

## RESTRAINTS, SECLUSION, AND AVERSIVE PROCEDURES

### Abstract

A survey of parents and caretakers of children with disabilities was undertaken to document the use of restraints, seclusion, and aversive procedures. A 23 item survey was presented using a web-based program. Participants were informed of the survey by different advocacy organizations. Within 2 weeks, 1300 individuals opened the survey and 1293 answered the first question which asked if their child had been subjected to the procedures. Of the 1293, 837 (64.7%) said “yes” and continued with the survey. According to the responses, children with disabilities were often exposed to restraints, seclusion and aversive procedures and most of the time the parents had not approved of the procedures beforehand. Implications for national, state, and local policies and practices are discussed.

### Executive Summary

Several recent reports have documented the use of restraints, seclusion and aversive procedures with students with disabilities and special needs in public schools and residential facilities receiving funds for education, including one by The National Disability Rights Network (NDRN, 2009) and a second by the Council of Parent Attorneys and Advocates (COPAA, 2009). Shortly thereafter, the U.S. House of Representative’s Education and Labor Committee scheduled a hearing that coincided with the United States Government Accountability Office (GAO, 2009) issuing a report, *Seclusion and Restraints: Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers*. The GAO report also noted the lack of data available on the pervasiveness of these practices and documented a fragmented set of policies and guidelines available to protect students from these practices in schools.

Several researchers have reviewed restraint use for different purposes. Ryan and Peterson (2004) concluded that restraint, as a form of intervention, was not well supported by the research literature. Delaney and Fogg (2005) found that children and adolescents most commonly restrained were those with who used inpatient services more often, those in guardianship arrangements, those in special education, and those with a history of suicide attempts. Nunno, Holden, and Tollar (2006) discovered a high incidence of death in restraint use, disproportionately for males and most often due to asphyxia.

Seclusion as an intervention has also been studied by researchers. For example, Earle and Forquer (1995) found that seclusion was more likely to occur at times of higher staff-child interactions and when there was less structured programming occurring. Cooper, Heron, & Heward (2007) and Wolf, McLaughlin, & Williams (2006) both noted that the practice can reduce inappropriate behavior, but also has several disadvantages including providing an opportunity for the person to engage in behavior that should be stopped or prevented, such as self-injurious behavior.

Beginning in the 1980s, multiple challenges to the use of seclusion, restraints, and aversive procedures as behavior change methods began to occur. Building on the foundation of Applied Behavior Analysis, the field of Positive Behavior Supports (PBS) emerged as an alternative because it uses a non-aversive, comprehensive orientation, and is considered to be a humane, non-aversive approach to behavior change. However, there is also a strong body of evidence that

offers an empirical defense for many of the components of PBS, especially the value of basing interventions on FBAs (Carr et al., 1999; Clarke, Dunlap, & Stichter, 2002; Hanley, Iwata, & McCord, 2003; Pellios, Morren, Tesch, & Axelrod, 1999; Safran & Oswald, 2003; and Smith & Iwata, 1997).

Trends in public policy have also reflected a discontent in the use of seclusion, restraint and aversive procedures. A consensus has emerged within children's mental health settings, hospitals, nursing homes, and psychiatric facilities over the last two decades that restraint and seclusion should not be included in treatment plans and that restraint should be used only for emergencies and targeted for elimination. Instead practices should be based on "trauma informed care," requiring an awareness of the psychological effects of aversive actions on children (Hodas, 2006). Further, the Children's Health Act (2000) regulates the use of restraint and seclusion practices in federal facilities such as hospitals, healthcare facilities that receive federal funds; and on children placed in certain residential, non-medical, community-based facilities that receive funding from the Public Health Services Act (GAO, 2009, p.3). But this law does not extend to children in public or private, day or residential schools responsible for providing education services to students.

The current study was undertaken under the auspices of APRAIS, *The Alliance to Prevent Restraint, Aversive Interventions and Seclusion*. APRAIS is comprised of 18 national organizations ([www.tash.org/aprais](http://www.tash.org/aprais)). The study was undertaken in order to form a more comprehensive picture on the use of restraints, seclusion, and aversive procedures with individual with disabilities while in public or private schools or residential facilities.

