STANDARDS OF PRACTICE: Seclusion and Restraint

(May 2000; Revised, May 2007; Revised, April 2014; Revised, February 2022)

Contents

- Definitions……………………………………………………………………………………...1
- Introduction to Standards……………………………………………………………………2
- Standards of Professional Performance…………………………………………….......3
  - Leadership………………………………………………………………………………3
  - Staff Training……………………………………………………………………...........4
  - Performance Improvement…………………………………………………………..5
- Standards of Care…………………………………………………………………………....6
  - Collaborative Work with Individuals and Caregivers upon Admission…………….6
  - Treatment Plans and Interventions…………………………………………………7
  - Initiation of Seclusion or Restraint…………………………………………………7
  - Monitoring and Assessment of Individuals in Seclusion or Restraint……………...9
  - Release from Seclusion and Restraint……………………………………………..10
  - Documentation………………………………………………………………………11

Definitions

Seclusion: "Seclusion is the involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior." (Medicare and Medicaid Programs: Hospital Conditions of Participation: Patients' Rights (42 CFR 482.13), published in the December 8, 2006, Federal Register (Volume 71, Number 236; page 71427)).

Restraint: "A physical restraint is (A) any manual method or physical or mechanical device, material or equipment that immobilizes or reduces the ability of a person to move his or her arms, legs, body or head freely; or (B) a drug or medication when it is used as a restriction to manage the person's behavior or restrict the person's freedom of movement and is not a standard treatment or dosage for the person's condition; (C) a restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort)." (Medicare and Medicaid Programs: Hospital Conditions of Participation: Patients' Rights (42 CFR 482.13), published in the December 8, 2006, Federal Register (Volume 71, Number 236; page 71427)).

Introduction to the Standards

The American Psychiatric Nurses Association (APNA) "Position Statement on the Use of Seclusion and Restraint" articulates both the vision of eliminating seclusion and restraint as well as the background and principles that support these standards. The original position statement emphasized prevention and reduction of the use of these restrictive methods and their application only in behavioral emergencies where violent or self-destructive behaviors pose an immediate risk of harm to a person or others. The foundation for the 2007 Standards revision included best practices that have supported successful seclusion and restraint reduction, and in some cases elimination, in settings across the nation. Clinical advances have played a significant role in the emerging best practices. However, considering the growing realization that hospital characteristics have substantial influence on seclusion and restraint use, the revised standards articulate important characteristics of a work culture that support minimal seclusion and restraint use, and that are necessary to realize the vision of elimination. The 2014 revision validated the fundamental principles and practices set forth previously, with minor changes made to the standards of care during initiation, monitoring and release from seclusion or restraint. Of note, the word “benefits” was removed from descriptions of the decision-making process that precedes the initiation of seclusion or restraint. The monitoring and assessment standards were changed to include the best practices of continuous monitoring for persons in seclusion as well as restraint, the measure of oxygen saturation during restraint assessment and inclusion of the “trained and competent registered nurse or physician’s assistant” in the decision-making process for release from seclusion or restraint. Standards revisions were informed by an understanding of the importance of recovery principles and of the need to provide trauma informed care. The 2022 revision recommends communicating in a person’s preferred language using preferred personal pronouns. It recognizes the need for use of evidence-based tools to predict aggression and measure characteristics of incidents of violence. Such tools can contribute valuable data that will enable nurses to test the effectiveness of clinical interventions designed to prevent the need for the use of seclusion and restraint.

Effective administrative and clinical structures, processes, and resources support psychiatric-mental health nurses to maximize the leadership they provide in establishing a treatment environment that is person-centered and non-coercive. Such an environment supports the goal of working within a collaborative relationship with the person, and a partnership with the caregiver, to formulate an individualized treatment plan. This plan is written in terms the person can understand and promotes the person's self-management.

Although it is recognized that the recipient of psychiatric-mental health nursing services has historically been referred to as "patient," the term "person" or “individual” is used in these standards to communicate their applicability to all populations and settings where behavioral emergencies occur.

