Current Issues in Restraint Use

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No, not these kinds of restraints
We will take a look at the 15 DOE guidelines for restraint and seclusion in schools.

We will examine the practice of focusing on restraint reduction instead of focusing on the attainment of long-term, meaningful clinical gains.

We will look at methods of producing the “illusion” of restraint reduction.

We will examine 6 areas that contribute to high rates of restraint use.
We will look at the actual vs. perceived risk of restraint use in schools.
Finally we will look at legal issues in restraint use, in other words…
How to avoid getting your ass sued!
Hopefully your ass has a good attorney.
P.S., we will mostly focus on restraint, not seclusion as they are often lumped into the same category.

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The DOE Guidance

RESTRAINT AND SECLUSION: RESOURCE DOCUMENT

U.S. Department of Education
The DOE Guidance

- Restraint or seclusion should not be used as routine school safety measures; that is, they should not be implemented except in situations where a child’s behavior poses imminent danger of serious physical harm to self or others and not as a routine strategy implemented to address instructional problems or inappropriate behavior (e.g., disrespect, noncompliance, insubordination, out of seat), as a means of coercion or retaliation, or as a convenience.
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- Imminent: ready to take place; especially: hanging threateningly over one's head <was in imminent danger of being run over>
- There is no description of the actual time that elapses between the detection of a threat and the actual occurrence of the behavior
 Serious Physical (Bodily) Harm: According to Georgia Code § 12-5-53, serious bodily injury means “bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.”
Serious Bodily Harm
Serious bodily harm is NEVER defined in the document
Examples of serious bodily harm are never given
Imminent is never defined
Using this nebulous definition, the teacher not only has to predict behavior, but also has to predict the severity!
Restraint: Defined by the DOE’s Office of Civil Rights (OCR) Civil Rights Data Collection (CRDC)

A personal restriction that immobilizes or reduces the ability of a student to move his or her torso, arms, legs, or head freely. The term physical restraint does not include a physical escort. Physical escort means a temporary touching or holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a student who is acting out to walk to a safe location. (and what exactly does “acting out” mean?)
News Flash!!!
Escorts are restraint!!!
ALL RESTRAINT INVOLVES TEMPORARY HOLDING! IT’S ALL TEMPORARY UNLESS ITS PERMANENT!
Restraint takes place when you limit the movement of the individual or some part of the individual and the individual is actively resisting this restriction of movement!
The DOE is attempting to parcel out escorts from restraints, but they both come down to what the police might call the “unlawful unprivileged touching of another human being”

A.K.A. “Battery”

It doesn’t matter if you’re holding to induce walking or holding to immobilize, it’s all (technically) battery.
The DOE Guidance

- Even the much revered and time-tested hand-over-hand prompting can EASILY turn into restraint
- The DOE does not make a statement about the criteria for the use of escorts
- Clearly, there are some problems with the DOE’s definitions that should be cleaned up considerably.
The involuntary confinement of a student alone in a room or area from which the student is physically prevented from leaving. It does not include a timeout, which is a behavior management technique that involves the monitored separation of the student in a non-locked setting for the purpose of calming people and not to punish problem behavior!
The Big 15!
Every effort should be made to prevent the need for the use of restraint and for the use of seclusion.

PBIS is cited as a behavioral system that will reduce or eliminate restraint.

Emphasizes the attainment of more appropriate behavior.
Schools should never use mechanical restraints to restrict a child’s freedom of movement, and schools should never use a drug or medication to control behavior or restrict freedom of movement (except as authorized by a licensed physician or other qualified health professional).

Seriously? When have schools ever directly used medications with children?
Physical restraint or seclusion should not be used except in situations where the child’s behavior poses **imminent danger of serious physical harm to self or others** and other interventions are ineffective and should be discontinued as soon as imminent danger of serious physical harm to self or others has dissipated.
The guidance states that restraint should not be used as a consequence of inappropriate behavior (out of seat, disrespect, non-compliance, etc.)

The problem is that if the student is being disruptive the teacher may choose to escort the child out of the classroom.

The act of starting an escort will VERY OFTEN cause individuals to become aggressive.

There is no guidance on when to use escorts, in the entire document, only a brief definition
Policies restricting the use of restraint and seclusion should apply to all children, not just children with disabilities.

