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Physical Restraints in Residential Facilities: Staff Members' Perspectives

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I am glad to say that I can finally answer positively to people when they asked me the dreaded question, "Are you done with your dissertation yet?"

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Abstract

The use of physical restraints among children and adolescents in residential facilities is a controversial and emotional topic, especially since children are four times more likely than adults to be restrained in a residential setting. In this study, staff members who have restrained children and adolescents in a residential facility completed a 20-question online survey. The intent of the study was to get a clearer picture of residential workers' thoughts, feelings, and perceptions toward restraints as well as their views on how effective they deem their restraint training to be. The information gathered from their answers can be helpful for future training involving the physical management of out-of-control and aggressive behaviors of children and adolescents.

Keywords: physical restraints, residential facilities, perceptions and restraints

Physical Restraints in Residential Facilities: Staff Members' Perspectives

Residential treatment facilities provide educational and mental health services to individuals who can no longer function within their home, community, or school (Anderson & Schwartz, 1986). Many of those placed in residential facilities have a history of property abuse, assault of others, and self-injurious behavior (Brendtro & Ness, 1991). These institutions provide services for individuals who act out through violent and aggressive means (Miller & Georger, 2006). One of the interventions used to diminish aggressive behavior is the use of restraints. The Children's Health Act (2000) defines restraints as "a personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely" (p. 8). Day (2002) also states that physical restraints "involve the use of physical force by one or more staff to restrict the movement of a child, using a variety of holding techniques with the least amount of force" (p. 26). Chemical and mechanical restraints are also used to control an individual's behavior or restrict movement (Fryer, Beech, & Byrne, 2002). This study specifically examines the use of physical restraints for children and adolescents.

Such physical restraint usage is a much-debated topic due to the injuries and deaths that have occurred. It has been reported that 26% of the 142 people who died in incidents related to restraints were children in inpatient settings. Although children account for only 15% of the inpatient population (Farragher, 2004), in some studies, children were found to be four times more likely than adults to be restrained (Alternari, Blint, Weiss, & Megan, 1998). These occurrences are among the over two million young people who have either witnessed or been involved in a restraint (Crespi, 1990). It is thus no surprise that, according to Wright (1999), "The physical management of violence and aggression is a controversial and emotive topic" (p. 459).

Overall, the mental health system is attempting to create a culture where restraint rates are kept at a minimum, with the ultimate goal of eliminating restraints as an intervention (Jonikas, Cook, Rosen, Laris, & Kim, 2004). In order to achieve this goal, many factors need to be considered. One factor that is looked at extensively in this study is the perceptions of physical restraints in residential facilities. Rates of restraint use; effectiveness of training; and thoughts, feelings, and statements about restraints are discussed. As a former residential staff member of multiple residential facilities, I can speak firsthand about the need to talk about both, training, and the perceptions of physical restraints. I first became interested in this topic when it was necessary for me to be restraint trained in the event that I would need to restrain a client. Initially, many negative feelings emerged. I felt at that time that I was not adequately trained in managing my experience of restraining a client. While my views on restraints have evolved over the years, what remains the same is the need to continue to have an open dialogue around restraints, and to ultimately have the end goal be to eliminate restraints. The results of this study are significant because they highlight the need to look deeper into how staff members perceive both restraints, and training to perform restraints. Discussing areas of concern and areas of satisfaction around restraints can eventually lead to changes in the way facilities view restraints, train workers in restraints, and consider how they can reduce any negative experiences associated with restraints (Jonikas et al., 2004).

Literature Review

The following is a review of the literature related to physical restraint use for children and adolescents in residential or inpatient settings. The number of studies conducted on children in residential facilities is limited. More research is thus needed to understand better the experience of physical restraints among this population. This literature review will include: (a)

reasons for restraint use and controls placed on restraints, (b) negative and positive aspects of restraints, (c) theoretical underpinnings, (d) factors associated with restraints, and (e) studies focusing on reducing the number of physical restraints.

Reasons for Restraint Use and Controls Placed on Restraints

According to a review of the literature, the seven most common reasons for restraints are: (a) to prevent harming oneself (b) to prevent harming others, (c) to prevent harming property, (d) to bring a sense of control to the setting, (e) to respond to a rule or noncompliance, (f) to act when other less restrictive methods have been found ineffective, and (g) to promote self-control and coping skills (Day, 2002). In Bell's (1997) qualitative study, three main themes emerged regarding situations in which restraints were used by direct child care workers: (a) where the child did not want to move to a different location, did not want to interact with his or her peers, or did not want to take part in the daily routine of the program; (b) where the child had been a danger to him or herself, others, or property; and (c) where the child had been distressed or angry about something that he or she had been told.

Regardless of the reason for the restraint, professional, ethical, and legal standards must always be addressed. Czyzewski, Sheldon, and Hannah (1986) cite several court cases used to determine the limitations on the use of restrictive procedures such as physical restraints. *Wyatt v. Stickney* (1971) was the first case to address the use of restrictive procedures with developmentally delayed and mentally ill clients. Time limits and staff check-ins were mandated along with clear guidelines that physical or mechanical restraints should not be used in place of another type of therapy or for the convenience of staff members. Czyzewki et al. summarize six parts of the most common court-ordered standards involving restraint procedures:

> 1) A stipulation that the procedures be used only during emergencies and for the prevention of injury to self and/or others. 2) Documentation that less restrictive procedures have been tried and failed, or at least considered and ruled out. 3) A maximum time limit for use. 4) A requirement for written documentation of all parameters (date, duration, evaluation, periodic checks, behavior that initiated the procedure). 5) Clear written procedures and policies explaining the use of these procedures. 6) Conditions under which seclusion and restraint may not be used (e.g., as a punishment procedure for the convenience of staff, or as a substitute for treatment). (p. 206)

The Mental Health Act and the Code of Practice (2001) states that restraining is an effective tool in the clinical environment. However, researchers and practitioners continue to study and question the use of restraints; regulatory agencies and professional groups agree that restrictive measures should only be used when an individual is in danger of harming oneself or others. Wright (1999) similarly argues that physical restraints are not the only strategy for managing violence and aggression. Therefore, staff members at care facilities must not rely solely on this technique. In fact, restraining is viewed as a last resort only if other nonphysical de-escalation techniques have been unsuccessful.

In 1999, The Department of Health and Human Services specified reforms for psychiatric hospitals through the Centers for Medicare and Medicaid Services. Specifically, all staff members were required to be trained in crisis intervention. A licensed practitioner must evaluate a patient within one hour of a restraint, and continued monitoring of the patient should occur (Donovan, Plant, Peller, Siegal, & Martin, 2003).

In October 2003, The Children's Health Act ruled that physical restraints should only be used in emergency situations such as when the immediate physical safety of the client, staff, or others is in jeopardy. The Children's Health Act also ruled that restraints must be implemented by a trained and certified individual (Jones & Timbers, 2003).

While there appear to be strict guidelines for the use of physical restraints, Harris (1996) raises the point that these guidelines may not always be followed. Harris further indicates that physical restraints are sometimes applied on an emergency basis without regard to procedures, durations, or consequences.

Nevertheless, there have been increased regulations and policies concerning physical restraints overall. Data are now being gathered on restraints and seclusion, and family notification of when and why a child was restrained is now being encouraged (Miller & Georgers, 2006). Additionally, some facilities have strict policies for staff training, notifying a client's guardians, having doctor's orders, and processing after the restraint occurred.

Negative and Positive Aspects of Restraints

As previously mentioned, the use of physical restraints among children and adolescents is often debated. Supporters contend that restraints are an effective therapeutic tool with positive clinical outcomes (Day, 2002). For example, Bath (1994) indicates that physical restraints provide external limit-setting and containment so that children can maintain a safe environment without hurting themselves or others. He believes that many children who are ultimately restrained lack the internal control necessary to manage their own behavior, thus requiring an external control. Providing external control through restraints can lead to less property destruction and a decrease in program disruptions. Overall, proponents believe that restraints help children and adolescents with psychiatric disorders learn internal control (Sourander,

Elliala, Valimaki, & Piha, 2002). Moreover, Barlow (1989) and Sourander et al. state that restraining encourages children to verbalize their feelings and use alternative ways to express strong emotions.

