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Perspectives on Restraint Reduction in Residential Facilities

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IN RESIDENTIAL FACILITIES**

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Abstract

This study was designed to explore how the youth and staff in long term residential treatment experience the use of physical restraints, as well as what they view as essential to reduce the need for these restraints. Youth placed in residential care typically have a history infused with trauma that is often more intense than the general population. As a result, these youth are at risk of engaging in dangerous behaviors that may be deemed demonstrably dangerous, which could warrant the use of a restraint. To date, restraint usage in residential treatment centers has decreased through the following means: (a) debriefing groups for staff, (b) restraint reduction committees, (c) milieu interventions, and (d) resource teams. There are still several unknowns in regards to restraint reduction− for example, how the youth in residential treatment centers believe restraint use could be reduced. This study attempted to fill that gap in the current research by obtaining more information from youth and staff members through semi-structured interviews. Interpretive Phenomenological Analysis (IPA) was utilized to analyze these qualitative data. Overall, participants discussed the need for continued staff training and education, less restrictive interventions, and positive staff qualities. This information can be useful to facilities, programs, and directors in their approach to training staff members. Further research might specify the optimal amount and content of this training.

Keywords: physical restraints, residential facilities, staff and youth perspectives, staff education and training, restraint reduction

Perspectives on Restraint Reduction in Residential Facilities

Staff members in residential care are taught to utilize restraints to keep youth safe when the youth are a demonstrable danger to themselves or others. This paper describes a study designed to explore how the youth and staff in this environment experience the use of physical restraints, as well as their ideas about strategies to reduce the need for these restraints. Overall, few studies have been conducted that attempt to understand perspectives of youth in residential facilities. More research is needed to better understand this population's perspective.

The following is a review of the literature related to the use of physical restraints with children and adolescents in residential settings. This literature review will include descriptions of: (a) residential care, (b) clientele in residential care, (c) restraints, (d) the use of physical restraints in residential care, (e) how restraints can be necessary and beneficial, (f) the risk factors associated with restraint use, (g) how restraint utilization has been reduced thus far, (h) results from studies investigating staff and youth thoughts on restraint reduction initiatives and de-escalation techniques, and (i) what is still unknown about restraint utilization to date.

Literature Review

Description of Residential Treatment

Treatment centers are 24-hour facilities that provide both educational and mental health treatment targeted at specific behaviors (Connor, Miller, Cunningham, & Melloni, 2002; Lyman, Prentice-Dunn, Wilson, & Taylor Jr., 1989; Miller, Hunt, & Georges, 2006). These facilities are designed to uphold therapeutic effectiveness and safety for clients and the community. Residential treatment facilities are typically matched to the clients' particular difficulties, and when created, were meant to be a cost effective treatment modality (Lyman et al., 1989). A

residential environment is intended to protect clients by filtering out negative experiences, maximizing positive experiences, and promoting desired changes (Gunderson, 1978).

Residential treatment was primarily intended to provide "the use of marginal interviewing, the use of the life experience in a therapeutic fashion, as well as the use of formal psychotherapeutic interviews" (Leichtman, 2006, p. 286). Today, "the use of life experience in a therapeutic fashion" is often referred to as a *therapeutic milieu*, a term that is often used synonymously with residential treatment (p. 286). Today, *psychotherapeutic interviewing* is referred to as "life-space interviews," which is what residential staff members use when an incident or crisis occurs with a youth on the unit. These life-space interviews are meant to be important learning opportunities for the youth because staff members address the incident "when the context was clear, affect was present, defenses were down, and emotional first aid could be applied before crises spiraled out of control" (p. 288).

According to the Health Care Financing Administration (2001), a *psychiatric residential treatment facility* is not a hospital, but it is a location "that may furnish covered Medicaid inpatient psychiatric services for individuals under age 21" (p. 28110). In regard to the continuum of restrictive settings, residential care is second only to inpatient and juvenile justice facilities (Walter & Petr, 2008). According to Leichtman (2006), residential treatment facilities differ from hospitals in several ways. For example, hospitals rely on the medical model of care whereas residential facilities focus on therapeutic caretaking and parenting for these youth. Within hospitals, doctors diagnose patients and provide care, while in residential facilities the therapeutic community and milieu atmosphere is a large component of the overall treatment. Additionally, Leichtman describes residential structures as similar to family structures because both change as a result of their size, location, economic resources, ages of the individuals in the

system, and the individual's unique difficulties, whereas, these factors are not as likely to alter the structure in a hospital.

Initially, residential treatment centers were isolated from the community and were designed to be a long term, possibly even life long treatment modality (Lyman et al., 1989). However the length of stay continues to shorten. This is a result of the cost of long-term treatment and the current consensus that it is harmful to keep a child away from home for longer than medically necessary (Leichtman, 2006). Research has also found that within residential facilities, at-risk behaviors typically reduce the most during the first 6 months of care, suggesting that a shorter length of stay is beneficial for overall growth and development (Hair, 2005).

Additionally, research has demonstrated that family participation is key in regard to successful residential treatment. More specifically, Sunseri (2001) found that children with frequent visits to or from home were 5.7 times more likely to complete treatment. More recently, research has discovered three key factors in regard to successful discharge from residential treatment to the community including: (a) how invested and involved the family was in treatment prior to discharge, (b) the stability of the living location post discharge, and (c) availability of aftercare to support the youth and their family (Hair, 2005). Out of these three factors, Hair discovered that family involvement and support had the most significant and consistent effect on maintaining growth made in residential treatment. As a result of this newer research, there have been ongoing initiatives to make residential treatment more family focused by involving the youth's family, increasing positive family functioning, and linking residential treatment with the community to ensure support and aftercare (Walter & Petr, 2008).

Clientele in Residential Treatment

Children and adolescents in residential care "are some of the most vulnerable in our

society" (Kendrick, Steckley, & Lerpiniere, 2008, p. 79). When a youth enters a residential facility, the youth often feels out of control and the family feels extremely discouraged (Durrant, 1993). This level of care is typically a last resort for individuals who have previously failed in many other less restrictive settings (Lyman et al., 1989). The duration of residential treatment can range from three months to a number of years (Lyman et al., 1989).

Youth in residential care typically have a trauma history that is more intense than the general population (Bloom, 2000). Characteristically, these youth have endured abuse, neglect, and multiple placements (Steckley, 2010). They also may have complex neuropsychiatric diagnoses, multiple attachment disruptions, and chronic traumatic experiences (Connor et al., 2003). In addition, youth with trauma histories are less likely to be able to self-soothe and may be chronically hyper-aroused as a result of the trauma they experienced. This can lead to observable symptoms and maladaptive behavioral attempts to decrease arousal, such as aggressive, assaultive, or self-harming behaviors (Bloom, 2000).

A study by Wells and Whittington (1993), albeit dated research, examined the characteristics of youth referred to a nonprofit residential facility over a 12-month period. This facility mainly served children with emotional disturbances who did not present as a danger to themselves or others. The study revealed that youth who were referred to this residential program came from impoverished families that had significant functional impairments. Fifty-one percent of the youth were in the custody of a county department of human services. The average age was 14.5 years old and the median family income was $13,936 (Wells & Whittington, 1993). Eighty-three percent of these youth reported problems beginning before adolescence. Additionally, these youth suffered from more family breakdown, less cohesiveness and adaptability within their families, and more stress than nonclinical families. These youth also had

more severe and diffuse behavioral problems and deficits in their social competencies when compared to the nonclinical youth.

In a similar study by Connor, Doerflet, Toscano, Volungis, and Steingard (2004), youth in another residential treatment facility were observed and studied from 1994 to 2001. Despite following the previous study, this research is also dated. Out of the 397 youth in this particular study, half had been physically abused in the past and nearly a third had been sexually abused. Interestingly, the majority of girls in this study had a primary diagnosis of mood or anxiety disorder and the boys had a primary diagnosis of disruptive behavior disorder. The youth in this study were found to exhibit more impulsive behaviors and higher levels of aggressive behavior when compared to nonclinical populations. Verbal aggression was the most frequent behavior, however, physical assault, property destruction, and self-harm were also noteworthy (Connor et al., 2004).

Definition and Use of a Restraint

Restraints refer to chemical, mechanical, and physical means of rendering clients incapacitated and immobile. For the purposes of this paper, the focus remained on physical restraints; physical escorts, which are utilized at some agencies, are not included in this definition. A universal definition of *physical restraint* has yet to be maintained across studies (Day, Daffern, & Simmons, 2010; Leidy, Haugaard, Nunno, & Kwartner, 2006)**.** The definition for the purpose of this paper is borrowed from Leidy et al.: a physical restraint is "…a restriction of a person's freedom of movement or access to one's body by one or more staff persons" (p. 341).

