion varies directly with the composition of the patient population and the treatment philosophy. For example, a setting designed to provide medication-free treatment to a unit for schizophrenia had a higher rate of restraint and seclusion. The patient demographics were discussed. The precipitants for the use of the procedures were discussed. Of the ten studies that measured precipitating events, nine cited non violent behavior as most often leading to seclusion. Seclusion was also used as an administrative sanction for verbal abuse or refusal to participate in activities. The wide disparity in the length of seclusion times led the authors to question whether the decision to use the procedure is arbitrary. The authors recommend research on the milieu and physical controls in order to focus on the interactive nature of the events. Research is also needed on the impact of the procedures on the patient. Clear clinical guidelines are needed to guide the use of these interventions.

32. Steel, Elizabeth (1999): Seclusion and Restraint Practice Standards: A Review and Analysis., .

This is an unpublished manuscript prepared under a contract with the National Mental Health Association. The author can be contacted via the NMHA Consumer Supporter Technical Assistance Center, 1021 Prince Street, Alexandria, VA 22314, 800-969-NMHA, email: consumerTA@nmha.org. This is a review of the literature with a standards and policy focus. The review covers existing guidelines, model standards and special populations (children, women, the elderly, developmentally disabled). Of particular note in this article is the finding that the use of restraint in European countries is dramatically lower than in the United States. This information can be located in: Strumpf and Tomes (1993) *Nursing History Review*, Volume 1, pp. 3-24 and in Ljunggren (1997) *Continuing and Rehabilitative Care for Elderly People: A Comparison of Countries and Settings, Age and Aging*, Volume 26 (6), 543. The article concludes that there is little or no consensus on restraint and seclusion, but that the existence of so many guideline documents shows that it is possible to develop standards for these interventions.

33. Troutman, Beth; Myers, Kathleen; Borchardt, Carrie; Kowalski, Richard; Bubrick, Jerome (1998): Case Study: When Restraints Are the Least Restrictive Alternative for Managing Aggression. *J. Am. Acad. Child Adolescence. Psychiatry* 37(5, May), 554-558.

This article discusses the use of restraints with a persistently violent psychotic girl on a child and adolescent psychiatry unit. This individual was not able to be treated successfully under standard protocols. The use of mechanical restraints (geriatric chair and ambulatory restraints) allowed integration into the milieu until the medication was effective.

34. Visalli, Hank; McNasser, Grace; Johnstone, Linda; Lazzaro, Cynthia (1997): Reducing High-Risk Interventions for Managing Aggression in Psychiatric Settings. *J. Nurs. Care Qual.* 11(3), 54-61.

Restraint and seclusion present risks to patients and staff. Although, the procedures are moderately successful in managing an immediate crisis, they are less successful in helping patients learn to manage their own aggressive behavior. The repeated use of the procedures results in negative patient attitudes. This article offers therapeutic and less restrictive interventions when teaching patients strategies for managing anger. The changes that were made at a New York State psychiatric center were: anger/aggression prevention techniques for staff and patients; changes in policy and procedures; patient surveys; sensitivity training for employees; changes in hospital structure; peer advocacy involvement; and improved monitoring and reporting techniques. This article focuses on two of these interventions, the anger management assessment tool and the "Triangle of Choices," a visual tool that describes choices available to the patients. The assessment tool, the "Triangle of Choices" and the data collection tool are all included in the article. The results indicate a decrease in the use of restraint for management of minor incidents, an increase in the use of preventative interventions, and a decrease in staff and patient injuries.

35. Walsh, Elaine; Randell, Brooke P (1995): Seclusion and Restraint: What We Need to Know. *JCAPN* 8(1), 28-40.

This paper covers key findings about restraint and seclusion and makes recommendations for research and improvement. The paper covers definitions, frequency, duration, characteristics of those restrained, precipitants, positive aspects of seclusion, negative aspects of seclusion and restraint, alternatives, staff and patient attitudes, and factors influencing the use of these procedures. In conclusion, little is known about these processes because of the high variability in definition and practice. Prospective studies are needed to establish predictors and develop more uniform criteria. It is difficult to argue for the total elimination of restraint and seclusion.