Opponents, however, argue that restraints are physically and psychologically damaging to the individual and to the staff, in addition to lacking long-term benefits (Day, 2002). Mohr, Mahon, and Noone (1998) suggest that the use of restraints may lead to abuse if viewed as therapeutic for children and may negatively reinforce aggressive behavior. Murray and Sefchik (1992) as well as Goren, Abraham, and Doyle (1996) agree that restraints do not teach appropriate behavior to children, may encourage the use of force when responding to a conflict, and may actually increase aggressive behavior. Stilling (1992) frames restraints as conflicting with autonomy, which bypasses a client's thinking mechanism and creates a sense of helplessness and loss of control (Lewis, 2002). Opponents are also concerned with the use of restraints for convenience and as a substitute for individualized treatment. Such reactions to physical restraint events are also held by staff. Overall, researchers demonstrate that restraints may easily become part of the culture of the workplace and can be viewed as the primary and easiest form of intervention (Bell, 1997).

Both opponents and proponents view restraints within a framework of abuse. For proponents, not using restraints can be seen as a form of abuse because the child is not protected from harm. Opponents note, however, that when restraints are used, children may view the technique as abuse or punishment. The latter view may also be heightened in children who have a history of physical and sexual abuse (Sourander et al., 2002). Opponents make their arguments on claims of morality and anecdotal evidence, while proponents cite ethical research (Day, 2002).

Attachment Theory

Attachment theory and other psychodynamic theories have been used both to justify and critique the use of restraints (Day, 2002). Attachment theory is based on the premise that the physical contact that comes through being held promotes a positive environment where the child is able to establish bonds. Since, during a restraint, a child is physically held, albeit unwillingly, the child, according to this theory, starts to form a bond with another human because that individual is helping to calm the child. Through restraint, staff is therefore promoting the same bond that primary caretakers form with their child when he or she is in distress.

Using attachment theory, Gair (1980) and Cotton (1989) offer a developmental rationale based on normal socialization processes and children's ego deficits in facilities where restraints were used. Many children who are restrained have been subjected to abuse and neglect and, therefore, lack appropriate socialization skills, have difficult temperaments, and have attention or learning difficulties. Restraints serve as a limit-setting technique that provides containment and protection for out-of-control behavior.

Psychodynamic Theory

Psychodynamic theory is also used to explain negative and positive factors pertaining to restraints. In terms of positives, from a psychodynamic perspective, restraints lead to cathartic releases of anger and the verbal expression of feelings. When children are restrained, they can express strong and often negative feelings in a safe and contained environment. A negative factor associated with restraints is counteraggression. Similar to countertransference, counteraggression is a situation in which residential staff members act on their own feelings of anger and helplessness, rather than what is necessarily good for the child (Day, 2002). Staff may feel helpless or feel as if their authority and autonomy are being compromised by the child's

behavior; thus, a power struggle occurs, which may lead to an unnecessary restraint. Counteraggression may also be problematic because staff may use more intense force, leading to more resistance from the child being restrained, and possible injury (Luiselli et al., 2000).

Behavioral Perspective

Jones and Timbers (2003) provide a behavior analysis perspective on physical restraints. They refer to physical restraints as a transaction between the client and the staff. Jones and Timbers describe the transaction as a cycle that ends with the client being returned to the group, or population, after an incident of escalation/aggression. The cycle is as follows: instruction given →noncompliance/defiance→ instruction repeated→ escalation/aggression →restraint →client subdued/secluded→ episode contained→ client returned to population. The point of the restraint, from a behavioral perspective, is to diminish aggressive behavior. However, Jones and Timber believe that, for both staff and client, restraints may also reinforce other elements, including the reinforcement of certain behaviors or the fulfillment of certain client and staff needs other than the containment of an aggressive client. Some of the common client reinforcers that they identified were power/control, physiological high, staff/peer attention, anxiety reduction, physical contact, sexual contact, escape from boredom, recreation of a chaotic family environment, victim image, peer sympathy, and the opportunity to be aggressive. Some of the possible staff reinforcers were power/control, physiological high, ending the acting out, reputation as an intimidator, sexual contact, peer recognition, retribution, peer sympathy, evidence of serving “tough” children, and spouse recognition/sympathy. Overall, they suggested that restraints may lead to increased aggression, by both staff and client, because of the many reinforcers that occur during the restraint cycle.

Restraints are not the only form of aggression management. The use of seclusion, medication, and verbal de-escalation techniques are all tactics used to help decrease aggression in residential and inpatient settings. Despite the alternative methods to restraining, there seems to be agreement that restraints cannot be completely eliminated from residential and inpatient settings. Because restraints cannot be eliminated, it is important to examine the question of how to train staff working in residential care so that restraints are used in the most ethical and professional manner. This issue is a difficult one, as Wright (1999) notes, because little research has been done on the efficacy and safety of methods used.

Staff members' attitudes, feelings, and experiences related to restraints are crucial to the development of research and have significance for future training. Wright (1999) states that it is important to examine these factors because "the feelings pertaining to staff behaviors and attitudes have obvious implications for training, particularly the management of potentially frustrating and aversive interactions with patients" (para. 1). Ethically, a health care professional's role is to alleviate suffering while promoting autonomy and self-determination (Wright, 1999). Physical restraints often violate that role, even if the restraints are absolutely necessary.

Factors Associated with Restraints

Several researchers have categorized the factors associated with the frequency of restraints (Fryer, Beech, & Byrne, 2003). Specific factors such as gender, age, length of stay at the facility, day of the week, low morale, staff conflict or disruption, and lack of support from administration were identified as being associated with the increased use of restraints (Fryer et al., 2003). Each factor will briefly be discussed; however, research on this topic is limited.

Gender. Males are more likely than females to be physically and verbally aggressive in residential facilities; these behaviors as well as typical restraint protocol make males more apt to be restrained (Fryer et al., 2003). Delaney and Fogg (2005) found that males in psychiatric hospitals are more likely to be restrained than female patients because male behavior is deemed to be more threatening and aggressive. Wynn (2000) further suggests that, due to this perception, staff may have a lower threshold for male aggressive behavior. Male staff members are also more likely to initiate restraints than female staff (Ryan & Peterson, 2004).

Age. Younger children were found to be restrained more often than older children (Fryer et al., 2003), perhaps because of developmental differences in aggressive impulses, an increase in the likelihood that younger children are admitted to facilities for aggression, and staff members' self-perceptions of having a smaller repertoire of de-escalation techniques for younger children (Fryer et al., 2003). In addition, younger children presumably possess fewer frustration tolerance skills compared to adolescents and adults. Younger children are also viewed by staff as being easier to restrain than older children who are often physically larger and may be viewed as more intimidating or difficult to restraint.

Diagnosis. Sourander et al. (2002) found that children who have conduct/oppositional disorders, attachment disorders, and disorders from the autistic spectrum were more likely to be restrained than children with other diagnoses. They also found that people with the diagnosis of mental retardation, developmental disabilities, and borderline personality disorder were more likely to be restrained than those who did not meet DSM-IV criteria for those disorders. In another study, Delaney and Fogg (2005) also found that patients with disruptive behavior disorders and psychotic disorders were more likely to be restrained than patients with other diagnoses. They suggest that this likelihood may be because individuals with psychotic disorders

or symptoms are hospitalized more often due to the complex nature of their treatment and are viewed as less manageable than the average person.

Length of stay. Garrison (1984) found that longer duration in an inpatient setting was correlated with more restraints. Delaney and Fogg (2005) also found that patients with a longer length of stay at a psychiatric hospital and patients with previous hospitalizations were more likely to be restrained than clients with shorter lengths of stay and no previous hospitalizations. Delaney and Fogg attribute this finding to the possibility that patients who have longer stays at the hospital and prior hospitalizations are more likely to have more serious emotional disturbances. They also hypothesize that patients who stay longer at psychiatric hospitals often are from underserved minority populations that generally receive fewer outpatient services before and after discharge.