Staff members have been utilizing restraints for over 200 years to help maintain the safety of youth exhibiting aggressive behaviors (Tilli & Spreat, 2009). As discussed above, some

youth in residential care frequently exhibit high levels of aggressive and self-harming behaviors. Therefore, when less restrictive interventions such as deescalation techniques do not keep the youth safe and the youth presents as an immediate safety concern to themselves or others, restraints are used as an intervention to ensure safety (Day et al., 2010; Leichtman, 2006)**.**

A study by Leidy et al. (2006) indicated that during a three and a half-year study, about 38% of the youth at the facility were restrained at least once. More specifically, Leidy et al. studied 415 youth in a single residential treatment facility from January 1999 to May 2002 (albeit a dated study). During that time period, 155 of those 415 youth were restrained. These researchers found that the average number of restraints for those youth was 8.1 restraints. The length of restraints ranged from 1 to 98 minutes with an average of 11 minutes per restraint. Notably, during this study, restraint utilization often occurred in clusters. For example, when one restraint occurred, another typically occurred shortly after. There were 42 days with five or more restraints. Those days accounted for 25% of the total number of restraints throughout the entire 1247-day study (Leidy et al., 2006). Overall, when restraints occur at residential facilities, they tend to produce a domino effect of restraints in the milieu.

A systematic review of the literature on restraint use, throughout the past 10 years, indicated that throughout the United States, Australia, and Europe a weighted mean of 29% of youth experienced at least one restraint episode during their treatment in residential care (De Hert, Dirix, Demunter, & Correll, 2011).

Restraints Can be Necessary and Beneficial

Most youth and staff in residential facilities deem restraint utilization as necessary and acceptable in some circumstances (Steckley & Kendrick, 2008). When a staff member was asked in a previous research interview, "How does restraining a kid improve trust?" she replied, "I

think security, and also he knows I'm not going to hit him and things, that I'm not going to be too rough and not going to hold him any longer than he needs to be held all that stuff. And also that I'm not just going to abandon him afterwards…" (Steckley & Kendrick, 2008, p. 565). In this situation, the restraint was described as therapeutic for that youth. Some youth in prior research have reported that restraint utilization can be cathartic (Steckley & Kendrick, 2008).

Additionally, restraints may be needed if a youth's behavior is deemed 'out of control' and they are a danger to themselves or others. For example, a child who is nonverbal may bang his head in residential care until his needs are met. However, for his safety, if staff cannot determine which need he wants met in an efficient manner, he may require a restraint so that his head will not get severely injured.

Risk Factors of Restraint Use

Although restraint use remains necessary in certain situations, its utilization inevitably comes with several risk factors. For example, restraints have been reported to be humiliating, demoralizing, retraumatizing, counterproductive, and countertherapeutic for the youth (Day et al., 2010; Miller et al., 2006). More specifically, as Mohr (2006) stated, "…the act of forcible restraint becomes one more layer of trauma on top of an already wounded psyche" (p. 1329). Furthermore, restraints do not appear to teach the youth coping or self-regulation skills and they may actually have the adverse effect of reinforcing coercive and aggressive behavior (Day et al., 2010; Holstead, Lamond, Dalton, Horne, & Crick, 2010). This is because the youth are learning to regulate in an aggressive and dominant manner, thus the youth will learn that aggression and dominance are needed for baseline feelings.

In addition to possible psychological traumatization, over half of the youth in a study by Steckley (2010) described restraints as physically painful and often too forceful. More

specifically, youth reported suffering from injuries such as bruises, carpet burns, and bloody noses (Steckley, 2010). Over two-thirds of the staff in this same study noted similar physical injuries, with more than half reporting more serious injuries, such as broken ribs, fingers, and noses, damaged backs, knees, and teeth, black eyes and knife wounds (Steckley, 2010). Importantly, in a separate study, Tilli and Spreat (2009) found that physical restraints had an injury rate of 48 per 1000 applications regardless of position in the restraint. Additionally, whether it is from improper technique, position, immobilization, or factors of the environment (e.g. lack of training, inadequate staffing ratios), youth have even died as a result of restraints (Mohr, 2006). In some nations, the use of restraints has been restricted due to a combination of these risk factors (Leidy et al., 2006).

How Restraint Utilization Has Been Reduced Thus Far

The following interventions have been studied in previous research to reduce restraint usage. More specifically: debriefing groups for staff, restraint reduction committee, milieu intervention and a resource team.

Debriefing groups for staff. According to Holstead et al. (2010), these groups are a place for open and honest discussions, where staff members support each other, and where administrators support their staff. These groups provide a form of *epistemological containment* by creating an open space for staff members to debrief and discuss their emotions in regard to chaotic incidents at work (Steckley, 2010). Within these groups, staff members are trained to be aware of their own internal experiences, especially during critical moments at work. This way they can be increasingly present in the here and now during chaotic situations with the youth (Holstead et al., 2010). Overall, Holstead et al. reported that debriefing groups for staff members reduced the need for restraints on a day-to-day basis.

In addition, Holstead et al. (2010) hypothesized that if each staff member involved in a restraint attended a mandatory debriefing meeting within 48 business hours, the number of restraints would reduce. Nayar (2008) supported this idea by noting that therapists who provide psychotherapy to individuals with trauma often receive supervision and consultation. Therefore, he suggested that direct-care staff, who work directly with traumatized residential youth, should also receive similar supervision and consultation.

Steckley (2012) hypothesized that when staff members have an opportunity to process and understand the youths projected feelings, they are better able to respond to that youth's needs, rather than the youth's negative behaviors. Without debriefing groups, staff may experience an "…immobilization of energy, a diminishing of insight into the issues that underlie behavior, an increased focus on control, emotional unavailability, irrational or erratic reactions, and provoking and/or punitive interventions…" (Steckley, 2010, p. 121) none of which promote optimal quality of care. Therefore, to reduce restraint usage, it appears that weekly debriefing groups are a viable option to consider (Holstead et al., 2010; Steckley, 2010).

Restraint Reduction Committee. A study by Miller et al. (2006) used a Restraint Reduction Committee (RRC) to reduce the number of physical restraints per week at two private residential facilities. This RRC was a group of senior and middle administrators along with direct care staff that came together to develop and implement a restraint reduction plan. Within this study, an RRC was implemented at both facilities and met once a month. In this particular study the RRC "…developed a statement of beliefs around the primary view that physical restraint is an emergency intervention that is to be used only when less restrictive interventions fail" (Miller et al., 2006, p. 204). The staff members in this group continuously taught other staff members less restrictive interventions such as assessment of the youth and situation, behavior management

techniques, and verbal deescalation skills (Miller et al. 2006).

When the RRC was implemented in the two facilities, there was a 20% (not significant) and 42% (significant) reduction in restraints at the north and south facilities respectively (Miller et al., 2006). The north sites reduction rate was likely not significant because of the larger size of the system. Therefore, the intervention may have needed more time to take full effect (Miller et al., 2006). A secondary intervention was applied to both facilities, which is addressed below.

Milieu intervention. As a secondary intervention, Miller et al. (2006) significantly changed the milieu behavior plan that was already in place at both facilities. For example, the RRC discovered that the original milieu plan for the youth had no extrinsic reason for the youth to behave positively on the unit because when youth lost privileges at school, the consequences followed them to the unit. Therefore, school and unit consequences were disconnected so that youth could have a fresh start on the unit. Secondly, to give the youth a sense of control and self-determination, courses such as chorus, woodworking, and aerobics were offered as a reward for good behavior in school. Third, the point system that was already in place was modified so that consequences only impacted the next activity, not the rest of a youth's day. Accordingly, youth could now maintain a feeling of hopefulness (Miller et al., 2006). After a two-year nine-month period, and after both the RRC and milieu intervention had been implemented at the sites, there was a "…large and significant overall reduction in restraint rates of 59%" (Miller et al., 2006, p. 205).

Resource Team. Holstead et al. (2010) implemented a similar restraint reduction initiation at Damar Services Inc., a private non-profit facility in Indiana. A resource team was implemented which was responsible for reducing the frequency of restraints and helping youth make more positive choices. This team is different than the RRC because the members on the

resource team directly responded to all incidents that involved aggression and were the primary

staff members involved in restraints, whereas the staff on the RRC taught direct care staff

successful techniques to manage the restraints independently. By the end of the initiative, the

frequency of restraints and facility injuries had reduced significantly. The facility even decided

to support a 24-hour resource team, so that they could continue to help the youth in a

restraint-free manner (Holstead et al., 2010).

Overall, previous research demonstrates that the following interventions have worked in

reducing restraint usage; debriefing groups for staff, restraint reduction committee, milieu

intervention and a resource team.

Results from Investigations of Staff and Youths' Thoughts on Restraint Reduction

Initiatives and De-escalation Techniques

Previous research has suggested that staff and youth alike experience "…a sense that

there must be a better way of managing potential and actual harm" (Steckley & Kendrick, 2008,

p. 560). Staff and youth have reported the importance of having "…less intrusive efforts at

deescalating situations…" (Steckley & Kendrick, 2008, p. 566). Additionally, staff have noted in

several studies their negative experiences and feelings in regard to restraint usage. For example,

in a study conducted in Scotland, staff described feeling guilty about restraining youth (Steckley

& Kendrick, 2008). Youth have reported feeling angry with staff after restraints, as well as with

themselves for the behavior that led up to and occurred during the restraint (Steckley &

Kendrick, 2008). Additionally, Lieberman (2014) noted, "a key factor in this dynamic is the

degree to which a parallel process is occurring internally for the staff" (p. 116). For example,

when staff witness violent or aggressive behavior, they respond automatically at times with the

human responses of fight, flight, or freeze. This could result in an immediate restraint instead of

an "explicit thoughtful process through which the youth is more likely to learn self-control" (p. 116).