Standards of Professional Performance

Leadership

Standard: Psychiatric-mental health nurses provide leadership to create a culture that minimizes the use of seclusion or restraint, while promoting a safe environment for persons served as well as staff. Organizational leaders working toward realizing the vision of seclusion and restraint free environments must ensure sufficient resources, as well as effective administrative and clinical structures and processes, to prevent behavioral emergencies and to support the implementation of alternatives.

Intent: Organizational factors influence nurses' ability to effectively utilize alternatives to seclusion and restraint. Therefore, nursing leadership participates with executive staff and medical staff leaders to foster a work culture that supports improvement and innovation in practice and is distinguished by:

- Shared ownership for minimizing and ultimately eliminating seclusion and restraint use.
- Collaborative processes and open dialogue to facilitate critical inquiry and increase organizational capacity to learn.
- Non-hierarchical communication that is centered on the needs of the individual and that fosters sharing of perspectives and ideas.
- Ongoing evaluation of training program content, administrative policy, and practices to ensure alignment that supports the use of alternatives to seclusion and restraint.
- Structures that support nursing practice governance and an environment within which the registered nurse utilizes critical thinking and judgment in determining courses of action.

Intent: Nursing leadership at all levels of organizations that use seclusion or restraint for behavioral management must ensure:

- Organizational commitment to the physical and emotional safety and health of individuals served and staff.
- Organizational responsibility to clearly identify the source of the highest standards that are the foundation for facility policies in order to facilitate policy evaluation and practice alignment.
- Organizational commitment to the ethical obligations described in the Code for Nurses (American Nurses Association, 2001) including protection of individual dignity and rights as well as mechanisms to report and investigate potential abuse and to resolve grievances.
- Facilitation of personal empowerment by providing opportunities in the clinical environment for individuals to learn to manage their own behavior rather than one that emphasizes staff control.
- Policy development at the organizational level that stresses the use of ... non-physical interventions and individuals' self-management as the preferred alternatives to seclusion and restraint.
- Necessary clinical structures, processes and resources are in place to support assessment, prevention, and early intervention in behavioral emergencies.
- Role functions and responsibilities are well-differentiated and based on licensure and demonstrated competencies.
- Necessary administrative structures are in place to fulfill the commitment to safety for the staff and the individuals served including provision of a defined program of support for

persons who are assaulted or who witness aggressive or other disturbing events, opportunities for debriefings, and thorough analysis of all staff injuries.
- Sufficient human resources are available to limit the circumstances that give rise to the use of seclusion and restraint, to maintain a safe environment, and to support sound practices for the prevention of restraint and seclusion.
- Adequate registered nurses, other nursing staff, and support services staffing levels are determined by such factors as characteristics of persons served, service intensity, context of care and provider expertise (APNA Position Paper on Staffing, 2022).
- Identification and resolution of environmental conditions that adversely influence safety or give rise to the use of seclusion or restraint.
- Recognition of the trauma and subsequent disruption to the therapeutic alliance that results from seclusion and restraint use.

Standard: Psychiatric-mental health nurses provide leadership for individual and staff safety in settings providing primary or emergency care, medical or surgical treatment, rehabilitative, residential, or educational services to persons needing or utilizing behavioral health services. In addition, psychiatric-mental health nurses provide services to people who have a mental illness and are involved in the criminal justice system.

Intent: When behavioral healthcare service needs emerge in the types of settings described in the above standard, registered nurses actively advocate and provide leadership that:
- Secures consultative expertise from trained and competent psychiatric-mental health providers at the earliest possible time.
- Ensures that services are provided in a manner that integrates the behavioral health care needs.
- Engages persons who are involved in the criminal justice system to address dynamic factors that can reduce risk, identify, and develop protective factors, and establish a treatment plan that does not rely on seclusion and restraint use to fulfill public safety obligations.
- Involves the person to identify triggers, precipitating factors and ways staff might help to prevent a behavioral emergency as well as alternatives that staff might implement during a behavioral emergency.