36. Wong, Stephen F; Rolph, Barbara; Martinez-Diaz, Jose; Thorne-Henderson, Margaret (1990): How Therapeutic is Therapeutic Holding? *Journal of Psychosocial Nursing* 28(11), 24-28.

The article describes therapeutic holding and provides a critique of its procedural ambiguities. The theoretical analysis of the procedure identifies the fact that the mechanism by which holding provides a therapeutic benefit is not identified. From a learning theory approach, therapeutic holding may be aversive. It also may serve to reinforce aggressive behavior, since adult attention is reinforcing. Restraint is highly intrusive and restrictive, therefore, professional and paralegal

monitoring should be ongoing. Recommendations: Teach and reinforce appropriate behavior, and do not teach while the child is still agitated after an aggressive incident. Include skill instruction as a part of the normal daily schedule. In order to control and reduce aggressive behavior: use empirically validated procedures such as time out from reinforcement. And finally, evaluate the effectiveness of treatment procedures empirically in order to determine the actual effectiveness of treatment.

37. Zusman, Jack (1997): *Restraint and Seclusion: Improving Practice and Conquering the JCAHO Standards*. Opus Communications, Marblehead, MA. 198 pages.

This book is a practical guide to addressing the standards of the Joint Commission on Accreditation of Healthcare Organizations relating to restraint and seclusion. It also includes suggestions about preventing the need for restraint and seclusion. The focus on the book is primarily on psychiatric hospitals and mechanical restraints.

Performance Improvement Literature

38. Ammerman, Max (1998): *The Root Cause Analysis Handbook, a Simplified Approach to Identifying, Correcting and Reporting Workplace Errors*. Quality Resources, New York. 135 pages.

This book describes an approach to problem identification and correction (PIC) that was developed at Florida Power and Light. This approach to root cause analysis is powerful if the process involved has been defined clearly. This approach to root cause analysis uses control barrier analysis. Control barriers are equipment or systems that have been put into place prevent errors, injury, etc. Part of the root cause analysis examines how the control barriers failed to prevent the event. The event and causal factor chart is a part of this approach. Causal factors are displayed in a flow chart of the process. The book also covers data collection methods, issues related to interviewing and report writing. A healthcare example is provided in the appendix. This approach can be a useful adjunct to the Joint Commission root cause analysis methodology.

39. Brassard, M (1988): *The Memory Jogger Plus, Featuring the Seven Management and Planning Tools*. Goal/QPC, Methuen, MA.

The Memory Jogger Plus is a great source of planning tools for quality improvement teams and organizational leaders. it contains tools useful for setting priorities and planning projects.

40. Brassard, Michael; Ritter, Diane (1994): *The Memory Jogger II, a Pocket Guide of Tools for Continuous Improvement and Effective Planning*. Goal/QPC, Lawrence, MA. 164 pages.

The Memory Jogger II is an excellent resource for anyone involved in performance improvement. This shirt pocket-sized guide contains the major analysis and planning tools used in performance improvement work. Each tool description includes sections on: Why Use It? What Does It Do? How Do I Do It? Graphic illustrations and tips. In addition to the pocket guide, materials are available for training purposes.

41. Gunn, Steven W (1998): *The Quality Imperative: An Answer to the Chaos of the Behavioral Healthcare Environment*. Residential Treatment for Children and Youth 16(2), 35-65.

This article describes the challenges that behavioral healthcare faces and discusses how quality improvement can address these issues. The article discusses some of the key concepts of quality improvement such as: employee participation and development, design quality, management by fact and customer-driven quality.

42. Oshry, Barry (1995): *Seeing Systems: unlocking the mysteries of organizational life*. First ed. Berrett-Koehler Publishers, San Francisco. 208 pages.

This book is the result of an ongoing laboratory experiment in systems. The book is written playfully, poetically and insightfully to describe the blindness that occurs in systems. The experience of the "tops," the "middles" and the "bottoms" are described, along with approaches to

solving the conflicts and dysfunction that occur when we are not aware of the way that our relationships within systems guide our behavior.

43. Pecora, Peter J; Seelig, William R; Zirps, Fotena A; Davis, Sally M (Eds.) (1996): *Quality Improvement and Evaluation in Child and Family Services*. First ed. CWLA Press, Washington, D.C. 303 pages.