The Unknowns of Restraint Reduction

Youth in residential facilities have had some opportunities to discuss their thoughts and feelings about being restrained with researchers. However, the youth in residential care have not had a sufficient opportunity to voice their opinion on exactly how to *reduce the need for restraint use*, what *deescalation skills* they feel would be beneficial in a personal time of crisis, or what would be beneficial when a peer is in crisis.

Importantly, the female adolescent population in residential care is growing at a faster rate than the male adolescent population (Leidy et al., 2006). Therefore, gaining information from female adolescents on how to reduce the need for restraints would be beneficial for the field as a whole.

Statement of Purpose

The purpose of this study was to fill the gap in the current research by obtaining more information from youth and staff members on the essence of how restraint use could be reduced, as well as, what deescalation skills are most helpful in times of crisis. The youths' thoughts were compared to staffs' thoughts on the same topics to examine any emerging crosscutting or common themes among participants. The goal of this study was to help establish realistic interventions for reducing restraint usage.

Research Questions

1. What commonalities exist, if any, among the perspectives that youth and staff in residential care experience, in regard to what interventions are most useful to reduce restraint utilization?

2. What are the participants' (i.e., youth and staff) views about when and where restraints are necessary?

3. When and where are alternatives to restraints most appropriate?

Methodology

Variables

Independent variable. Participant individuality (race, class, SES, history, etc.).

Dependent variable. Participant responses.

Participants

The sample size was seven participants (four staff members and three youth) selected from one Residential-Educational program for adolescents in Massachusetts. This program serves females from ages 12 to 22. Inclusion criteria for youth participants included: (a) living at a long-term residential or group-home level of care in Massachusetts, (b) between 12 and 17.11 years of age, (c) restraint free for 7 days (I delayed interviews with those youth that were involved with a restraint until they had been restraint free for 7 consecutive days; giving the individual sufficient time to process the incident.), (d) been involved in or witnessed, a restraint within the last 5 years (at this program or another program), and (e) custodial consent. The inclusion and exclusion criteria for youth participants are presented in Figure A1 within Appendix A.

The three youth participants were all female, their ages were 13, 14, and 15 and their ethnicities were Caucasian, Hispanic, and Caucasian/Hispanic. All three youth were in custody of the state at the time of their participation.

Staff members that work on the treatment unit included in this study were invited to participate until the desired sample size was met. The inclusion criteria for staff included: (a) had

worked at a long-term residential or group home level of care in Massachusetts; (b) had been restraint utilization free for 7 days; and (c) had been involved in, or witnessed a restraint within the last 5 years (at this program OR another program). The inclusion and exclusion criteria for staff participants are presented in Figure A2 within Appendix A.

Out of the four staff participants, two were female and two were male. Staff participant ages were 23, 27, 30, and 55. Staff participant ethnicity included Caucasian and Caucasian/Hispanic. Of note, I worked as a clinician at the location where these data were gathered and all three of the youth participants also engaged in weekly therapy sessions with me. However, I was not personally involved in restraints with any of these youth. While working as a clinician at this facility, I often brought my certified therapy dog to work as an additional intervention for the youth. This therapy dog was present throughout all staff and youth interviews.

Interview Protocol/Data Sources

Qualitative data was collected through semi-structured interviews. With consent, each interview was recorded, and notes were taken. The interview consisted of several open-ended questions to gain information about the essence of the participants' views on how restraints can be reduced (e.g., "When are restraints acceptable?"). Prompts were provided as needed. The interview protocols for youth and staff participants are presented in Appendices B and C. Each interview took about one hour and was facilitated in the clinical office on the housing unit.

Qualitative Design

This study utilized phenomenological research, which is a qualitative research method. This type of research attempts to describe a lived experience of a phenomenon through narrative data. This narrative data is typically collected through an interview, written or oral self-reports,

or even personal forms of aesthetic expression (e.g., art or poetry). Once these are collected, they are coded into themes.

In this study, phenomenological research helped discover the essence of what youth and staff, in residential care, view as helpful to reduce the use of physical restraints. I utilized these discovered themes to explore similarities and differences between the youth and staff members' perspectives. Similar perspectives between the two populations are discussed as possible intervention approaches to reduce the need for restraint utilization.

Procedure

The procedure for data collection is outlined step by step below. First, I filed an IRB application at an agency in Massachusetts. Second, I filed an IRB application at Antioch University New England. Next I recruited participants by calling and describing the study to guardians and asking guardians of the youth for their verbal consent. When a guardian granted verbal consent, I emailed or mailed them a cover letter and consent form, these are presented in Appendices D and E. I scheduled dates for the interviews, ensured signed consent was obtained, received signed ascent and interviewed the three youth participants. Simultaneously, I invited staff members on the residential unit to provide their written consent for participation in the study and scheduled interviews with those staff members whose written consent was provided.

Analysis

I utilized Interpretive Phenomenological Analysis (IPA) to analyze the data. I (a) listened to the audio, (b) transcribed the audio, (c) read the transcripts two to three times, (d) identified *meaning units*, which are important quotes from the participants, (e) coded the meaning units by assigning each with a main topic, (f) created *themes* by grouping similar meaning units, (g) created *clusters* by combining similar themes, (h) compared and contrasted the clusters, and (i)

utilized blind peer review to get outside judgment on the accuracy of the findings.

Results

I sought to discover the essence of what youth and staff members in long-term residential care view as essential to reduce the need for physical restraints. I compared the responses of the two groups (youth and staff members), to determine if similar and different themes emerged. Qualitative data collection and analysis were conducted using Interpretive Phenomenological Analysis (IPA). Responses to interview questions were considered meaning units and were reviewed to look for common themes. Some of these themes were similar across groups and some were unique, thus they were coded as crosscutting or unique. All of these themes were reviewed for commonalities and then grouped into clusters.

A total of four clusters, eight crosscutting themes, and two unique themes were identified. The first cluster that emerged from these data was the importance of staff education and training. Within that cluster, there were two crosscutting themes between youth and staff including: (a) teamwork and communication as well as (b) consistency. The second cluster that emerged was titled anxiety-inducing environment, representing the anxiety both staff and youth experience on a residential care unit. Within that cluster, there were two crosscutting themes of: (a) restraints can be unsafe and (b) restraints can be imperative to maintain safety. The third cluster that emerged from these data was the importance of least restrictive interventions. Within that cluster, there were three crosscutting themes of various intervention techniques including: (a) deescalation skills (b) youth-focused interventions, and (c) peer support. The fourth cluster that emerged from these data was the importance of positive staff qualities. Within that cluster, there was one crosscutting theme: (a) theory of mind and empathy and two themes unique to staff interviews including: (a) frustration tolerance skills and (b) creativity/flexibility. These

results are presented in Table F within Appendix F. The table helps readers visually see the

clusters and themes in relation to one another. The results are also presented in Figure G within

Appendix G. The conceptual map helps the reader understand the sequential flow of the results

as well as the interplay between the clusters and themes that may reduce restraint usage.

Staff Training and Education

Both youth and staff members at an acute residential facility provided responses that

reflected an overall need for continued staff training and education in order to reduce the number

of restraints occurring in the milieu. For example, a youth interviewee shared, "When I am upset

and staff yell at me, I become more upset." A staff interviewee stated, "power struggles do not

work… you have some staff that will say to a child, you have to sit and take a time out until I say

otherwise. However, that does not work. It took the kid 14 years to get this way, they are not

going to change overnight. When you see a staff power struggling just switch out with them."

This same interviewee stated, "When a restraint happens too soon, or didn't need to happen, it

can harm the relationship with that child." Another staff interviewee stated, "When a kid is

calling you names and saying bad things about your family, you have to not take it personal; you

can't show the emotional response in your face for the youth to see." Lastly, a staff interviewee

stated, "Do more trainings on de-escalation and make them mandatory. Every six months it

would become monotonous because you will hear a lot of the same stuff, but its also good

keeping it fresh and remembering where the kids are coming from." Participant responses

throughout this cluster, staff training and education, reflected important themes of teamwork and

communication as well as, consistency on a residential unit.

Teamwork and communication. An important theme derived from staff training is how

imperative teamwork and communication can be in this type of environment. One staff

interviewee stated, "You cannot run an efficient unit if you don't have trust in the people you are working with everyday." Another staff interviewee stated, "It's typical to join a restraint halfway through—can you give a hand—or switch someone out." Another staff participant shared, "I have been in restraints that other people have initiated that were not needed. But you have to back the staff up. And talk to them about the inappropriateness of the restraint after the fact." These responses displayed how important teamwork and communication can be in this environment. In response to the prompt, "think back to the last time you were restrained, what could have been done differently?" a youth participant replied, "I could have been talked to instead of having been restrained. Someone could have tried to talk to me instead of putting hands on." Another youth stated, "don't tell me my consequences while I am still in the restraint, think about my reaction first because hearing my consequences at that point is just going to overwhelm me." A third youth stated, "If I try to help someone who goes AWOL by chasing them, restraining me would be unnecessary. They should talk to me and ask what I am doing before trying to restrain me. They could say are you trying to run, are you trying to help, what are you doing?" Those examples displayed that teamwork and communication are important for staff-staff interactions, as well as, staff-youth interactions.