Staff Training

Standard: Any staff providing care to persons at risk for harming themselves or others and who participate in seclusion and restraint shall have received training and demonstrate current competency in all aspects of dealing with behavioral emergencies.

Intent: Training programs focused on the prevention and use of seclusion and restraint must:
- Be standardized throughout the institution.
- Be approved by the organization ensuring that program components include adequate attention to the clinical contributors to behavioral emergencies, the actual management of those emergencies, and the assessments and interventions necessary to maintain physical well-being.
- Be evaluated at regular intervals to ensure incorporation of evidence based and best practices.
- Be provided during a staff member’s orientation period and at least annually thereafter.

- Include an opportunity for staff to demonstrate competency in both knowledge and applied skills.
- Include content related to the risks for positional asphyxia, aspiration, and traumatization.
- Include content related to the use of a team, i.e., team roles as well as techniques for facilitating team communication and cohesion.
- Address concepts related to prevention such as treatment processes, transference, countertransference, use of de-escalation techniques, mediation, providing a least restrictive environment, problem solving and other non-physical interventions including pharmacological and nonpharmacological interventions.
- Increase staff self-awareness of how their own culture, biases, values, and perceptions influence their response to a behavioral emergency and how their behavior may escalate a potentially volatile situation.
- Include information on organization-approved policies including physical holds, application and removal of mechanical restraints, principles of monitoring the person in seclusion or restraint and behavioral criteria for release.
- Promote understanding and recognition of the underlying physical and emotional conditions, medications, and their potential effects as well as how age, developmental level, cultural background, history of physical or sexual abuse, and prior experience with seclusion or restraint may influence behavioral emergencies and affect the response to seclusion or restraint.
- Differentiate chemical restraint from medication that may support and assist the person to successfully manage circumstances that could give rise to a behavioral emergency.

Performance Improvement

Standard: Data are systematically collected on all incidents of seclusion and restraint to both monitor performance and guide improvement initiatives.

Intent: Organizations establish a system for data collection and analysis of all seclusion and restraint episodes to:

- Ensure that seclusion and restraint use is limited to behavioral emergencies.
- Identify work culture, system, and process changes that would support the use of alternatives to seclusion and restraint.
- Identify the instances where less restrictive methods could be used more effectively.
- Identify thresholds such as multiple incidents and prolonged use that require treatment teams to identify factors that sustain, promote, or reinforce behavioral emergencies and develop plans to address those factors.
- Examine patterns or trends of seclusion or restraint use that may be associated with person, unit, or staff characteristics.
- Satisfy the requirements of all regulatory agencies and contribute to a national data set available for cross-organization benchmarking.

Intent: Methods of data collection are integrated with the daily work processes, build a data set on seclusion and restraint, and include for all episodes:

- Time and date episode occurred.
- The names and job classifications of staff involved.
- Circumstances and location of behavioral emergency.
- Length of episode.

- Type of restraint used.
- Injuries to the individual or to staff.
- Other less restrictive methods attempted prior to seclusion or restraint.
- Data derived from debriefings including when it occurred, who was present and content.

Intent: Aggregate data are analyzed at monthly intervals and include examining:
- Number of episodes of seclusion and restraint use.
- Number of hours of seclusion and restraint use.
- Number of persons in seclusion and restraint.
- Average number of hours per person in seclusion and restraint.
- Number and severity of injuries to individuals served and staff
- Other setting-specific indicators of quality in the clinical care and treatment processes that may relate to seclusion and restraint use.
- Ongoing evaluation of the degree to which communication within the work culture supports the prevention of behavioral emergencies and the use of alternatives to seclusion and restraint.

Intent: Aggregate data are reported annually to the appropriate regulatory agencies using a methodology that supports benchmarking and that include:
- Deaths and other sentinel events.
- Total number of episodes of seclusion and restraint calculated as a rate per 1000 patient days.
- Monthly average rate of episodes of seclusion and restraint.
- Total number of hours of seclusion and restraint calculated as a rate per 1000 patient hours.
- Monthly average rate of hours per person in seclusion and restraint.