This book is a valuable collection of articles on quality improvement and program evaluation. Leaders and managers interested in these topics should find it full of useful tools and guidance. The chapter entitled, *How Do We Propose to Help Children and Families?* by Sue Ann Savas, describes a tool called the "logic model." This is a simple model for describing the client population served, the major program components, program processes and immediate and long term outcomes. This is a valuable tool because it forces us to make clear linkages among these program components, customer needs and outcomes. Any attempt to measure outcomes should apply this model in order to answer Demming's question: "By what method" (will you improve outcomes)?

42. Pennsylvania Office of Mental Health and Substance Abuse Services (1999): *Introduction, Pennsylvania State Mental Hospital Performance Measurement System*. Revised 1/99.

The Pennsylvania Office of Mental Health and Substance Abuse Services is a leader in performance improvement in the area of restraint and seclusion. This material is a description of the data collection and measurement system. A number of performance measures have been developed, including rates of restraint and seclusion. The data are analyzed using control charts. Other data analysis can be conducted on request. The data are compared between psychiatric hospitals

43. Rogers, E M (1995): *Diffusion of Innovation*. 4th ed. The Free Press, New York. This is a classic work that describes how innovations become integrated into the culture. Rogers discusses the varieties of change, for example, change based on technological innovation and change based on policy and regulation. This work gives insight into the current status of innovation in the area of creating restraint-free environments.

44. Sink, D Scott; Morris, William T; Johnston, Cindy S (1995): *By What Method? Industrial Engineering and Management Press, Norcross, Georgia*. 343 pages.

This is a resource for developing the competencies of the organizational change agent. It covers common implementation and deployment problems, the fundamentals of change, the phases of client change, the professional skills of the change agent, integrating professional skills and methods of improvement, and planning and leading large scale improvement efforts.

45. The Association of Maryland Hospitals and Health Systems Quality Indicator Project (1999): *Review of Data Leads to Program to Reduce Use of Restraints and Seclusion*. *Target Quality* (June, 1999), 3.

The Maryland Hospital Association Quality Indicator project is a fifteen year old quality measurement project that has extended to multiple states and numerous hospitals. Target Quality is the newsletter of the project. This article describes the work done at Sheppard Pratt Health Systems in Towson, MD. In response to the analysis of data collected via the Quality Indicator project, The staff at Sheppard Pratt adopted the Triangle of Choices developed by a Utica, NY psychiatric hospital. The tool is used to train staff and assess patients. No evidence has yet been collected to determine the success of the intervention.

46. Wheeler, Donald J (1998): *Avoiding Manmade Chaos*. SPC Press, Inc., Knoxville, TN. 68 pages.

This is a series of articles on the use of quality methodology. As usual, Wheeler's writing is clear, simple and understandable. His primary focus is on the proper use of statistical techniques to avoid adding manmade chaos to work environments. Tampering in the quality field refers to reacting to data in such a way that more chaos is added to the situation rather than improvement. Wheeler describes the proper use of graphs to add real understanding of data rather than obfuscation.

47. Wheeler, Donald J (1993): *Understanding Variation, the Key to Managing Chaos*. SPC Press, Inc., Knoxville, Tennessee. 136 pages.

Donald Wheeler's book is a superb primer on the use of control charts. It describes this crucial analytic tool in common sense language, and with understandable examples. The control chart is the "voice of the process." The process itself, can "speak" to us. The voice of the process is contrasted to the voice of the customer, which includes plans, goals, budgets, targets and all specifications. There are three ways to meet targets: distort the process, distort the data or improve the process. The book focuses on how to use the voice of the process to improve the process. This book is a must-have for anyone who wishes to improve the quality of any product or service.

48. Wheeler, Donald J; Poling, Sheila R (1998): *Building Continual Improvement, a Guide for Business*. SPC Press, Knoxville, Tennessee. 320 pages.

This is a textbook for performance improvement. It provides clearly written and simply presented descriptions of the major statistical methods use in the quality field. In this book, Wheeler introduces his terminology for control charts: process behavior charts. He believes that this terminology provides a better common sense understanding of the purpose of these charts. This book is an excellent text for quality professionals. Wheeler's writing makes the material understandable by those without extensive training in statistics and quality.