      Consistency. A second theme derived from this cluster, staff training and education, was the importance of consistency and reliability on a residential unit. One youth participant stated, "some staff are basically different, some are more strict than others, and some are not respectful, like some staff don't realize what our past has been so they do not understand us or why we talk back." This response demonstrates how a lack of consistency can be confusing for youth in this environment. A staff participant indicated how important boundaries are in this environment. For example, "Boundaries are a big thing. The kids are not your friends, you are not suppose to be

their friend, you can be there for them and support them, that doesn't mean you are chummy-chummy friends all the time, that creates an unrealistic bond and they think they can do silly things with staff who are 25-26 years old and that creates too much of a blurred line." Another staff interviewee stated, "It is very important to keep the unit structured and to keep the youth engaged because when they are bored is when they are going to act out." A third staff interviewee stated, "Be consistent, if you are consistent the kids feel safe and behave better." A fourth staff shared, "I am a strong believer of routine. Kids still need some kind of structure and when they don't get the structure is when they are like, yes, I got away with something!" A different staff member shared, "When I moved up to supervisor I felt it was important to implement routines, it gives the kids something to look forward to so they know what to expect next, instead of just surprising them." Another staff shared, "I could definitely pick out multiple staff that will give kids anything to not get a restraint. The kid is not learning anything from that, you have to see the bigger picture and if you cant, you cant do your job efficiently. You shouldn't work here if you can't look at the larger picture." Overall, in this environment, consistency in regard to routines, expectations, rules, regulations, communication, interventions (while remaining youth-focused) and staff/youth boundaries are important for both the youth and the staff members. Additionally, consistency can enhance teamwork and collaboration.

Anxiety-Inducing Environment

Youth and staff members at a residential facility provided responses that signify how this environment can elicit natural feelings of anxiety. For example, a staff participant shared, "You have to think immediately about the youth and the youth's safety but then there is that small back part of your brain that is like *well what about me, what is going to happen to me?"* Another staff interviewee shared, "I've seen staff kicked, punched, spit on. Spitting is the worst I would rather

get punched. They [the youth] feel powerless and that is the easiest, most effective way to get back, you're holding me down and I want to get back at you. They know it will elicit a reaction." Another staff reported, "I have seen staff get fired because they have lost their cool in a restraint and hit a kid." Another staff shared, "When I first started having to put my hands on a kid for unsafe behavior, I was nervous. During my first restraint my hands were shaking and I felt butterflies in my stomach; emotionally it had an impact." These responses demonstrate how this environment elicits natural feelings of anxiety from staff members who are working there. Youth participants also experienced feelings of anxiety within this environment. For example, a youth participant stated, "Other clients also sometimes give us a hard time, it is really frustrating and it gets me mad." One youth participant provided a clear example of this from her past, "One time at my last program, one of the other clients, my best friend supposedly, began talking about why I was there and how my family didn't want me. She did it for a few days and I told her to stop and she never did. I told staff and they never did anything about it. One day I went Ham. I asked her to stop and she didn't so I attacked her, I beat her up." Overall, this cluster revolving around feelings of anxiety reflects two important yet contradictory themes including, restraints can be unsafe and restraints can be imperative to maintain safety.

Restraints can be unsafe. An important theme derived from the anxiety that is experienced in this environment is that restraints can be unsafe. For example, a staff participant shared, "I don't think you are ever ready to go into a restraint. I have been doing it for a while and I still am never really ready. You are fighting in a way and you don't know what can happen. I have seen people get their knees kicked in, head butted in the face, the list can go on and on, so it is not really beneficial." A youth participant stated, "Once staff threw me down so hard that I hit my head off the ground. Sometimes the staff members trip me on an escort or restraint and I

twist my ankle. Sometimes newer staff members that are nervous squeeze my wrist very hard, my hand has turned purple before." Another youth participant stated, "I was restrained in a previous program and my left rib got crushed and still hurts at times." Those are all concrete examples of both youth and staff participants being hurt in restraints.

Restraints can be imperative to maintain safety. Another important, yet contradictory theme in regard to the anxiety that is experienced within this environment is that restraints can be imperative to maintain safety. For example, a staff interviewee reported, "Restraints are acceptable or necessary if the youth are being unsafe toward themselves or others and I have tried everything in my power to talk them down. Pretty much when I have no other option." This same staff shared, "You get to a point when you are like I have to protect myself too. I am not going to die doing this because a kid got black out angry." A youth participant reported, "If I am punching someone you have to restrain me." Another youth stated, "For example if Maebelle (therapy dog) was a person and I went and punched her it would be OK for me to be restrained because that is me trying to hurt somebody just like if you were to shoot someone you would go to prison." These examples display that both youth and staff feel that under some circumstances restraints are imperative to maintain overall safety.

Least Restrictive Intervention (Restraints as a Last Resort)

Both youth and staff members at an acute residential facility provided responses that reflect an overall calling for least restrictive interventions in order to reduce the number of restraints occurring in the milieu. For example, a staff interviewee stated, "If a kid is just telling you no, then you need to dig deep in your skills and figure out what is really going on with them to get them to cooperate, even if it just sitting and waiting. It will get old but you have to be better at it." Another staff reported, "First I try to do calm talking with them, I use others things

before the restraint, I utilize occupational therapy techniques. My go to is humor, trying to play around/joke around with them first, not about what is going on but maybe tell a joke to break the barrier so they can talk to staff. Then if they continue to go on and harm themselves more that is when we will restrain or place hands on." Another staff suggested "make the unit more homey, less like a program, and don't have the kids in their bedrooms all the time." A youth made a similar suggestion, "There is a lot of white walls, it looks like we are in a lock up system or something. Maybe a colorful room with new curtains, more homey… and customized." All of these examples demonstrate the need for various interventions prior to a restraint. Overall, this cluster focused on least restrictive interventions reflects 3 important themes addressing interventions for a residential milieu including: (a) de-escalation techniques, (b) youth-focused interventions, and (c) peer support.

De-escalation techniques. In regard to utilizing least restrictive interventions, using deescalation techniques to maintain safety is always important. One staff interviewee stated, "I can use the technique of calm talking, approaching the client in a non-stern way and not too quickly. I can talk friendly with them 'hey what's up' and maybe use some humor to see if I can get them out of the funk. And I can encourage them, if they want to scream or yell a positive and okay place to do this is in the safe room. It is okay to let their anger out in there." Another staff stated "If we see a kid is getting verbally aggressive or physically that is when we try the calm talking, sometimes planned ignoring, not saying anything until they are able to ask to talk with us appropriately." Another staff interviewee reported, "Humor, diversion, and validation also work because when kids vent, when anyone vents, validation is very important, it just makes people feel like you are listening, sometimes people don't want to get fixed, they just want someone to listen to them." All staff members agreed, "Escorts are a first choice before restraints." These

responses demonstrated that to maintain safety in this type of environment there are multiple

deescalation techniques that can be utilized prior to placing a youth in a restraint.

Youth-focused interventions. In addition to the above interventions, staff and youth

responses consistently focused on how important and helpful youth-focused interventions can be

to maintain safety. For example, a youth interviewee shared, "I have social story plans, or I use

self-talk, or I use another coping skill like play with Legos and take a coping shower." This same

participant suggested that when agitated she would prefer a "pep talk" from the staff. For

example, "Do you want to talk with me in a different room? If I say No, the staff should say, I

think it's a good idea to go talk about it because it is better to let things out rather than bottle

them up." A different youth participant stated, "I want more rewards; for example, if I was not

restrained I would like to go eat outside and celebrate. Celebrating my successes would be

helpful." Another youth reported, "When I slam a door it helps me- it is a loud noise and it helps

that is also why sometimes I blast my music." These three youth participants provided differing

responses for what assists them in times of stress. A staff interviewee reported, "Know your kids;

if you know the kids you can prevent a lot, not everything, but a lot. For example, the more you

know a kid the better you can avoid those upsetting situations. Plan ahead with the kid, they can

tell you what works and what doesn't work. Some kids want to talk to you, some kids want to be

left alone. You wont know until you know the kid better." A second staff discussed how using

different communication styles can be a youth-focused intervention, "We could use different

ways of talking, tones make a difference with each kid. If you are too stern kids push back and

there are others who listen better to sternness. It is dependent on the kid and how they are raised

and a little bit of everything." Those examples demonstrate why youth-focused interventions can

be important. Another staff participant stated, "If it is a kid that needs space to process and she

won't hurt herself you can give her that space because she will calm down and then be able to talk with you about it." Overall, youth-focused interventions are seen as desirable interventions by both staff and youth participants.