Timing. Restraint use occurs more often on busier days in inpatient facilities, such as weekdays, mornings, evenings, and times of transitions (Fryer et al., 2003). In a qualitative study conducted by Bell (1997), times of transition were defined as returning from school, mealtimes, and bedtimes. Children are restrained more during times that are more demanding due to higher levels of staff and client interactions. One study found higher occurrences of restraints on Mondays and Fridays compared to the middle of the week (Ryan & Peterson, 2004), due possibly to anxiety about the upcoming weekends, which for some children may mean visits or other unstructured activities (Ryan & Peterson, 2004).

Staff concerns. Fryer et al. (2003) examined staff concerns about restraints. Many staff members working in residential facilities felt that restraints were used more frequently when staff perceived the facility to be an unsafe place to work. Staff also thought that when communication was poor between other staff members, the use of restraints was more likely.

Lastly, staff felt that more restraints occurred when they had a lower tolerance of noncompliance and verbal threats from the children (Freyer et al., 2003).

Setting. Persi and Pasquali (1999), as cited in Ryan and Peterson (2002), conducted a study tracking the frequency of restraint use among 281 children, ages 4 to 17, who were in four different settings: a psychiatric inpatient unit, a residential group home, a day treatment program, and a day treatment program located in the community. The number of restraints varied greatly among settings.

Social service factor. Delaney and Fogg (2005) identified another factor in their study on the trends of physical restraints in psychiatric hospitals, finding that patients who were in the custody of social services had a higher incidence of restraints. They attributed this incidence to patients having multiple caregivers as well as difficulty controlling their aggression and regulating their emotions.

Studies Focused on Reducing Physical Restraints

This literature review has thus far discussed the definition of restraints, arguments for and against restraints, theoretical underpinnings of the crisis intervention technique, and factors that may contribute to the use of restraints in residential and inpatient psychiatric facilities. A brief discussion of the studies aimed at reducing the number of restraints will now be discussed.

Crosland, Dunlap, Sager, Neff, Wilcox, Blanco, and Giddings (2008) conducted a study evaluating the effectiveness of a behavioral staff training program for reducing the number of restrictive interventions, including the use of restraints. The training took place at two locked residential facilities in Florida, with a total of 44 staff members taking part. The training curriculum consisted of a 15-hour module. The skills taught were based on positive parenting skills, with an additional coaching element to help staff execute the skills they learned in their

training. Crosland et al. (2008) found that the number of physical holds and "take-downs considered physical restraints in this study—at both facilities decreased after training was completed. Thus, staff training focusing on positive interactions with children in placement can lead to a decrease in physical restraints, according to the researchers. However, this study only had a 3-month posttraining phase and did not examine the long-term effects of the training.

Jonikas et al. (2004) also conducted a study of methods for decreasing the use of restraints. They studied three inpatient settings: an adolescent hospital unit, a general adult population unit, and a third unit enrolled in clinical trials. The study involved two components: (a) interviewing patients to identify triggers of stress and strategies to manage personal crises as well as creating a unique crisis intervention plan; and (b) staff training in nonviolent intervention that focused on teaching staff members nonviolent ways to manage aggressive behavior. All three units experienced a reduction in the number of physical restraints used following this intervention (all restraint rates declined by 97 to 99 percent) and remained low throughout the year following the study.

Research Question

A review of the literature indicates a goal for many residential facilities is to decrease the amount of restraints occurring with children and adolescents. Research has indicated that with increased training restraint rates decline. The majority of the studies found for this study were focused on factors leading to the use of restraints as well as the theoretical underpinnings of the use of restraints. Only one study was found that specifically asked staff members for their view on restraints (Fryer et al., 2003). Understanding staffs' views on restraints and training can help facilities develop more detailed and targeted trainings to help decrease the use of restraints with children and adolescents.

This study thus asked restraint-using staff questions based on the themes that emerged in the literature about their experience restraining children. The research question is as follows: What are staff members' perspectives on the use of physical restraints in residential child and adolescent settings? Possible outcomes of this study are a better understanding of the experience of staff when restraining and information to develop better training models for staff in residential settings. The more effective training can be for staff, the higher the likelihood that restraint rates may be low or eventually be eliminated.

Methodology

Participants. Staff members working in residential facilities for children and adolescents were recruited as participants in this study; therefore, a purposive sample was used. In order to recruit participants for this study, an email message was sent to the directors of multiple residential treatment facilities or units for children and adolescents. The residential facilities involved in the study were located in Massachusetts and New Hampshire and were chosen based on this researcher's knowledge of current residential facilities in these states. The email (see Appendix A) described the purpose of the study and included a link to a survey that could be completed online. Directors were asked to forward the email to their employees who worked in child or adolescent residential settings. The link included a description of the study, implied consent, and the survey.

Data were collected over a one-month period. Within one month, 63 participants completed the survey; however, the actual response rate is unknown due to the anonymity of the survey. All participants were 18 years of age or older and were current employees of a residential facility working with children or adolescents. Additionally, all participants were fluent in English

and had Internet access, as the survey was written in English and the data were collected using an Internet survey.

Data collection procedures. Data were collected using a 20-question survey focusing on issues pertaining to staff member's views on restraints. Survey questions had been formulated based on findings in the literature review about training and factors related to the use of physical restraints in residential facilities. The survey was written by this author, approved by the University Internal Review Board (IRB), and was placed on Survey Monkey. Participants accessed the survey via an online link that included an informed consent form (see Appendix B).

The survey consisted of basic demographic questions, questions concerning training to use physical restraints, and questions concerning staff members' thoughts and feelings surrounding restraints. Some of the questions used a Likert-type scale, while others required the participant to check a box to select one of several options. All questions were closed-ended and quantitative in nature, with the survey taking approximately 10 minutes to complete. Participants were asked to complete the survey at a convenient time when they had access to a computer and the Internet (see Appendix C for the survey). The survey was posted on Survey Monkey for one month. The participants' responses were anonymous and were only seen by this researcher. All results are presented in aggregate form.

Ethical considerations. The three primary ethical considerations, according to Fontana and Frey (2003), are informed consent, right to privacy, and protection from harm. As mentioned earlier, the study included an informed consent form (see Appendix B) at the beginning of the survey. Participants were required to read and agree to this information before progressing to the actual survey. This survey had no known risks and posed no major harm to participants. Thinking about restraints may have caused some discomfort, but no more than on a typical day at

their job. This survey was voluntary, and participants had the option to end at any time without penalty. While participants were recruited by their directors from their places of employment, it is important to know that participants were anonymous, and responses were not shared with employers or identified by place of employment. Employers did not know if an employee had participated in the research survey or not.

Data analysis. The aim of this study was to gain some understanding concerning the perceptions of staff members in residential facilities with regard to the use of physical restraints with children and adolescents. Descriptive statistics were used to summarize the frequency of responses to each question. Frequencies, means, and standard deviations were calculated and are presented in the following chapter.

Results

Forty-seven emails were sent to various directors of residential facilities in New Hampshire and Massachusetts. It is unknown how many prospective participants received the email with the link to the survey due to its anonymous character. Overall, 63 participants started the survey. One refused to provide informed consent and, therefore, was ineligible to complete the survey. Fifty out of the 62 participants answered all survey questions. All participants' answers were used to calculate the results, even if a participant did not answer all of the questions. The number of participants who answered each question is indicated in the tables throughout this section.

Demographic Information. Participants were asked to provide the following demographic information: gender; age; total years working in a residential facility; number of years working with children, adolescents, and adults; and education level (see Tables 1–3 for demographic data). The majority of participants were female (63.6%). The mean age of

participants was 35 years, with a standard deviation of 1.17, while the mean total number of years working in a residential facility was 10.04 years, with a standard deviation of 9.46. Furthermore, the participants' mean number of years working with children was 8.02, with a standard deviation of 8.77; the mean number of years working with adolescents was 9.84, with a standard deviation of 8.59; and the mean number of years working with adults was 3.42, with a standard deviation of 5.09. Most participants held a Bachelor's Degree (47.1%) or a Master's Degree (41.2%).