Standards of Care

Collaborative Work with Individuals and Caregivers upon Admission

Standard: During the individual's admission, the psychiatric-mental health nurse collaborates with the individual and caregivers to formulate strategies that may minimize the potential for a behavioral emergency and the subsequent use of seclusion or restraint.

Intent: The psychiatric-mental health nurse uses the admission event as an opportunity to:
- Discuss the organizational philosophy on the use of seclusion and restraint with the individual and caregiver.
- Ascertain the existence of any applicable Behavioral Health Advance Directives.
- Assess the individual's risk factors for a behavioral emergency.
- Gather data on effective strategies that have been used by the individual and/or caregivers to reduce or prevent behavioral emergencies.
- Teach individuals and families to assess for risk factors, triggers, and warning signs of escalation.
- Discuss medications that the individual finds effective in assisting him/her to manage circumstances that could trigger a behavioral emergency.
- Formulate individualized treatment objectives and interventions that emphasize the person's strengths and minimize the potential for a behavioral emergency.

- Discuss with the individual and caregiver methods that are used in the treatment setting to prevent behavioral emergencies and promote safety/risk management.
- Discuss the role of the caregiver and the individual's wish for caregiver/significant other's notification of a seclusion or restraint episode.

Treatment Plans and Interventions

Standard: The nursing response to persons during evolving behavioral emergencies is least restrictive and based on a comprehensive initial and ongoing assessment of the person. The assessment includes behavioral and affective presentation as well as understanding of situations that trigger escalation. The assessment also includes interventions that have been successful in preventing escalation in the past.

Intent: A least restrictive response to manage behavioral emergencies is contingent upon:
- Accurate assessment of the evolving behavioral emergency and knowledge of the person's preferred methods to help the person manage the behavior.
- Assess risk for aggression using a standardized tool that staff are able to perform with good interrater reliability.
- Knowledge of an array of communication techniques and de-escalation methods, including use of reduced stimulation, supportive limit setting, problem solving, and presence of staff.
- Valuing persons' perceptions, their treatment priorities and their active participation in developing treatment plans.
- Creating a trauma informed culture of empathy that is least restrictive.
- Applying knowledge of past efforts that were effective to decrease the level of intensity of the person's response to situations that trigger dyscontrol.
- Utilizing as needed medication as well as other nonpharmacological interventions at the earliest signs of distress, to facilitate the person's ability to mitigate triggers and manage their behavior.
- Offering choices to the patient on the preferred route of medication.

Initiation of Seclusion or Restraint

Standard: Seclusion or restraint is initiated only when less restrictive measures have proven ineffective, and the behavioral emergency poses serious and imminent danger to the person, staff, or others. Staff involved have been adequately trained and deemed competent to initiate these measures.

Intent: The decision to initiate seclusion or restraint is made only after all other less restrictive, non-physical methods have failed to resolve the behavioral emergency.
- All potential physical and psychological risks of the procedures are considered.
- Specific attention is given to risks associated with vulnerable persons such as: those who are obese, frail, dually diagnosed; those who have medical co-morbidities, intellectual or developmental disabilities; those whose repeatedly challenging behaviors put them at risk for incomplete assessments, and those who are victims of trauma and/or abuse.
- It is determined that the risks associated with failure to take immediate action outweigh the risks of harm associated with the use of restraint or seclusion.

- All measures necessary to protect the person's confidentiality, privacy and dignity are in place.

Standard: Persons are never restrained and left alone in a locked room. Seclusion and restraint should not be used as a means of coercion or punishment, for the convenience of the staff, or when less restrictive measures to manage behaviors are available. When deciding which intervention to use, the risks considered must include an individualized assessment of the person's known history of physical or sexual abuse, as well as current physiological and psychological status. In addition, the factors that contribute to the sustained behavioral emergency must be examined and personal preference must be considered. When an individual is physically restrained, immediate action is required to mitigate positional risks: prone restraint requires monitoring for the risk of positional asphyxiation; supine restraint requires monitoring for the risk of airway obstruction.