        Peer support. Peer support is another successful intervention that many participants addressed throughout these interviews. For example, a youth participant stated, "You know how some kids on the unit are funny? I know there are some funny clients who will cheer me up. And I ask to speak with them but I am not allowed to speak with them because I am grounded and worked up. Staff do not let me because I am worked up, but it would help me feel better if I could talk to a funny peer to help me calm down." A staff interviewee stated, "Sometimes a kid will listen to a kid before they will listen to an adult." Another staff interviewee stated, "Peers can be appropriate to one another. Be kind to one another. Know that everyone of your peers is going through something just as you are, so don't take it out on them." Overall, peer focused interventions and general support are seen as desirable interventions by both staff and youth participants when discussing restraint reduction.

Positive Staff Qualities

        Both youth and staff members at a residential facility provided responses that reflected the importance of positive staff qualities in reducing the number of restraints occurring on the milieu. For example, a youth stated, "The staff could have talked to me and put me in a different room. They could say 'can you go to this room for a few minutes so if you want to talk to us we are available.' It would have been helpful because sometimes I think its better for people to express their feelings rather than be shoved down on the ground." That particular youth indicated that she enjoyed staff members that were willing to communicate with her prior to using a restraint. One staff member shared her belief that a particular personality style triumphs in this

type of work environment, "It takes a special person to cope with being verbally and physically abused everyday. It takes the right personality. If you are not prepared to put these kids before yourself then there is the door." Overall, this cluster, dedicated to positive staff qualities, reflects an important crosscutting theme of theory of mind/empathy, as well as, two unique themes of frustration tolerance and creativity, all three of which are important in the reduction of restraint usage.

      Theory of mind/empathy. The ability for a staff member to access theory of mind skills and empathy were discussed as important for both staff and youth throughout these interviews. For example, a youth participant stated, "Staff members make things worse by not paying attention or listening to what we have to say. The staff don't understand why you're upset and just say, you need to calm down, you shouldn't be that upset over that." In this situation, if a staff displayed empathy by listening to and validating this youth, it may have helped this participant feel more understood. Another youth shared, "When staff say, 'I am going to ground you' that makes me more frustrated and does not help me calm down." A staff member discussed the importance of theory of mind when working with this population by stating "Staff can be more friendly, they can have a positive attitude and encourage the youth to use or learn new coping skills or even encourage the youth to talk. Friendliness is a good way to show the youth they can be comfortable around staff, staff can model that people experience similar emotions while being friendly and professional." This staff elaborated, "It should be all about the kid. Its not for my convenience, its for the kids."

      Frustration tolerance skills. Frustration tolerance represents a unique theme from solely staff participants. One staff discussed her personal experiences with frustration tolerance, "I try really hard not to put kids in restraints. I definitely had those moments where I have said to staff

'I need you to switch with me right now. I am not going to be appropriate.' You need to know yourself to take a break when you need it. And sometimes there is no staff to switch and you have to pull it together." She continued to state, "There are some days when you have to say to yourself, you are working and frustrated but you are working, so get over it pretty much." Another staff reported, "Sometimes staff don't have the patience or frustration tolerance to deal with a youth's particular behavior and the staff's response get laced with attitude, the kids can read that the staff is frustrated." This staff suggested an alternative response to the youth, "You don't want to talk right now, OK. We can try again later." The staff elaborated that "this response modeled the mature way of handling things, rather than just arguing with the youth."

   Creativity/flexibility. Creativity also represents a unique theme from solely staff participants. A staff shared, "You have to be creative, think outside the box, try something, if it doesn't work you are no worse off then when you started. You never know if it will work, especially with some of the off the wall stuff you can try. With little kids, distractions work wonders, like shinny objects, dogs, etc." Another staff stated, "Thinking outside the box, being out there and thinking creatively, for example with the latency kids who are aggressive toward us, we play punch the hand, we try to think outside the box to keep the child entertained as long as they are not hurting us or themselves." Another staff noted, "Everyone has their own strength, I try to use humor a lot. Some people are good with physical stuff, like helping the kids get their energy out in the gym. Everyone brings their own strength to the kids." This staff continued to state, "if a staff is not funny that works even better; now you are annoying the kid, the kid is like 'you're not funny dude' and guess what, she stopped swearing and you can say to her 'how about you tell me a joke that is funny then.' You started a conversation and diverted their mind, and

now you are there telling jokes with them." Another staff discussed the importance of being creative with your living space "use what you have and be creative with the space you have."

Discussion

Qualitative results provided insight into common themes that both youth and staff participants believed would be helpful in reducing the use of restraints. This was discovered by reviewing each interview transcript for information identifying what individuals who live in or work at a long-term residential care facility view as essential to reduce the need for physical restraints.

Summary and Key Findings

What commonalities exist among the perspectives that youth and staff members in residential care experience, regarding what interventions are most useful to reduce restraint utilization? It first is important to note that participants in this study discussed that restraints may be utilized even when they are not the most appropriate intervention for two significant reasons: (a) natural feelings of anxiety that arise during stressful situations and (b) a lack of training on how to respond to the emotions elicited from that anxiety. For example, when staff members' witness violent or aggressive behavior, they may respond automatically with the human responses of fight, flight, or freeze. This could result in an immediate restraint instead of an "explicit thoughtful process through which the youth is more likely to learn self-control" (Lieberman, 2014, p.116). Fortunately both staff and youth participants discussed several interventions that they believe would be most useful in reducing restraint usage. More specifically, staff and youth participants indicated staff education and training, less restrictive interventions, and positive staff qualities as important categories to address in order to reduce the need for restraint usage. Within those general categories, staff and youth participants indicated

specific ideas that also would be important to address, including teamwork, consistency, de-escalation techniques, youth-focused interventions, peer support, and theory of mind/empathy.

Youth and staff member participants identified an overall need for continued staff training and education in order to reduce the number of restraints occurring in the milieu. Training was discussed as important not only because it can decrease unnecessary power struggles that occur on the milieu, but it can also help educate staff how to not to take incidents or comments from youth personally. For example, when a youth says "no" they will not do something, staff members need to use their knowledge from their training to find an alternative approach with the youth (i.e., listening, empathizing, validating, etc.) rather than implementing a restraint. Continued training can also encourage staff members to practice and utilize verbal deescalation techniques as a preferred alternative to a restraint. Participants throughout this study also discussed that encouraging teamwork and trust in one another throughout the continued training is vital. This is because, as one participant noted, "you cannot run an effective unit if you don't trust the people you are working with."

On top of encouraging teamwork, providing training on the importance of consistency was discussed as vitally important in reducing restraint usage. Participants discussed how a lack of consistency from staff member to staff member could be confusing for youth. For example, when there is a lack of structure or a change in routine, youth may act out behaviorally. Additionally, when the rules are not consistently enforced, youth may seek out staff members who bend the rules to avoid arguing with that client. Unfortunately, in the long run, that youth does not receive the treatment he or she needs. Thus continued and ongoing staff training is important for promoting positive treatment and reducing overall restraint usage.

This training could look similar to the debriefing groups that were utilized (and described) in research by Holstead et al. (2010). Holstead et al. found that debriefing groups reduced the need for restraints on a day-to-day basis because staff members had an opportunity to process and understand the youths projected feelings. Thus they were better able to respond to youths' needs, rather than youths' negative behaviors. These groups also provided an opportunity for staff members to discuss barriers experienced on the day to day job, such as, difficultly enforcing unit rules due to lack of consistency or feeling like the "bad staff" when enforcing a rule.

An additional strategy is to consider a restraint reduction committee similar to the type utilized (and described) by Miller et al. (2006) where there was also a significant reduction in restraint usage. Staff members in this group continuously taught other staff members less restrictive interventions such as assessment of the client and situation, behavior management techniques, and verbal de-escalation skills. Both of these interventions, debriefing groups and restraint reduction committees, support the finding from this study of the need for continued staff education and training.

Both youth and staff participants also discussed that less restrictive interventions are preferred to reduce restraint usage on the milieu. Previous research by Steckley and Kendrick (2008) similarly found it important to utilize the least intrusive efforts when attempting to deescalate situations. The preferred interventions discussed in this study included de-escalation techniques, youth-focused interventions, and peer support. De-escalation techniques discussed included calm talking; occupational therapy techniques; and using humor, validation, and planned ignoring. Youth-focused interventions discussed included personalized social stories, reward charts, and self-talk. The peer support intervention discussed was talking with a

supportive peer about the situation. Fortunately, these less restrictive interventions can be taught

and practiced through the continued staff training discussed above.

Positive staff qualities were also discussed as imperative to reducing restraint usage.

These qualities included conversational skills, personality style (primarily putting the clients

needs before one's own), and ability to display empathy and theory of mind. Participants

throughout this study discussed preferring staff members who had the ability to listen, validate,

and understand the youth's point of view. Of note, most of these skills could be taught and

practiced in the on-going staff trainings, again circling back to the importance of that training.