Table 1

Participants' Gender

Variable	*n*	%
Gender		
Male	20	36.4
Female	35	63.6

Table 2

Age, Number of Years Working in Residential Care, and Number of Years Working With Each Population

Variable	*n*	*M*	*SD*
Age	53	35.18	1.17
Year working in a residential facility	50	10.4	9.46
Years working with each population			
Children	42	8.02	8.74
Adolescents	50	9.84	8.59
Adults	31	3.42	5.09

Table 3

Participants' Educational Level

Variable	*n*	%
Education level		
Attended, but did not graduate high school	0	0
High school or GED	3	5.9
Associate degree	3	5.9
Bachelor's degree	24	47.1
Master's degree	21	41.2
Doctoral degree	0	0

Survey Questions

After obtaining the demographic information of survey participants, the following information was gathered to understand better participants' experiences in restraint methods and training and to garner participants' thoughts and emotions when restraining.

Restraint training and effectiveness. The overwhelming majority of participants (n=51, 96.2%) stated that their facility had a written restraint policy, they knew where to find the written restraint policy (n= 49, 96.1%), and they received restraint training when they started their current job (n=51, 96.2%). The mean number of hours of the initial training was 16.13, with a standard deviation of 14.01, with results ranging from 4 to 64 hours. Most participants received refresher courses in restraint training (n= 46, 92%); the majority of those who received refresher courses had them on a yearly basis (n=49, 94.2%). A large percentage of participants' training included techniques for verbal de-escalation (n=53, 98.1%). When participants were asked to

rate their overall restraint training on a scale of 1 to 5 (1 = *not effective* and 5 = *very effective*), 42.6% (n=23) rated their training as a 5 (*very effective*) and 38.9% (n=21) rated their training as a 4. When participants were asked to rate the effectiveness of training in verbal de-escalation techniques, 31.3% (n=15) rated their training as a 5 and 37.5% (n=18) rated their training as a 4 (see Tables 4–7 for frequencies and percentages).

Number of restraints, injuries, and support. Participants were asked to estimate the times they had spent over the last six months, restraining alone, restraining with a partner or multiple people, verbally de-escalating alone, and verbally de-escalating with a partner or multiple people. The mean number of times that participants restrained alone was 0.20, with a standard deviation of 1.15, ranging from 0 to 8 times. Ninety-four percent (n=48) did not restrain alone, 4% (n=2) restrained alone one time, and 2% (n=1) restrained alone eight times. The mean number of times that participants restrained with a partner or multiple people was 3.85, with a standard deviation of 5.57, with results ranging from 0 to10 times. Twenty-four percent (n=12) did not restrain at all with a partner or multiple people. Twenty percent (n=10) restrained with a partner or multiple people two times, 12% (n=6) restrained one time with a partner or multiple people, 12% (n=6) restrained 10 times with a partner or multiple people, 10% (n=5) restrained three times with a partner or multiple people, and 8% (n=4) restrained four times with a partner or multiple people. Lastly, 2% (n=1) restrained 8, 12, 20, or 30 times.

In contrast, the mean number of times that participants verbally de-escalated alone was 21.60, with a standard deviation of 35.15, ranging from 0 to 180 times. Nineteen percent (n=8) did not de-escalate alone at all, while 14% (n=6) de-escalated alone 50 times, and 12% (n=5) de-escalated alone 5 or 10 times each. Six percent (n=3)

de-escalated alone 2 two times and 5% (n=2) de-escalated alone 4, 20, or 100 times each. Finally, 2% (n=1) de-escalated alone 1, 6, 35, 50, 60, or 180 times each. The mean for verbally de-escalating with a partner or multiple people was 18.83, with a standard deviation of 30.32, ranging from 0 to 150 times. Sixteen percent (n=7) de-escalated with a partner or multiple people 10 times, 9% (n=4) de-escalated with a partner or multiple people 3 times, 6.8% (n=3) de-escalated with a partner or multiple people 0, 2, 3, 5, 12, 20, 25, or 100 times each, 4.5% (n=2) de-escalated with a partner or multiple people 1, 4, 19, 30, or 50 times each (see Table 8 for means and standard deviations).

Table 4

Restraint Policy

Variable	*n*	%
Does your facility have a written restraint policy?		
Yes	51	96.2
No	1	1.9
Don't know	1	1.9
Do you know where to find the policy?		
Yes	49	96.1
No	2	3.9
Don't know	0	0

Table 5

Restraint Training

Variable	*n*	%	
Did you receive restraint training when you started your current job?			
Yes	51	96.2	
No	2	3.8	
Did your training include techniques for verbal de-escalation?			
Yes	53	98.1	
No	1	1.9	
	n	*M*	*SD*
Total hours of restraint training	46	16.13	14.01

Table 6

Number and Percentage of Participants Who Received Refresher Restraint Training and Frequency of Refresher Courses

Variable	*n*	%
Do you receive refresher courses in restraint training?		
Yes	46	92.0
No	4	8.0
How often do you receive refresher courses in restraint training?		
Monthly	0	0
Quarterly	3	5.8
Yearly	49	94.2

Table 7

Effectiveness of Restraint and Verbal De-escalation Training

Variable	*n*	%
How would you rate your training?		
1-Not effective	0	0
2	2	3.7
3	8	14.8
4	21	38.9
5-Very effective	23	42.6
How would you rate your training in verbal de-escalation techniques?		
1-Not effective	0	0
2	5	10.4
3	10	20.8
4	18	37.5
5-Very effective	15	31.3

Table 8

Number of Restraints and Use of Verbal De-Escalation Techniques

Variable	*M*	SD
The number of times you restrained alone	0.20	1.15
The number of times you restrained with a partner or multiple people	3.86	5.57
The number of times you verbally de-escalated alone	21.60	35.16
The number of times you verbally de-escalated with a partner or multiple people	18.83	30.32

Thirty three participants (64.7%) stated that they had not been physically injured during a restraint. Eighteen participants (35.3%) stated that had been physically injured during a restraint. When asked on a scale of 1 to 5 (1 = *not supported at all* to 5 = *very supported*) how they rated their experience of being supported by their direct supervisor after a restraint, 34.0% (n=17) of participants rated this question a 5 and 36.0% (n=18) rated it a 4 (see Table 9 for percentages and frequencies).

Table 9

Support by Direct Supervisor After a Restraint

Variable	*n*	%
How do you rate your experience of being supported by your direct supervisor after a restraint		
1-Not supported at all	2	4.0
2	4	8.0
3	9	18.0
4	18	36.0
5-Very supported	17	34.0

Feelings during last restraint. Participants were asked to think back to their last restraint and check off feelings that they experienced during that restraint. There was a section labeled "Other feelings" for participants to add their own feelings if they felt that the ones provided were not adequate. Overall, five feelings emerged with the highest percentage. The feeling with the greatest response was "in control" (n=36.75%), followed by "competent" (n=29, 64%), "calm" (n=24, 43.8%), "worried" (n=21, 43.8%), and "frustrated" (n=15, 31.3%). Six participants (12.5%) felt sad, five participants (10.4%) felt afraid, and four participants each (8.3%) felt vulnerable, excited, or uncertain. Two participants (4.2%) felt positive. Two participants added their own feelings. One participant stated that he or she felt "anxious," and one participant stated that he or she felt "traumatized." Out of the 16 feelings provided, four received a response of 0% (terrified, happy, detached, and helpless) see Table 10 for percentages and frequencies.