Intent: The risks of seclusion or restraint use are different for each person and each behavioral emergency requiring that:

- An individualized assessment of the factors associated with each episode of a behavioral emergency is completed.
- The appropriate level of sensory input, stimulation, and physical presence is considered.
- The application of restraint(s) involves only organization approved physical holds or organization approved mechanical restraints that are consistent with sound body mechanics and do not obstruct the person's airway or restrict circulation. In addition, weight or pressure on a person's body parts must be avoided.
- The use of techniques and/or methods that cause pain to the person are prohibited.
- The least restrictive and least number of restraint points to safely secure limb(s) must be utilized.
- Ambulatory restraint (securing limb[s]) rather than bed restraint (full immobilization in a bed) is utilized whenever possible.
- Bed restraint must be avoided when the person has a physical condition that would pose undue risk and when the person has a history of sexual abuse.
- Rationale for the use of bed restraint or restraint involving securing more than limbs must be documented.

A written modification to the plan of care shall be completed after the initiation of seclusion or restraint.

Standard: Seclusion or restraint is initiated by qualified staff authorized by the organization to initiate seclusion or restraint in a behavioral emergency and must be followed by an order from a physician or Licensed Practitioner (LP) who is responsible for the care and treatment of the person.

Intent: The initiation of seclusion or restraint should:

- Follow all state, federal and regulatory agency guidelines concerning physician, LP and RN responsibilities, as well as attending physician notification.
- Involve notification of a physician or LP for a written, verbal, or telephone order to include the reason for the seclusion or restraint, the specific type of restraint to be utilized, the duration of the order and the behavioral criteria for release.
- Include consideration for the person's individual risks related to seclusion or restraint, especially positional asphyxia, aspiration, and traumatization, and take action to mitigate these risks.
- Include a clear explanation to the person of the reason for seclusion or restraint and the behavioral criteria for release. The explanation must be in the person's preferred

language and in terms the person can understand and repeated as necessary to facilitate understanding.

Standard: Within one hour of the initiation of seclusion or restraint the person must be seen and evaluated by a physician, LP, or a trained and competent registered nurse (RN) or physician assistant (PA) who ascertains the person's response and determines if seclusion or restraint is to continue. The attending physician or other LP responsible for the care of the person must be consulted as soon as possible when the one-hour evaluation is conducted by a trained and competent RN or PA.

Intent: Within one hour of the initiation of seclusion or restraint a face-to-face evaluation by a physician, LP, or a trained and competent RN or PA is conducted to:

- Determine the person's current physical, emotional and mental status, with special attention to cardiac and respiratory status.
- Discuss with the treatment team involved in the initiation of the seclusion or restraint, the triggers of the event, less restrictive measures employed, the clinical rationale for seclusion or restraint and the person's response.
- Identify and implement interventions to expedite release from seclusion or restraint as soon as possible.
- Review the original order and revise the type of restraint, duration or behavioral criteria for the person's release as indicated by the treatment team review and person's response.

Monitoring and Assessment of Persons in Seclusion or Restraint

Standard: Persons in restraint and seclusion are continuously monitored in accordance with federal, state, and regulatory agency guidelines. Persons are monitored and assessed by staff trained and competent to recognize and report adverse physical and psychological reactions, as well as to facilitate release from seclusion or restraint at the earliest possible time.
Intent: Monitoring is critical to ensure the person's safety and to ensure that the person is released from seclusion or restraint at the earliest possible time. Monitoring and assistance should be systematically and judiciously performed:

- By staff qualified to observe the psychological and physiological status of the person, recognize adverse reactions, and facilitate release from seclusion or restraint.
- In a manner that protects the person's privacy.
- With close attention to any sign of injury or distress from the initiation and/or continuation of seclusion or application of restraint.
- With close attention to any signs of cardiac or respiratory difficulty.
- Considering and anticipating the individual's level of hydration, nutritional needs, skin integrity, circulation, hygiene, elimination needs and any signs of physical discomfort or emotional distress.
- Ensuring that the room being used has adequate lighting, is free of any safety hazards, is a comfortable temperature, clean, and adequately ventilated.