Interestingly, the youths' discussion on positive staff qualities stopped at discussing

empathy and theory of mind. Conversely, staff participants discussed two additional ideas: (a)

the importance of frustration tolerance and (b) creativity, as desirable qualities in a residential

staff member. For the amount of similarities between the youth and staff responses it was

surprising to have this unique set of responses from staff participants. This could be because

youth participants in this sample did not yet have an understanding of these higher-order thinking

skills such as how to tolerate frustration. Additionally, most youth participants within RTF had

poor frustration tolerance (hence the need for treatment) and as a result may not have understood

this skill in others, or have had the language to discuss this skill. Furthermore, youth participants

may not have discussed creativity as important to reducing restraint usage because youth may

have viewed staff members as a blank slate, without emotions, who should unconditionally be

available to assist and support clients.

On the other hand, it was also initially surprising that there were so many similarities

between staff and youth responses in regard to what could reduce restraint usage. This was a

surprise primarily because of the general lack of research on youth perspectives. Reviewing

participant responses and understanding the general idea that residential facilities inherently induce anxiety and stress helped to explain why some unnecessary (not used to ensure safety) restraints occur. More specifically, the anxiety evoked in this environment can cause people to react instantaneously, without thinking through the potential consequences of their response. After identifying this information, it was less surprising that continued education and training were viewed by both youth and staff member participants as vital in reducing negative responses to situations and restraint usage. Overall, participants in this study discussed that the more staff members are educated and the more they practice that education, the better equipped they will be when stressful situations arise.

Clinical Implications

The goal in conducting this study was to discover new insights into both youth and staff perspectives about how restraint utilization might be reduced within residential care. Similar to previous research, it was found that staff training (referred to in previous research as debriefing groups or restraint reduction committee) as well as teamwork, structure, and consistency are all viewed as vital in reducing the need for restraint usage on a residential milieu; additionally in this study it was found that less restrictive interventions and positive staff qualities are also important in order to reduce restraint usage.

This information can be of great use to facilities, programs, directors, and therapists in their approach of training staff members. Ideally, the governing agencies of residential facilities would implement a policy stating that all staff members receive a certain amount of training and continued education each year, as well as, provide the funds to support that. In Massachusetts the governing agencies would include Department of Early Education and Care, Department of Children and Families and Department of Mental Health. This continued training would be on

top of any mandatory training required to begin employment. Currently in Massachusetts where these data were gathered, the Department of Early Education and Care (EEC) mandates one hour per month of on-going clinical training. The specific number of hours required would need to be parsed out through additional research, as training hours required for success was not the focus of this particular study. Required training will be very important because of the general idea that residential facilities inherently induce anxiety and stress, which can cause people to react instantaneously, which, without adequate training, could lead to excessive restraint usage that potentially could have been avoided if trained properly.

In addition to implementing policies at the governing agency level, the information gained from this study indicates that program directors and therapists at residential facilities should review and, if necessary, update their staff training agenda and frequency of trainings in order to better serve their staff and youth in reducing overall restraint usage. Optimally, this training should review the importance and practice of less restrictive interventions, teamwork, structure, and consistency on the milieu. More specifically, staff should be trained and reeducated on various forms of alternative interventions such de-escalation techniques, calm-talking, how to appropriately use humor, personalized social stories, and other alternative techniques with youth.

Further research might specify the optimal amount and content of training. However, one way to start might be providing training in the form of a two-part, monthly staff meeting, where one topic is addressed in each session (e.g., how to create a personalized social story with a client or how to use calm-talking with a client). After a didactic presentation, the second half of this training might provide staff members with time to practice this skill through examples (e.g., work with a partner to create a social story to help a youth who is arguing with a friend or engage

in a role play with provided case example of an angry client making negative comments toward staff and as the staff, practice how to best respond). With these monthly trainings, staff would receive increased and regular continued education and training.

This training should also encourage team building through various activities. Activities that encourage and practice collaborative problem solving and teamwork would be responsive to the findings of this study and the suggestions of participants. The usefulness of each session and the effectiveness of the enhanced training approach will need evaluation and improvements over time.

Training sessions should also provide a space for staff members to process any difficult incidents that occurred on the unit in an effort to minimize countertransference and prepare for future similar situations. This should occur in small groups to ensure participation (8-10 members maximum). Ideally, the time to process difficult incidents would be prescheduled as a mandatory staff and therapist meeting. This could occur in addition to content-driven staff trainings. These process sessions would encourage trust, open communication, validation, and support. It would be important for a team therapist to be present to help staff members understand incidents from a psychological viewpoint.

Specifics of timing, number, duration, and content of continued trainings were not a focus in this study. However, this research may stimulate further research into the effectiveness of these training methods as a way to better optimize training for successful reduction of restraint usage at long-term residential facilities.

Additionally this research suggests that personnel who interview potential new staff members may find it beneficial to advertise for and select applicants with qualities including theory of mind, empathy, good listening skills, creativity, and strong frustration tolerance. When

interviewing these applicants, directors and therapists can examine the qualities mentioned above through particular interview questions.

In addition to these systematic changes initiated by directors and therapists, this research suggests that staff members at long term residential facilities can also educate and train other staff members in real time on the job. For example, if staff members witness a power struggle between a youth and another staff member, they can offer to change places with that staff member in the interaction and then later, without the youth present, address how the power struggle might have been avoided.

What are the participants' (i.e., youth and staff) views about when and where restraints are necessary? Both youth and staff participants discussed that restraints are only necessary under some limited circumstances, that is when a youth attempts to hurt themselves or another person. For example, a youth stated that if they were punching someone, it would be necessary for them to be restrained. Staff members discussed the need to keep themselves safe when a youth is 'out of control' and aggressing toward them, another staff member, or another youth. Participants agreed that overall, in some instances, restraints can be imperative to maintain safety.

Previous research identified that staff members have been utilizing restraints for over 200 years to help maintain the safety of youth exhibiting aggressive behaviors (Tilli & Spreat, 2009). Research has also found that most youth and staff in residential facilities deem restraint utilization as acceptable and necessary in some circumstances (Steckley & Kendrick, 2008). Thus, the results from this research support prior research.

When and where are alternatives to restraints most appropriate? As discussed above, restraint usage can be necessary to maintain safety. On the other hand, restraint usage can

be dangerous. For example, staff and youth participants in this study discussed incidents of personal harm that occurred as a result of a restraint including a head injury, twisted ankle, and temporary loss of blood circulation. Overall, this research supports prior research in acknowledging that alternatives to restraints are the best practice in many situations due to the potential physical and psychological dangers associated with restraint usage.

Staff and youth participants in this study discussed that appropriate alternatives to restraints are always preferred when safety is not an immediate concern. For example, if a youth is attempting to elicit a negative response from a staff member (i.e., making negative comments about the staff member's family, continuously saying "no" to a staff request) an alternative intervention such as calm talking was viewed as always preferred over a restraint. Participants discussed that if less restrictive interventions (i.e., humor, distraction, validation) would deescalate a situation it would always be preferred over the use of a restraint. Participants also discussed that when youth-focused interventions such as personalized social stories, self-talk, and music would defuse a situation, they would also be preferred as alternatives to the use of a restraint. These preferred interventions could be taught and practiced in the on-going staff trainings, again circling back to the significance of that training.

Clinical implications. Gathering this information from participants increases our general awareness about times when restraints are viewed as appropriate forms of intervention, as well as times when they are not. The information learned through this research about preferred alternative interventions to restraints helps to refine our training curriculum discussed above. More specifically, during the proposed staff meetings, important training topics might include the following topics suggested by participants: how to use humor as a de-escalation skill, how to avoid a power struggle, calm talking, validation and its relationship to restraint reduction, how to

use distraction as a de-escalation skill, how to create and use social stories, how to use self-talk

with clients, and how music might be used as an intervention. Future research might examine the

benefits and pitfalls of this continued staff training in order to reduce physical restraint usage.

Feasibility

The original goal was for this study to include a total of eight participants (four youth and

four staff members). In the end, three youth and four staff members participated fully. All three

youth were in the custody of department of children and families (DCF). I received consent from

each of their DCF social workers, as well as ascent from them personally. Overall, access to

youth participants was relatively difficult to obtain due to the additional need for guardian

consent, whereas, staff participation and consent were easier to obtain. The protection of this

youth population could be one of the reasons why there is such little research on youth

perspectives in regard to restraint usage. Fortunately a phenomenological method was utilized

for this specific study, which can be of value with a smaller sample size. Thus, the unmet sample

size goal was not detrimental to what can be learned from this study.

Interestingly, the three youth who participated were all female. This is significant because

previous research has indicated that the female adolescent population in residential treatment is

growing at a faster rate than the male adolescent population (Leidy et al., 2006). Thus, gaining

perspectives from this growing population of adolescent females is important.

Of note, the three clients interviewed in this study (along with being female) were also in

custody of the state. Previous research, albeit dated, indicates that 51% of youth in RTF are in

the custody of the state (Wells & Whittington, 1993). Thus, the three youth participants were not

outliers relative to the general RTF population. Regardless, without information from male

clients and youth who are not in custody of the state, the data may not represent the entire

population of RTF clients.