#### Participants

The participants in the study were predominantly parents and caregivers who were members of the constituent organizations that comprise APRAIS who were either a) contacted by their organization by email with a request to participate in the study, b) saw a notice of the study on an APRAIS member's organization website, or c) learned about the study because information about it was forwarded to them by email from someone aware of it. We estimate that between 10,000 and 20,000 individuals may have been aware of the survey.

The web-based survey was accessed by exactly 1300 respondents who also were automatically recorded as completing the survey. The survey included 23 items which were presented on SurveyMonkey, a commercial web-based program ([www.surveymonkey.com](http://www.surveymonkey.com))<sup>1</sup>.

When a respondent opened the questionnaire website, an initial page provided the following definitions:

- Restraint: The use of physical procedures by one or more individuals or mechanical devices in order to limit freedom of movement. Example: Holding an individual in an immobile position for a period of time.
- Seclusion: Placement in an isolated area for an extended period of time and prevention from leaving the area. Example: Placing an individual in a locked room or closet.
- Aversive procedures: Actions taken against a person causing pain or injury. Example: Pinching or slapping an individual.

---

<sup>1</sup> A Microsoft word version of the questionnaire is available from the senior author.

## Results

In two weeks, 1300 individuals accessed the questionnaire through SurveyMonkey. Of the 1,293 responses: 837 (64.7%) responded “yes,” their child had been restrained, secluded or subjected to aversive interventions; 414 (32.0%) responded “no” and 42 (3.2%) responded “don’t know.” Those responding yes reported the following:

- An average of 8.4 separate incidents of these procedures being used on a child (with a range of 1 to 45); and throughout their school life, the procedures had been used an average of 30.3 times per child (with a range of 1 to 184).
- Restraints used included strapping the child to a chair, using basket holds, using four-point holds (one adult holding each limb), twisting the arm behind the back (which resulted in a broken arm), turning off wheelchair to prevent movement, using handcuffs, and various other physical holds.
- Aversive interventions included denying restroom all day; holding nose to get to swallow; kicking, punching and choking; putting spit on face; pushing into a wall; and throwing onto a mat, face first (chipping a tooth), among others.
- The most common other person involved in the procedures was a paraprofessional. Common additional reactions to the procedures described by respondents included the child developing inappropriate behavior such as stereotypical behavior, running away, ripping clothes, self-injury, or tics.<sup>2</sup>
- Procedures occurred most commonly in special education classrooms
- More than 27% reported restraints lasting between 30 minutes and more than three hours.
- More than 50% of the respondents said their child was placed in seclusion for between 30 minutes and more than three hours.
- 92.9% of the respondents said the procedures resulted in emotional trauma.
- Incidents often resulted in physical injury to the child (42.2%) or in obvious signs of pain (33.5%).
- 66% of respondents reported that they rarely or never were informed when an intervention had been used and only 21.8% said they had authorized the use of the interventions as assessment of behavior.

---

<sup>2</sup> All lists of text entries are available from the senior author.

## Implications

Limitations of a survey-based study notwithstanding, the findings are nevertheless extremely disturbing and warrant actions to be taken in the development of policies and practices at the national, state, and local level to ensure that all children are safe from harmful interventions at school. These should include the following:

1. Strict controls on interventions used to manage student behavior, including requiring use of evidence based, safe, positive alternatives such as positive behavior supports; prohibition of any technique that restrict airflow; require that any non-prohibited form of restraint is only used in situations involving a *clear and imminent physical danger* to the student or others, can only be implemented by staff who have received intensive training in restraint as well as in trauma-informed care and effective de-escalation, can only be implemented under rigorous supervision, and must cease as soon as the emergency is ended.
2. Rigorous enforcement of such requirements.
3. Require data collection on all incidents of restraint and seclusion use, including effective correction action in states or districts where data does not reflect statewide commitment to school-wide PBS.
4. Ensure that all school personnel are trained and adequately prepared to implement a coherent, multi-tiered support system designed to keep all children safe; develop standards for such training and provide funding to support such activities.
5. Require that parents or guardians be fully informed of all emergency interventions used on their children and ensure that parents/guardians have the right to meaningfully participate in the development of safe and positive interventions and supports for their children and to appropriate recourse when required procedures and protocols are not implemented.

### **Contact Information:**

Please send contact Barbara Trader, TASH – Executive Director with any questions or comments. She can be reached at: [btrader@tash.org](mailto:btrader@tash.org) or (202) 540-9013.