Achieving Better Outcomes for Children and Families

REDUCING RESTRAINT AND SECLUSION

Child Welfare League of America • Washington, DC

The Child Welfare League of America is the nation's oldest and largest membership-based child welfare organization. We are committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm.

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Contents

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Introduction

In September 2001, when the Substance Abuse and Mental Health Services Administration (SAMHSA) funded the Child Welfare League of America (CWLA) in partnership with the Federation of Families for Children's Mental Health as the Coordinating Center for the Restraint and Seclusion Training Grant, CWLA members and staff viewed ourselves as experts in the field of behavior support and intervention. After all, we were familiar with the dangers associated with restraint and seclusion, had participated in forming the language of the Children's Health Act of 2000, and had recently finished writing the *CWLA Best Practice Guidelines for Behavior Management* (2002b). Given the breadth of CWLA's experience to date, none of us could have guessed how much we were to learn in the next three years.

In 2001, CWLA did have a thorough understanding of the risk involved with the use of restraint and seclusion. A *Hartford Courant* series of articles had documented 142 reported deaths in the previous decade as a result of restraint and seclusion (Allen, 1998). Of those deaths, 26% involved children—nearly twice the proportion children constitute in mental health settings. CWLA was also aware of the adverse psychological effects associated with restraint and seclusion. Children and adolescents who have been restrained in psychiatric hospitals report painful memories, fearfulness at seeing or hearing others being restrained, and a mistrust of mental health professionals (U.S. General Accounting Office, 1999). It was clear that the long-term, negative consequences of restraint and seclusion far outweighed any short-term benefits gained by their use, except for situations in which imminent danger to either consumers or staff members existed.

We also knew that training alone, without the support of leadership and a shift in organizational culture, would not significantly reduce the number of emergency safety interventions; thus, we changed the name of the grant from the Restraint and Seclusion Training Grant to the Best Practices in Behavior Management Project: Preventing and Reducing the Use of Restraint and Seclusion. Later, in September 2003, we again changed the project's title, this time to Best Practices in Behavior Support and Intervention: Preventing and Reducing the Use of Restraint and Seclusion. This final change reflected the belief that for behavior to be truly managed, the individual must manage it, with the support of skilled caregivers. The evolution of the project name in many ways reflected the advancement of knowledge regarding successful interventions to reduce restraint and seclusion.

Despite our awareness from the outset that training alone would not sufficiently reduce restraint and seclusion, we did not realize the degree of commitment that successfully reducing restraint and seclusion required. The project showed that

- agency leadership must model a sustained commitment to any reduction initiative,
- organizational culture must reflect a person-centered environment and focus on relationship building,
- comprehensive agency policies and procedures must emphasize reducing restraint and seclusion,
- the treatment milieu must demand safety while providing a predictable environment, and
- the agency must have strong continuous quality improvement processes in place.

These lessons were not easily learned, but they have been invaluable as we have begun disseminating our findings to community-based residential treatment facilities, psychiatric treatment facilities, and youth-serving hospitals that are committed to reducing restraint and seclusion.

This monograph provides background on the Best Practices in Behavior Support and Intervention Project, outlines the project's results, details the specific interventions implemented by the project demonstration sites, summarizes promising practices to reduce restraint and seclusion, and provides direction for future research. CWLA's hope is that the reader might benefit from the lessons learned to reduce restraint and seclusion in behavioral health settings nationwide. The safety and well-being of our children and staff members depend on it.

—Lloyd Bullard
Project Director, Best Practices in Behavior Support and Intervention