Limitations of the Study

As is true for most studies, this study was not without limitations. For example, this study

was solely conducted at one agency in Massachusetts. Thus, the results may not be generalizable

to other agencies or regions of the United States or the world. Additionally, this study had a

small sample size, which could have biased the results. When using interviews as the method of

data collection for qualitative research there are several additional limitations such as a reliance

on self-reports and memory, as well as an inherent degree of subjectivity. For example, if the last

restraint the participant experienced was 10 years ago, the amount of time that has passed may or

may not have impacted her memory of that event differently than if the restraint were more

recent.

To minimize these limitations, several steps were taken. For example, participants were

not limited to discussing restraint scenarios from only this one facility. If appropriate,

participants could discuss restraint scenarios from other facilities. Inclusion criteria for

participants contained a clause which stated, "been involved in or witnessed, a restraint within

the last 5 years" to mitigate the limitation of altered memory. Additionally, the interview data

were disconnected from participant personal data making the data confidential for peer review.

I worked as a clinician at this residential facility and engaged in weekly therapy with all

three of the youth participants, which could have impacted the results as well. Youth and staff

might have provided inaccurate information due to a desire to make accusations about their

current program or to support it, to please the researcher, or for other reasons. Youth may have

left out information or may have provided more information because of the previous relationship

with the researcher. Additionally, a therapy dog was present in the room throughout the interviews, which also may have impacted the results. The therapy dog is typically utilized as an adjunct intervention; her presence may have impacted how much information participants chose to share or not to share.

Personal biases. An important aspect of a phenomenological study is for the researcher to *bracket her bias* (i.e., to clearly state her preconceptions that could impact the research process, as a way to mitigate the effects those preconceptions may have on the overall study). More specifically, bracketing ones biases is a way to help the reader to understand the researcher's position, biases, and assumptions that may impact the study. Therefore, I outline my position and biases below.

I believe that restraints are used much more often than necessary, which could have skewed how I analyzed the data. I worked as a direct-care staff member at a long-term residential care facility full-time for a year, and then continued to work on a per-diem status for 3.5 years. I initiated several restraints throughout that portion of my career. Looking back on those restraints, some were necessary to ensure safety, while some likely would have been preventable with verbal deescalation techniques (e.g., calm talking). I believe that it is difficult to justify the frequency with which restraints are used given the negative effects that accompany their use (i.e., the physical and psychological harm discussed in the literature review). I have witnessed a client become distraught during a restraint and scratch his forehead until he bled profusely. I witnessed another client attempt to strip naked in efforts to escape a potential restraint. Overall, I have seen the detrimental effects of being restrained, implementing a restraint, and witnessing a restraint. As a staff member, I have often worried because I did not feel the youth were learning how to regulate their bodies or their emotions while we, the adults, ultimately had three staff holding

them on the floor. As a result, I personally try to use all other interventions prior to utilizing a restraint.

Throughout this study, I was careful not to add my personal thoughts or feelings into the participant interviews, data analysis, or report of the results. For this reason, I utilized a peer reviewer to check on my understanding of the data. A potential personal source of bias was that I worked for the facility where I collected data. Working at a facility has the potential of skewing the analysis as employee or trainee might not want to portray their place of employment in a negative manner, or conversely, might be motivated to primarily do just that. For this, I utilized a supervisorial reviewer to check on my understanding of the data.

Conclusion

Previous research notes the use of physical restraints for the past 200 years (Tilli & Spreat, 2009), as well as indicates that most staff members believe that restraint usage can be necessary in certain situations (Steckley & Kendrick, 2008). On the other hand, research also indicates that restraint usage can be physically and psychologically dangerous (Day et al., 2010; Miller et al., 2006). To date, youth in residential care have not had a sufficient opportunity to voice their opinion on exactly how to reduce the need for restraint use or what deescalation skills they feel would be beneficial in a personal time of crisis.

The purpose of this study was to fill that gap in the research by interviewing both youth and staff participants at a long-term residential facility and then exploring similarities and differences in their responses. When reviewing the responses, many commonalities were found between youth and staff member perspectives in regard to what interventions they believed to be most useful to reduce restraint utilization. Overall, participants discussed the need for continued staff training and education, less restrictive interventions, and positive staff qualities.

This continued training would focus on the importance of de-escalation techniques (i.e., calm talking), structure and consistency on the milieu, and team building. Optimally this training would allow staff members to practice less restrictive interventions such as calm talking, encourage teamwork through team building activities, and provide space for staff members to process any difficult incidents that occurred on the unit. Previous training programs implemented to reduce restraint usage that are supported in the research include debriefing groups (Holstead et al., 2010) and restraint reduction committees (Miller et al., 2006). These training programs respectively allow staff a place to process incidents as well as practice skills and receive training in real time on the milieu.

Participants in this study also discussed the need for less restrictive interventions, such as de-escalation techniques, youth-focused interventions, and peer-support interventions in order to reduce restraint usage. De-escalation techniques discussed included calm talking, occupational therapy exercises, humor, validation, and planned ignoring. Youth-focused interventions discussed included personalized social stories, reward charts, self-talk and use of personal coping skills (i.e., music). Peer support was discussed as receiving verbal support from a peer on the unit when distressed. Ideally, continued staff training and education on these interventions would occur in addition to pre-employment training and would occur on an ongoing basis. Specifics on the frequency and content of trainings were not a focus in this study. However, this research may stimulate further research into the effectiveness of specific training approaches. The suggestions of participants in this study provide a starting point for practice and the evaluation of the effectiveness of ongoing training in reducing restraint use.

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Appendix A
Participant Inclusion and Exclusion Criteria

Figure A1: Youth Participant Inclusion vs. Exclusion Criteria

Youth Inclusion Criteria	Youth Exclusion Criteria
Youth that live at long-term residential and/or group home level of care	Youth that do not live in long-term residential or group home care.
Age: 12-17.11 years old	Under 12 and 18 +
Restraint free for 7 days	Youth who have been in a restraint can participate when they have been restraint free for seven consecutive days (providing time to process the incident).
Been involved in, or witnessed, a restraint within the last 5 years (at this program OR another program)	Not been involved in, or witnessed, a restraint within the last 5 years.
Youth in the custody of their legal guardian	Youth in the custody of the Department of Children and Families (DCF). If I do not get enough participants then I will contact DCF to apply for a DCF Institutional review board hearing and request permission from the state to interview youth under their guardianship.

Figure A2: Staff Participant Inclusion vs. Exclusion Criteria

Staff Inclusion Criteria	Staff Exclusion Criteria
Staff that work at long-term residential and/or group home level of care	Staff that do not work at long-term residential or group home care.
Restraint utilization free for 7 days	Staff members that have been involved in a restraint can participate when they have been restraint free for seven consecutive days.
Been involved in, or witnessed a restraint within the last 5 years (at this program OR another program).	Not been involved in, or witnessed, a restraint within the last 5 years.

Appendix B
Semi-Structured Interview for Youth

Date/Time of Interview:	Place:	Interviewee ID:	Position of interviewee:

Purpose: The purpose of this interview is to learn about your ideas concerning the use of physical restraints on this unit and any other programs you have been in. I especially want to learn about your thoughts in regard to reducing the use of physical restraints. I'll be asking your peers these questions as well. I greatly appreciate your talking to me and sharing your ideas with me. As a reminder, this researcher has tried to make sure no one else will know everything you said. Additionally, no one else at this agency will see your answers in a manner that is associated with your name. I appreciate your agreeing to talk with me about your thoughts and feelings regarding physical restraint use.

- Do you have any questions for me?

- Are you ready to begin?

1. What is your experience like on this unit that you are currently living on?
   - **Prompt:** What is it like to live here?
   - **Prompt:** What is the primary emotion you've experienced on this unit?

2. What is your definition of a physical restraint?

3. Have you ever been restrained?
   - **Prompt:** What types of restraints have you experienced?

4. When and where was the last time you were restrained?
   - **Prompt:** Have you been restrained on the unit you are currently living on?

Follow up questions:

What was happening before you were restrained?	
Was the restraint necessary?	
What could have been done differently?	
If the restraint did not occur here, what was your experience like on that unit (other than being restrained)?	

5. What do you feel is the purpose of a physical restraint?

6. When do you think restraints are acceptable or necessary?

7. When do you think restraints are unacceptable or unnecessary?

8. How have restraints been helpful to you or someone you know (pros)?

9. How have restraints been harmful to you or someone you know (cons)?

10. What do you see as your role, if any, in regard to controlling restraint usage when you are starting to feel dysreguated?

11. What helps prevent you from getting restrained?

Follow up Questions/Prompts:

Is there anything **you** can do to help prevent you from getting restrained?	
Is there anything **staff** can do?	
Is there anything **peers** can do?	
Is there any way the **environment** could be changed to help prevent you from getting restrained?	

12. Have you seen or been in a restraint that could have been prevented or handled differently?
    - **Prompt:** What could have been done differently?

13. Is there anything peers or staff have done that has escalated the situation with your peers or yourself, requiring a restraint to become necessary?

14. Is there anything a clinician could do if they are nearby to help calm a youth before staff members deem a restraint is necessary?

15. Think about the last time you were restrained, could staff have done anything differently to prevent that restraint?

Prompt for:

Where was that restraint?	
If that restraint was not here, think of a restraint you've witnessed here… were there things staff members could have done differently to prevent that restraint?	