Standard: Persons are assessed by a registered nurse at the time the seclusion or restraint is initiated and at least hourly thereafter or more frequently, as guided by institutional policy. The registered nurse may delegate monitoring of persons in seclusion or restraint to qualified staff as appropriate.

Intent: Registered nurses are responsible for ensuring ongoing cycles of assessment, planning, interventions, and evaluation of the person's response during seclusion and restraint. These actions are directed toward:

- Determining the person's mental and physiologic status as well as response to seclusion and restraint through direct observation and interaction. At a minimum, support and reassurance of safety is provided, and during restraint, vital signs including measure of oxygen saturation must be taken, fluids offered, circulation and skin integrity assessed as soon as possible and in no case less than hourly intervals. Range of motion exercises must be performed at least every two hours when restraints are utilized, or more frequently as guided by institutional policy
- Evaluating the person's response to other interventions designed to promote release.
- Engaging the person to formulate plans that will expedite release.
- Directing additional or ongoing interventions, including administration of medications, that will further expedite release as well as promote the individual's safety and comfort.

Release from Seclusion or Restraint

Standard: Seclusion or restraint is discontinued at the earliest possible time based on the assessment that the behavioral criteria for release are met.

Intent: Release from seclusion or restraint should depend on:

- The person's demonstration of the behavioral criteria for release formulated by the physician/LP or a trained and competent registered nurse (RN) or physician assistant (PA), based on knowledge of the individual and their behavioral responses and specified in the seclusion or restraint order.
- Other individualized indicators that merit review and evaluation for release. These include behavior that was not specified in the release criteria but may indicate readiness for release as well as behavior that indicates that the use of seclusion or restraint is increasing behavioral dyscontrol. These also include medical emergencies.

Standard: As soon as possible, following the release from seclusion or restraint, the nurse, the person, and others as appropriate should participate in a debriefing.

Intent: A debriefing is done with persons who have been secluded or placed in restraints to:

- Discuss and clarify any possible misperceptions the person may have concerning the incident.
- Ascertain the person's willingness to involve family or other caregivers in a debriefing to discuss and clarify their perceptions as well as identify additional alternatives or treatment plan modifications.
- Support the person's re-entry into the milieu.
- Identify alternative interventions to reduce the potential for additional episodes.
- Hear and record the person's perspective on the episode.
- Ascertain that the person's rights and physical well-being were addressed during the episode and advise the person of processes to address perceived rights grievances.
- Address any trauma that may have occurred as a result of the incident.
- Modify the treatment plan as needed.

Documentation

Standard: All aspects of the seclusion and restraint episode, including the behaviors and events leading up to it, the less restrictive interventions employed, the care provided during the episode, person's reaction to the restraint or seclusion and the release from seclusion or restraint are recorded in the clinical record.

Intent: Documentation of the restraint and seclusion episode should include:

- The events and behavior that led to the use of seclusion or restraint.
- Non-physical and least restrictive interventions that were attempted and the person's response.
- All necessary notifications of attending physicians, LP, parent/ guardian and, if such notification is designated by the person, the caregiver or significant other.
- Specifics of the episode including triggers, precipitating events, time of initiation, physical interventions, and patient response to interventions.
- Monitor, assessment, documentation of the person in seclusion or restraint to include but not limited to position, circulation, and range of motion.
- Interventions provided to promote comfort and safety as well as expedite release and the person's response to interventions.
- Criteria for release patient understanding the criteria and meeting criteria.
- Time of release from seclusion or restraint.
- Debriefing with the person involved, staff, and caregivers as indicated.

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