Table 10

Percentage and Frequency for Feelings Felt at Last Restraint

Variable	*n*	%
In control	36	75
Competent	29	60.4
Calm	24	50.0
Worried	21	43.8
Frustrated	15	31.3
Sad	6	12.5
Afraid	5	10.4
Vulnerable	4	8.3
Excited	4	8.3
Uncertain	4	8.3
Positive	2	4.2
Terrified	0	0
Happy	0	0
Detached	0	0
Helpless	0	0
Other Feelings:		
Anxious	1	2.1
Traumatized	1	2.1

Thoughts during last restraint. Participants were asked to think back to their last restraint and check off what they were thinking. Participants were also given the option to add other thoughts they had during their last restraint. The two responses that generated the highest percentage involved the issue of protecting others' safety. Thirty-eight participants, or 77.6% of them, indicated that they were "Pretty sure they needed to do this for the safety of others," and 32 participants, or 65.3% of them, indicated that they were "Pretty sure they needed to do this for the client's safety." The next set of thoughts that generated the highest percentage of responses involved the staff member "Wondering what the client was feeling" (n=28, 57.1%) and "Wondering what the client was thinking" (n=26, 53.1%). Eighteen people (36.7%) stated that they were "Worried I might hurt the client while restraining him/her." Thirteen people (26.5%) were "Pretty sure I need to restrain to prevent property abuse." Twelve (24.5%) were "Concerned whether or not there are any safety hazards that could cause the restraint to be unsafe." Eleven people (22.4%) were "Worried I might get hurt restraining the client." Lesser endorsed thoughts about restraints are indicated in Table 11. Three participants selected "Other thoughts." Those thoughts were "Confident that it was to prevent a client from harming herself and others," "Worried about others who were hurt," and "Wishing that this could have been avoided." The three thoughts that received no responses were "Worried I might get in trouble for restraining the client," "Wonder if I like doing this," and "Wondering if I am doing this out of feeling helpless about the situation" (see Table 11 for all percentages and frequencies).

Table 11

Percentage and Frequency for Thoughts at Last Restraint

Variable	*n*	%
Pretty sure I need to do this for the safety of others	38	77.6
Pretty sure I need to do this for the client's safety	32	65.3
Wondering what the client is feeling	28	57.1
Wondering what the client is thinking	26	53.1
Worried I might hurt the client while restraining them	18	36.7
Pretty sure I need to do this to prevent property abuse	13	26.5
Concerned whether or not there are safety hazards that could cause this restraint to be unsafe	12	24.5
Worried I might get hurt restraining the client	11	22.4
Not sure if this is the best way to help the client in this situation	6	12.2
Wondering if this is the best place to be doing the restraint	6	12.2
Wondering if I am trying to show that I am in control	4	8.2
Wondering if I am doing the right thing	3	6.1
Not sure if I should be restraining this client	2	4.1
Concerned whether or not I am doing this restraint correctly	2	4.1
Wondering if I know how to do this	2	4.1
Wondering if this is the best time to be doing the restraint	1	2.0
Wondering if I am restraining the client so they will follow directions	1	2.0
Worried I will get in trouble for restraining this client	0	0
Wondering if I like doing this	0	0
Wondering if I am doing this out of feeling helpless about the situation	0	0
Other thoughts:		
Confident that it was to prevent a client from harming himself and others	1	2.0
Worried about others who were hurt	1	2.0
Wishing that this could have been avoided	1	2.0

Statements about restraints. The last section of the survey asked staff to rate, on a scale of 1 to 5 (1 = *strongly disagree* to 5 = *strongly agree*) statements about restraints. Several statements are noteworthy. Forty-three participants (86%) rated "Training is necessary for an effective physical restraint" as a 5 (*strongly agree*), with a mean of 4.72 and standard deviation of 0.86. Twenty-seven participants (54%) rated "No one should restrain alone" as a 5 (*strongly agree*), with a mean of 4.14 and a standard deviation of 1.24. Thirty-three participants (67.3%) rated "Restraints are a 'power trip' for staff" as a 1 (*strongly disagree*), with a mean of 1.4 and standard deviation of 0.79. Thirty three participants (66%) rated "Youth should be restrained for refusal to move" as a 1 (*strongly disagree*), with a mean of 1.54 and standard deviation of 1.06 (see Table 12 for all frequencies, percentages, means, and standard deviations).

Table 12

Descriptives for Statements About Restraints

Survey Item	% (*n*)					*M*	*SD*
	1= Strongly disagree	2	*3*	*4*	5= Strongly agree		
Restraints are a "power trip" for staff.	67.3 (33)	24.5 (12)	6.1 (3)	0.0 (0)	2.0 (1)	1.45	0.79
Youth should be restrained for refusal to move.	66.0 (33)	22.0 (11	6.0 (3)	4.0 (2)	2.0 (1)	1.54	0.93
Some staff members restrain younger children more because they are easier to restrain than older children.	48.0 (24)	24.0 (12)	20.0 (10)	2.0 (1)	6.0 (3)	1.86	1.07
Restraints represent a failure by staff to anticipate negative events.	46.0 (23)	26.0 (13)	13.0 (8)	6.0 (3)	6.0 (3)	2.00	1.19
Some staff members restrain male clients more than female clients because male clients are usually more physically aggressive than female clients.	35.4 (17)	22.9 (11)	33.3 (16)	6.3 (3)	2.1 (1)	2.17	1.06
Children should never be restrained.	38.0 (19)	26.0 (13)	20.0 (10)	10.0 (5)	6.0 (3)	2.20	1.24

(table continues)

Table 12 (continued)

Survey Item	% (*n*)					*M*	*SD*
	1= Strongly disagree	2	3	4	5= Strongly agree		
Restraints occur because of staff being undertrained in alternative methods.	26.0 (13)	38.0 (19)	26.0 (13)	4.0 (2)	6.0 (3)	2.26	1.08
Youth should be restrained to prevent property destruction.	28.6 (14)	30.6 (15)	24.5 (12)	12.2 (6)	4.1 (2)	2.33	1.14
Restraints are used too often.	20.0 (10)	34.0 (17)	36.0 (18)	4.0 (2)	6.0 (3)	2.40	1.07
Restraints occur more when staff members are unable to communicate properly with one another.	26.0 (13)	32.0 (16)	22.0 (11)	14.0 (7)	6.0 (3)	2.42	1.20
Youth should be restrained to prevent them from running away.	16.0 (8)	20.0 (10)	44.0 (22)	18.0 (9)	2.0 (1)	2.70	1.02
Clients gain a sense of safety and security when they are restrained.	12.0 (6)	18.0 (9)	54.0 (27)	12.0 (6)	4.0 (2)	2.78	0.95
Clients are helped by physical restraints.	10.0 (5)	22.0 (11)	44.0 (22)	20.0 (10)	4.0 (2)	2.86	0.99

Discussion

The purpose of this study was to obtain a better picture of residential care workers' views about their restraint training as well as their thoughts, feelings, and perceptions with regard to the use of restraints. The study was informed by the limited literature available on these topics, and a survey was created using existing empirical data. This chapter presents a discussion of the findings of the survey, examines the clinical implications for potential training topics, and explores the limitations of this study. Future research directions will also be discussed.

Summary and Key Findings. The results of this study indicated more positive attitudes toward training and the use of restraints than expected. A review of the literature indicated that there is a need to decrease the number of restraints in residential facilities, as well as improve future training of staff working with children and adolescents in residential facilities. However, results of the study indicated restraint rates were extremely low and participants thought that their training was very effective. While no current restraint rates for residential facilities in Massachusetts, New Hampshire, or on a National level were found while conducting the literature review, several studies looked at specific agencies or provided information on how restraint rates have decreased with increased training. A recent review of the literature on restraints conducted in 2011 found an average of 29% of clients being restrained in residential or inpatient settings (De Hert, Dirix, Demunter, and Correll, 2011). However, the percentage of clients restrained is not comparable to the number of residential staff who restrained clients in this survey.

The thoughts, feelings, and statements that participants endorsed were also overwhelmingly more positive than expected. The overall positive attitudes of participants in this current study may be an indication that facilities over the last ten years have increased their

training, and may be striving for a restraint-free culture within their agencies. However, this is just an interpretation and no direct relationships between training and restraint rates were examined in this study. Other possible interpretations of the results of the study will be discussed below.