16. If a staff notices that a youth is becoming verbally aggressive and might become physically aggressive, what could staff do in that moment to help reduce the likelihood of a necessary restraint?

17. Is there anything that could be changed about the way the unit runs to reduce restraints?

Prompt for:

Visible setup of the unit	
Unit Schedule	
Unit Rules/Administration	
People and how they relate to each other	
Clarity of why restraints occur?	

18. Do you have other ideas about ways to reduce restraints?

19. That is the end of my questions,

- How are you feeling?

- Do you have any questions or concerns for me, or anything you would like to talk about?

Appendix C
Semi-Structured Interview for Staff

Date/Time of Interview:	Place:	Interviewee ID:	Position of interviewee:

Purpose: The purpose of this interview is to learn about your ideas concerning the use of physical restraints on this unit and any other programs you have worked at. I especially want to learn about your thoughts in regard to reducing the use of restraints. I'll be asking your fellow employees these questions as well. I greatly appreciate your talking to me and sharing your ideas with me. As a reminder, this researcher has tried to make sure no one else will know everything you said. Additionally, no one else at this agency will see your answers in a manner that is associated with your name. I appreciate your agreeing to talk with me about your thoughts and feelings regarding physical restraint use.

- Do you have any questions for me?

- Are you ready to begin?

1. What is your experience like on this unit that you are currently working on?
   - **Prompt:** What is it like to work here?
   - **Prompt:** What is the primary emotion you've experienced on this unit?

2. What is your definition of a physical restraint?

3. Have you ever restrained a youth?
   - **Prompt:** What types of restraints have you utilized?

4. When and where was the last time you restrained a youth?
   - **Prompt:** Have you restrained a youth on the unit you are currently working on?

Follow up questions:

What was happening before the restraint?	
Was the restraint necessary?	
What else could have been done differently?	
If the restraint did not occur here, what was your experience like on the unit it occurred on (other than restraining the youth)?	

5. What do you feel is the purpose of a physical restraint?

6. When do you think restraints are acceptable or necessary?

7. When do you think restraints are unacceptable or unnecessary?

8. What are some ways you feel restraints been *helpful* to clients (pros)?

Follow up Questions

Physically	
Psychologically	
Emotionally	

9. What are some ways you feel restraints have been *harmful* to clients (cons)?

Follow up Questions

Physically	
Psychologically	
Emotionally	

10. What are some ways you feel restraints been *helpful* to staff members (pros)?

Follow up Questions

Physically	
Psychologically	
Emotionally	

11. What are some ways you feel restraints have been *harmful* to staff members (cons)?

Follow up Questions

Physically	
Psychologically	
Emotionally	

12. What do you see as your role, if any, in regard to controlling restraint usage?

13. What have you noticed can help prevent clients from getting restrained?

Follow up Questions/Prompts:

Is there anything **the client** can do to help prevent themselves from getting restrained?	
Is there anything **staff** can do?	
Is there anything **peers** can do?	
Is there any way the **environment** could be changed to help prevent you from getting restrained?	

14. Have you seen or been involved in a restraint that could have been prevented or handled differently?
    - **Prompt:** What could have been done differently?

15. What do/can staff members do when they see a youth who is demonstrating early warning signs such as yelling and cursing?

16. How do staff members decide whether to approach a youth or to give a youth space that is becoming verbally aggressive and may become physically aggressive?

17. How many times will/do staff typically attempt to deescalate an aggressive youth before determining a restraint is necessary?
    - **Prompt:** Do you feel this reasonable?

18. Have you ever looked back on a restraint and felt it was not necessarily done as a way to prevent demonstrable danger?

19. What could a clinician do if they are nearby to help deescalate youth before staff members deem a restraint is necessary?

20. What could be changed about the way the unit runs to reduce restraints?

Prompt for:

Visible setup of the unit	
Unit Schedule	
Unit Rules/Administration	
People and how they relate to each other	
Clarity of why a restraint occurred?	

21. Do you have other ideas about ways to reduce restraints?

22. That is the end of my questions,

- How are you feeling?

- Do you have any questions or concerns for me, or anything you would like to talk about?

Appendix D
Cover Letter to Participants

RE: Dear Participant or Guardian of Potential Youth Participant,

I am writing to formally correspond with you about the research study titled, *Perspectives on Restraint Reduction in Long-Term Residential Facilities* being conducted by this clinician and student at Antioch University. I received your verbal permission for your daughter's participation in this study by phone on [INSERT DATE]. I am now sending the written consent for legal purposes.

The purpose of this study is to discover the essence of how clients and staff in long-term residential care believe the need for physical restraints can be reduced, as well as, the essence of which deescalation skills reduce the need for restraints. I hope to learn which interventions for reducing restraint usage can be implemented at residential facilities so that increased quality of care can occur. Your daughter is eligible for this study because she currently resides at a long-term residential facility.

If you are interested in learning more about this study, please review the enclosed information, complete the enclosed consent form, and mail it back in the pre-paid envelope. You can also call us at (INSERT PHONE NUMBER) if you have any questions or concerns.

It is important to know that this letter is not to tell you to allow your daughter to join this study. It is your decision. Your consent for your daughter's participation is voluntary. Whether or not you decide she can participate in this study will have no consequences or effect on your relationship or hers with the agency.

You do not have to respond if you are not interested in this study. If you do not respond, no one will contact you, but you may receive another reminder letter in the mail, which you can simply disregard.

Thank you for your time and consideration. We look forward to hearing from you.

Sincerely,

Ashley Welch

Ashley Welch, PsyD Candidate

Appendix E
Written Informed Consent

Volunteer Consent for a Study about Restraint Reduction in Residential Settings

Study Name.
     Perspectives on Restraint Reduction in Long-Term Residential Facilities

Researcher.
     Ashley Welch, 3rd year PsyD Student, Clinical Psychology, Antioch University New England.

Dissertation Chair.
     Kathi Borden PhD.

Antioch University New England asks you to take part in a research study about restraint reduction in long-term residential facilities.
     The purpose of this study is to help understand the essence of how clients and staff in long-term residential care believe the need for physical restraints can be reduced. As well as, which deescalation skills youth and staff believe will successfully reduce the need for restraints.
     Data will be used to examine similarities between youth and staff's thoughts about how restraints can be reduced in long-term residential care.
     This knowledge will inform realistic interventions for reducing restraint usage that can later be implemented at residential facilities.

If you agree to participate in this research, some of your story will be incorporated into the research results. However, you and your family will not be named or identified.
     The researcher will interview you using a semi-structured interview protocol to learn about the essence of your thoughts on how restraint usage can be reduced. The researcher may ask a few more questions to learn more about your particular story.

Participating in this study will take at most <u>2 hours of your time</u> and will take place in an office at the residential program you reside at.
     This researcher plans to interview you for about one hour in an office at the residential program you reside at. This interview will be audio recorded and notes will be taken. Of note, you can decline to answer any questions that may cause you discomfort.

The benefit for partaking in this study is to add knowledge about reducing restraints in long-term residential facilities.
     By participating in this study, you will help the field gain knowledge about how to successfully reduce restraint use in residential facilities. This knowledge will make people more aware of your situation, as well as, will help inform further research.

You may experience discomfort when taking part in this study. However, Antioch University and this researcher have tried to prevent any risk to you.

You may feel uncomfortable answering some of the questions. However, you are not obligated to answer any question that you see unfit.

This researcher has tried to make sure no one else will know everything you said.
Your name is not on the interview protocol with your responses. Only a special code number is there. The researcher will keep your code number and name locked up. When the research is complete all materials will be destroyed.

You have rights as a research volunteer.

Taking part in this study in voluntary.
If you do not take part there will be no penalty.

You may stop taking part in this study <u>at any time</u>.
You may stop participating at any time, with no penalty or less of any benefits.

If you have any questions about your rights as a research participant, you may contact the chair of the Antioch University New England IRB.

Consent Statement:
I have read and understood the information above. The researcher has answered all the questions I had to my satisfaction. She gave me a copy of this form. I consent to take part in the Restraint Reduction in Residential Facility Research Study.

Signature: _____ **Date:** _____

Witness: _____**Date:** _____

Youth Ascent:_____ **Date:** _____

(Note: The readability of this Consent Form is 8th grade. There are 40 sentences with an average length of 13 words and only 15% are in the passive voice. The text is 597 words.)

Appendix F

Table F. Results as Clusters, Crosscutting Themes and Unique Themes

Clusters/ Themes	Anxiety-Inducing Environment	Staff Training and Education	Least Restrictive Intervention	Positive Staff Qualities
Crosscutting Themes	Restraints Can Be Unsafe	Teamwork and Communication	De-escalation Techniques	Theory of mind/Empathy
Crosscutting Themes	Restraints Can Be Imperative to Maintain Safety	Consistency	Individualized Intervention	
Crosscutting Themes			Peer Support	
Unique Themes to Staff Participants				Frustration Tolerance Skills
Unique Themes to Staff Participants				Creativity/Flexibility

Appendix G

Figure G. Conceptual Map of Results as Clusters, Crosscutting and Unique Themes