Overall, participants in this study rated their training in physical restraints and verbal de-escalation techniques as very effective, but felt that their training in physical restraints was more effective than their training in verbal de-escalation techniques. Most participants received not only initial training that included verbal de-escalation techniques but also yearly refresher courses. It is significant to note that training included not only physical but also verbal techniques to help manage aggressive behaviors in children and adolescents. Almost all participants knew where to find their agency's written restraint policy and felt supported by their direct supervisor after a restraint.

The results of this study are in line with the current requirements from the Department of Health and Human Services that state that all staff members be trained in crisis intervention (Donovan et al., 2003). Studies focusing on reducing physical restraints have shown that, with increased training, and with training that included nonphysical interventions, the number of restraints decreased (Jonikas et al., 2004). It is important that residential facilities continually obtain feedback on the perceived effectiveness of their staff training, and include training in both physical and verbal de-escalation techniques to manage aggressive behavior, to keep the rate of restraints low.

The rates of physical restraint use found in this study were surprisingly low, for both single-person and partner or group restraints. The rates for verbal de-escalation techniques were also low, but higher than restraint rates. This noticeable difference suggests two possibilities; (a)

staff may prefer a less invasive technique to manage aggressive behavior or (b) staff attempted verbal de-escalation prior to physical restraint and found it to be successful in many cases, thereby, avoiding physical restraints. The range was larger for the number of times staff verbally de-escalated alone than it was for the number of times staff physically restrained alone, which is intuitive, since verbal de-escalation is physically less dangerous than physical restraint. Staff workers may be hesitant to restrain alone due to higher chance of injury, and a higher likelihood for a lawsuit to occur. Staff may also be hesitant to restrain alone due to difficulties being able to monitor and access the child or adolescent's physical and psychological well-being, while at the same time physically holding the individual (Child Welfare League of America, 2004).

Furthermore, most participants agreed that training is necessary for an effective restraint and that no one should restrain alone. In fact, the majority of participants did not restrain alone. If a person restrains alone, it may lead to restraints being applied without regard to procedures, duration, and consequences, because they are not communicating with another staff member over how to handle a situation that may or may not require a physical restraint (Harris, 1996). Partner or group restraint is preferred because of the increasingly strict guidelines and protocols that residential placements facing when reporting to the client's guardians (Miller & Georgers, 2006). If there are multiple staff members involved, there may be more accurate reporting of incidents, as well as a witness available if a client or guardian makes a complaint, or if an injury occurs during the restraint.

Another interesting finding was that, although the feelings that staff experienced during a restraint varied widely, the three feelings that had the highest frequencies of occurrence were positive feelings (e.g., in control, competent, and calm). The positive feelings may indicate that staff felt prepared for the restraints and had the necessary training for a restraint. If a staff

member is able to model feeling "competent," "calm," and "in control," then clients may follow suit, leading to less escalation of problematic behavior, and fewer behaviors that would initiate the use of restraints. Staff may have felt differently when they restrained alone, versus when they restrained with a partner or group. However, this survey did not differentiate between the experience of restraining alone or with multiple people. Perhaps more negative feelings would have been endorsed when restraining alone, compared to restraining with a partner or group. Examples of those negative feelings that could have possibly been endorsed more frequently, if asked what they felt restraining alone, would be "uncertain," "vulnerable," "helpless."

Two other feelings were also highly endorsed: "worried" and "frustrated." Feeling worried and frustrated may lead to what Day (2002) called "counteraggression" or staff acting on their own negative feelings, which may lead to an unnecessary restraint. Further inquiry about what the staff was worried or frustrated about would be helpful, as well as data on the frequency of restraints when specific feelings are experienced during an earlier restraint.

The four most significant thoughts acknowledged by staff on the survey were "concern for the safety of others," "concern for the safety of the client," "wondering what the client was feeling," and "wondering what the client was feeling". These concerns may influence staff members' decisions about whether to physically restrain or verbally de-escalate clients. The concern for the client's safety, the safety of others, and for what the client is feeling and thinking may suggest that staff overall feel empathy for clients, and may be trying to create what the Children Welfare League of America (2004) calls a person-centered environment. In a person centered environment, staff are trying to create a safe environment, where each client is looked at from an individual standpoint, and where the staff can approach clients from a collaborative, rather than a controlling manner.

It is important for staff to think about the safety of their clients, and others around them. Sometimes physical restraints may be what the client needs at that time, in order to safely calm down, without seriously hurting themselves, other residents, or staff. Ziegler (2004) highlights several therapeutic values of physical restraints that staff may be thinking about when making the decision to either verbally de-escalate or physically restraining a client. Ziegler (2004) believes that physical restraints can be therapeutic if staff implement them properly, and with the client's best interest in mind, rather than as standard treatment. Therapeutic benefits include giving reassurance to an acting out child and others in the environment that an adult can safely manage a situation, adults not placing all the responsibility to a child to calm down, especially if they have serious emotional disturbances, and helping traumatized children realize that not all forms of touch end in abuse.

Furthermore, counter to the findings in the literature, the majority of participants in this study strongly disagreed that restraints were a power trip for staff and strongly disagreed that youth should be restrained for refusal to move. The results of this study show that staff appear to be following the protocol that restraints should be used as a last resort, and not arbitrarily or just for convenience.

Clinical Implications

The clinical implications of this study are a better understanding of staff experience, which can inform future trainings and continued reduction in the use of restraining, perhaps moving toward elimination of the practice. Many residential facilities have formed restraint committees focusing on decreasing the number of physical restraints and creating programs through which staff become aware of what may trigger restraints in children and adolescents ("Achieving Better Outcomes, 2004). Restraint committees can serve as a way to study what is

helpful and useful to staff, as well as to monitor factors related to restraint within the facility (e.g. tracking overall restraint rates, identifying clients who are restrained more than others, effectiveness of training, peak times for restraints).

In order to inform future trainings it is necessary to know what was covered in staff trainings, and what was particularly helpful to staff. While there is no way of knowing what program or training protocol staff members took part in, the overwhelming majority of clients found their training program effective. Couvillon, Peterson, Ryan, Scheuermann, and Stegall (2010) conducted an Internet search and found 22 programs that offer training in crisis de-escalation procedures. They found that the amount of time for basic training varied considerably, although most programs were between 12 to 16 hours. The major topics discussed in trainings were consistent, but each program put more emphasis on different topics. The six components that Couvillion et al. (2010) focused on were general information and definitions of restraints, crisis antecedents and de-escalation, restraint procedures, restraint monitoring procedures, debriefing and follow up, and other additional training topics. The most significant difference found between the 13 training programs that took part in the study was the emphasis placed on restraints versus conflict resolution skills and de-escalation skills. Four out of the 13 training programs focused approximately 50% of their training time on crisis antecedents and de-escalation techniques (Nonviolent Crisis Intervention-NCI, Professional Assault Crisis Training ProAct, Therapeutic Crisis Intervention-TCI, and Satori Alternatives to Managing Aggression). Overall, restraint monitoring procedures and debriefing and follow up issues were the two components of training that all 13 programs spent little to no time covering (0 to 2.8 hours).

What needs to be looked at further is how much emphasis is placed on each component of training. One main topic that appears to be of great importance is debriefing clients and staff

after a restraint. The goal of debriefing is to minimize post-restraint stress and to review and see if a restraint can be avoided in the future, under similar circumstances. It is surprising that training programs focus so little of their time on debriefing considering that national standards for restraints (Child Welfare League of America, 2004) state that debriefing must occur within 24 hours after the use of a restraint and that staff and client involved must have a face-to-face discussion. A recent study by Brown et al. (2012) also found that only 34% of residential facilities always debriefed their clients and staff after a restraint.

Debriefing staff and clients on how they felt, what they were thinking, and overall themes of how they view restraints can only help better understand how to minimize restraints and to prevent further restraints from occurring. Debriefing can also lead to staff receiving the support they need from supervisors and coworkers if they are feeling uncertain or uneasy about restraints. Also, debriefing is necessary for the staff to engage in trauma informed care with their clients. Paying attention to what the client is thinking and feeling (two items that staff members generally endorsed in this survey) leads to a better understand of how a client's past trauma may play a role in the restraint.

It is also clinical necessary for staff to develop alternatives to restraints, as well as offer alternatives to verbal de-escalation techniques to help clients calm down in a safe and controlled manner. Examples of alternatives to restraint are offering clients a safe and quiet space to calm down such as a time out room, sensory tools such as weighted blankets, or giving clients preidentified objects that have been identified as calming to the client.

Limitations of the Study

There are several limitations to this study. For one, it had a small sample size (n = 63), and only 50 of 63 participants completed all of the questions. Correlations between demographic

factors and survey responses could not be calculated in this study due to little variance in variables such as level of education and frequency of refresher courses. Future research might include a larger sample, which could be obtained by including a larger geographical area or eliciting engagement through national associations.

In addition, a large percentage of participants had earned bachelor's and master's degrees and had worked in their job for an extended period of time and with each population longer than expected. This background may have indicated participants were not representative of residential care workers and may have been in supervisory or trainer roles. Trainers and supervisors may have also had a greater interest in taking the survey than those staff who are not in such roles. If in fact, a number of respondents were supervisors or trainers, cognitive dissonance may have played a role in the positive attitudes about restraints and training found in this study. Staff members, especially if they were supervisors or trainers, may have endorsed the more positive thoughts, feelings, and statements in the survey because of their roles in conducting training and enforcing policies regarding restraints. More negative feelings might have conflicted with their being comfortable with what their job as a trainer or supervisor entails. Naturally, participants would want to endorse more positive thoughts, feelings, and statements in order to look good, feel that they are doing the right thing, and show that they are doing their job successfully as a residential supervisor.

The method for data collection also may have limited the participants who took the survey. Because the survey was completed using Survey Monkey, an on-line survey tool, it was necessary for the participant to have access to a computer, as well as the internet. Residential care workers usually interact directly with children and adolescents for the entire length of their shift, and may not have time or access to a computer at work to take the survey. Supervisors or

trainers may have had more time and access to a computer during their normal work day. Participants with a higher socio-economic status may have also been indirectly favored, due to the need to have a computer and internet access at home, if a participant was not able to complete the survey during work. Participants with higher education and literacy levels may have also been indirectly favored due to the reading level required to take this survey.

No matter what their specific role or title, more experience in the field may mean that staff were better at deescalating clients, and/or were satisfied with their training and jobs. More experience with children and adolescents in residential facilities may have led to better job performance, or perhaps those staff members were already very good at their job and stayed in the field longer. To clarify this possibility, it would have been useful to include in the demographic section a request to include their position at the residential facility, and ratings of effectiveness and job satisfaction. Interpretation of the results would have been clearer if we understood these factors more fully.

Many of the participants had not conducted a restraint at all within the last six months. While this may be a desirable state of affairs, it may not have given the most accurate and current view of how a staff member feels and thinks about restraints. It is also unknown the last time each participant actually engaged in a restraint. Memory may fade over time, and therefore some of the thoughts, feelings, and statements endorsed are based on retrospective data, rather than prospective data in real time.

Lastly, it is also unknown whether participants were from one or multiple agencies. The culture around restraints may vary from one residential facility to another. However, the anonymity of the survey precluded knowing where each participant worked.

Recommendations for Future Research

While this study did answer the question asked, it also brought up many more questions to be explored in future research. This study provided a glimpse into the way staff in residential facilities view physical restraints for children and adolescents. However, further research with a much larger sample is needed. Creating a study comparing the perceptions of physical restraints from the staff's perspective to that of the child or adolescent would also be useful. Such a study could be done using a similar survey method or interviews with each group.

The use of interviews to gather qualitative data might help clarify the phenomenological experience of what it is like to restrain as well as to be restrained. An interview could explore issues such as self-awareness skills and countertransference. It would be interesting to see how staffs' background, attitudes, and interactions affect how they approach aggressive clients. According to this survey, most staff were concerned with what the client was thinking or feeling. The thought process behind staff decision making would be useful to research. For example, what factors do staff members use to make the decision to verbally de-escalate, or restrain a client?

Surveys could also be agency specific to help supervisors determine the culture of the agency and evaluate whether training, policies, or procedures need to be modified. Knowing what type of training program residential staff have been versed in, as well as any other measures the agency has taken to train workers, or reduce restraint rate would also be helpful to know. A reliable and valid instrument of measure that could also be used to help determine and agency's culture is the Work Environment Scale (WES). The WES, written by Dr. Rudolf Moos is a survey tool that measures organizational climate (Poltio, Davis, & Vokurka, 2002). The WES measures ten constructs: work pressure, coworker cohesion, supervisor support, autonomy,

innovation, involvement task orientation, clarity, managerial control and physical comfort. A study examining the relationship between those ten constructs and restraint rates may be useful.

The goal of this study was to better understand residential workers' thoughts, feelings, and perceptions of restraints and the perceived effectiveness of restraint training. Participants viewed their training in using restraints and in verbal de-escalation techniques as very effective and the rate of physical restraints was low. It would be helpful to directly ask what in the training was specifically helpful to direct care workers and what additional training would be helpful to them.

A key area of future research that needs to be explored is why restraint rates have declined over the years. What factors, whether positive or negative have emerged since the trend to minimize restraints? Have restraint rates decreased due to increased training, or do other factors apply such as increased costs that occur after a restraint, such as staff time and emotion involved in writing an incident report, notifying a guardian, and time spent with staff and client debriefing. Are policies getting stricter on national and state levels? What are the alternatives to restraints that staff are using to help manage aggressive and out of control behaviors? What tracking systems are facilities using to gather data on restraints, and how are they using those data? In addition, it would be interesting to know the number of injuries among staff and incidents of property abuse, to see if these negative incidents increase as the use of restraints is minimized.

Conclusion

One controversial intervention that residential facilities use to manage violent and aggressive behavior in children and adolescents is physical restraints. This study examined staff perceptions of physical restraints by using a 20 question survey. The survey included

demographic questions, questions related to the effectiveness of restraint training, effectiveness of verbal de-escalation techniques, number of restraints and verbal de-escalations within a six-month period, as well as feelings, thoughts, and statements that staff members had about physical restraints. Generally, the data indicated that participants felt their training in restraints and verbal de-escalation techniques was effective. There were low rates of restraint use, and staff seemed to rely more on verbal de-escalation techniques than physical restraints to manage aggressive behavior. Staff thoughts included a mixture of positive and negative emotions, but the most frequently endorsed feelings were positive (e.g., in control, competent, and calm). Staff focused mostly on issues of safety with clients and themselves when presented with a variety of thoughts about restraints.

Many children and adolescents placed in residential and inpatient care have difficulty managing their aggressive behavior. There is an ongoing debate about the usefulness of restraints, the positive and negative aspects of restraints, as well as thoughts, feelings, and factors associated with this intervention. While often seen as necessary, the mental health system is attempting to create a culture where restraint rates are kept at a minimum, with the ultimate goal of eliminating restraints as an intervention (Jonikas et al., 2004). Despite the differences in how people view restraints, continued research and attention should be placed on how to train staff members effectively to work directly with children and adolescents in residential care to minimize the use of restraints, as well as to pay close attention to the thoughts and feelings that arise among both staff and clients around the restraint process. Only through continued research and exploration of staff and clients' attitudes toward restraint can facilities be close to the ultimate goal of being restraint free.

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Appendix A

Introductory Email to Directors of Residential Facilities

To whom it may concern,

My name is Mary Ledoux and I am a Doctoral Candidate studying Clinical Psychology at Antioch University New England. I am currently seeking participants for my proposal entitled *Physical Restraints in Residential Facilities: Staff Members' Perspectives.* The purpose of this study is to gain insight into staff members' experiences with physical restraints for children and/or adolescents. It is my hope that the information I obtain in the survey will help aid in the development of future trainings surrounding the use of physical restraints.

All staff members over the age of eighteen who currently work at your facility and who have been involved in a physical restraint may take the survey. The survey will take approximately ten minutes to complete, and participation is completely voluntary. All answers to the survey will be kept confidential, and all answers will remain anonymous and not be connected back to the names of the participants or the agency. Staff members can access the informed consent form and survey by clicking on the following link:

(SHOW SURVEY MONKEY LINK ONCE IRB APPROVAL IS ATTAINED)

If you have any questions about your rights as a research participant, you maycontact Dr. Kevin P. Lyness, Chair of the Antioch University New England Human Research Committee, (603) 283-2149.

Appendix B

Informed Consent

Background: This consent form is for a study involving staff members' experience with physical restraints in residential facilities that work with children and adolescents. This study has minimal psychological risk.

Physical Restraints in Residential Facilities: Staff Members' Perspectives

Mary Ledoux of Antioch University New England is conducting research on staff members' perceptions of physical restraints in residential facilities.

The study will consist of a short, closed-question survey.

Participants will be asked to complete an online survey. It should take approximately 10 minutes to complete. It is voluntary, and you can stop at any time without penalty.

There are no major risks to being in this study.

This study presents no major risks beyond your typical risk of feeling discomfort when thinking about the use of restraints at your job.

We will guard your confidentiality.

No information will be released to your employer, and all answers are kept confidential and will not be linked back to your place of employment. No one will know you or the identity of those who choose to participate or those who choose not to participate.

Benefits of the study

Once data is collected and analyzed, the benefits of this study include knowing more about staff members' experiences with physical restraints.

Consent Statement

By completing this survey, you are providing implied consent to participate in this study.

If you have any questions about your rights as a research participant, you may contact Dr. Kevin P. Lyness, Chair of the Antioch University New England Human Research Committee, (603) 283-2149.

Appendix C

Staff Survey

1. **Your Gender:** Male __ Female__
2. **Your Age:__**

Please answer the following questions based on your experience as a residential worker.

3. **Total years working in a residential facilities**:__
4. **Number of years working with each population:**

Children__
Adolescents__
Adults__

5. **Education Level:**

High school or GED__
Associate Degree__
Bachelor's Degree__
Master's Degree__
Doctoral Degree__
Other Specialized Training__ (Please Specify)

6. **Does your facility have a written restraint policy**? Yes__ No__ Don't Know__
7. **If yes to question 6, do you know where to find the policy**? Yes__ No__ Not Sure__
8. **Did you receive restraint training when you started your current job?** Yes__ No__
9. **If yes to question 8, please estimate the total number of hours of the training**.__
10. **If yes to question 8, do you receive refresher courses in restraint training?** Yes__ No__
11. **If yes to question 10, how often do you receive refresher courses in restraint training?**

Monthly__
Quarterly__
Yearly__
Other__ (Please specify)

12. **On a scale of 1 to 5 (1 being Not Effective, and 5 being Very Effective), how do you rate your training?**

Not Effective 1 2 3 4 5 *Very Effective*

13. **Did your training include techniques for verbal de-escalation?** Yes__ No__
14. **If yes to question 13, on a scale of 1 to 5, how do you rate your training for verbal de-escalation techniques?**

Not Effective 1 2 3 4 5 *Very Effective*

15. **For the past six months, please estimate the number of times you have performed the following:**

The number of times you restrained alone__
The number of times you physically restrained with a partner or multiple people__
The number times you verbally de-escalated alone__

The number of times you verbally de-escalated with a partner or multiple people__

16. **Have you been physically injured when implementing a restraint?** Yes__ No__
17. **If yes to 16, on a scale of 1 to 5 (1 being Not Supported At All and 5 being Very Supported), how do you rate your experience of being supported by your direct supervisor after a restraint?**

Not Supported 1 2 3 4 5 *Very Supported*

18. **Thinking back at your last restraint, what were you feeling? Please check all that apply.**

Afraid__
Angry__
Excited__
Terrified__
Worried__
Frustrated__
Vulnerable__
Happy__
Positive__
Calm__
Sad__
In Control__
Detached__
Competent__
Uncertain__
Helpless__
Other Feelings (Please Specify)__

19. **Thinking back at your last restraint, what were your thoughts during the restraint? Check all that apply.**

Not sure if this is this the best way to help the client in this situation.__

Not sure if I should be restraining this client.__

Worried I will get in trouble for restraining this client.__

Worried I might hurt the client while restraining him/her.__

Worried I might get hurt restraining the client.__

Pretty sure I need to do this for the client's safety.__

Pretty sure I need to do this for the safety of others. __

Pretty sure I need to do this to prevent property abuse.__

Concerned whether or not I am doing this restraint correctly.__

Concerned whether or not there are any safety hazards nearby that could cause this restraint to be unsafe.__

Wondering if this is the best time to be doing this restraint.__

Wondering if this is the best place to be doing this restraint.__

Wondering what the client is thinking.__

Wondering what the client is feeling.__

Wondering if I know how to do this.__

Wondering if I am doing the right thing.__

Wondering if I like doing this.__

Wondering if I am trying to show that I am in control.__

Wondering if I am doing this out of feeling helpless about the situation.__

Wondering if I am restraining the client so s/he will follow directions.__

Other thoughts (Please specify)__

20. **Please rank the following statements on a scale of 1 to 5 (1 being Strongly Disagree, 5 being Completely Agree)**

Restraints represent a failure by staff to anticipate negative events.
Strongly Disagree 1 2 3 4 5 Completely Agree

Restraints are a necessary evil.
Strongly Disagree 1 2 3 4 5 Completely Agree

Restraints are a "power trip" for staff.
Strongly Disagree 1 2 3 4 5 Completely Agree

Restraints are cries for physical contact from desperate clients.
Strongly Disagree 1 2 3 4 5 Completely Agree

Children should never be restrained.
Strongly Disagree 1 2 3 4 5 Completely Agree

Training is necessary for an effective physical restraint.
Strongly Disagree 1 2 3 4 5 Completely Agree

Restraints are used too often.
Strongly Disagree 1 2 3 4 5 Completely Agree

Restraints occur because of staff being undertrained in alternative methods.

Strongly Disagree 1 2 3 4 5 Completely Agree

Restraints occur more when staff members are unable to communicate properly with one another.
Strongly Disagree 1 2 3 4 5 Completely Agree

No one should restrain alone.
Strongly Disagree 1 2 3 4 5 Completely Agree

Youth should be restrained to prevent property destruction.
Strongly Disagree 1 2 3 4 5 Completely Agree

Youth should be restrained for refusal to move.
Strongly Disagree 1 2 3 4 5 Completely Agree

Youth should be restrained if they are physically fighting another peer.
Strongly Disagree 1 2 3 4 5 Completely Agree

Youth should be restrained to prevent running away.
Strongly Disagree 1 2 3 4 5 Completely Agree

Clients are helped by physical restraints.
Strongly Disagree 1 2 3 4 5 Completely Agree

Clients gain a sense of safety and security when they are restrained.
Strongly Disagree 1 2 3 4 5 Completely Agree

Clients feel abused when they are physically restrained.
Strongly Disagree 1 2 3 4 5 Completely Agree

Clients sometimes seek excitement by provoking a physical restraint.
Strongly Disagree 1 2 3 4 5 Completely Agree

Some clients view physical restraints as a form of sexual contact.
Strongly Disagree 1 2 3 4 5 Completely Agree

Some clients experience physical restraints as reenacted child abuse.
Strongly Disagree 1 2 3 4 5 Completely Agree

Some staff members restrain younger children more because they are easier to restrain than older children.
Strongly Disagree 1 2 3 4 5 Completely Agree

Some staff members restrain male clients more than female clients because male clients are usually more physically aggressive than female clients.

Strongly Disagree 1 2 3 4 5 Completely Agree

Thank you for taking the time to participate in this survey.