No problems there.
Any behavioral intervention must be consistent with the child’s rights to be treated with dignity and to be free from abuse.

- Basically a plea for ethical behavioral programming
- No problem here
Restraint or seclusion should never be used as punishment or discipline (e.g., placing in restraint for out-of-seat behavior), as a means of coercion, or retaliation, or as a convenience.

Examples are using restraint for a failure to follow rules, non-compliance, bad language, as punishment, or so staff can have uninterrupted time to discuss school issues.

WTF???

“We need to have a meeting about the over-use of seclusion. Can somebody put Jimmy in time-out so we get some quality planning time?”
More than likely, it is the use of seclusion that is overused for non-dangerous behavior, but more than likely it involves telling the individual to go to seclusion (the kid who burped)

I have never witnessed a child who was restrained because of cursing, non-compliance, or any other minor behavior problem.

The issue is that minor behavior problems are often approached in a manner that causes MAJOR behavior problems which THEN causes a need for restraint
Restraint or seclusion should never be used in a manner that restricts a child’s breathing or harms the child.

The report then goes on to say that prone restraints should never be used.

We (PCMA) take issue with that because our prone hold doesn’t restrict breathing at all, although some kinds of prone restraint may restrict breathing.
Regarding harming the child, it is IMPOSSIBLE to guarantee that a child will not be harmed in some manner during ANY kind of restraint as there are inherent risks for individuals who are aggressive and/or self-injurious at extremely high levels.

The document should have made clear that the procedures should be designed in such a manner that their correct application should not produce pain or discomfort.
Regarding harm to a child, and the use of restraint, these three things will always hold true:

1. If you choose not to restraint, the child could be harmed.
2. If you use restraint incorrectly, the child could be harmed.
3. If you use restraint correctly, the child could be harmed.

All things being equal, the timely use of a well-designed restraint procedure, that is implemented correctly will provide the greatest minimization of the risk of injury.
The use of restraint or seclusion, particularly when there is repeated use for an individual child, multiple uses within the same classroom, or multiple uses by the same individual, should trigger a review and, if appropriate, a revision of behavioral strategies currently in place to address dangerous behavior; if positive behavioral strategies are not in place, staff should consider developing them.

Ok, good guideline
This guideline also calls for re-evaluation of FBAs and/or BIPs when restraint continues, and this is probably one of the biggest problems for many facilities.

“In all cases the reviews should consider not only the effectiveness of the plan, but also the capability of school staff to carry out the plan.”

This is a very important point!
Behavioral strategies to address dangerous behavior that results in the use of restraint or seclusion should address the underlying cause or purpose of the dangerous behavior.

No arguments here!

Point 9 actually gives a decent description of what an FBA does and what a good BIP should do.
Teachers and other personnel should be trained regularly on the appropriate use of effective alternatives to physical restraint and seclusion, such as positive behavioral interventions and supports and, only for cases involving imminent danger of serious physical harm, on the safe use of physical restraint and seclusion.

- Positive behavioral interventions are onlys effective alternative to restraint if you are pretending that restraint is your treatment!
- Positive behavioral interventions are NOT an alternative to restraint in the middle of a crisis!
“school personnel should be trained in how to safely implement procedures for physical restraint and seclusion and only trained personnel should employ these interventions”

Reporting and documenting is emphasized

Excessive use of restraint by individual staff also emphasized

“Fire Drills” emphasized (rehearsing de-escalation and restraint use)
Every instance in which restraint or seclusion is used should be carefully and continuously and visually monitored to ensure the appropriateness of its use and the safety of the child, other children, teachers, and other personnel.
School staff engaged in monitoring should be knowledgeable regarding (1) restraint and seclusion procedures and effective alternatives; (2) emergency and crisis procedures; (3) strategies to guide and prompt staff members engaged in restraint or seclusion procedures; and (4) procedures and processes for working as a team to implement, monitor, and debrief uses of restraint or seclusion.

Great idea, but extremely staff intensive and requires highly trained staff.
Parents should be informed of the policies on restraint and seclusion at their child’s school or other educational setting, as well as applicable Federal, State or local laws.

Incredibly important regarding the prevention of litigation.

Encourages communication of definitions of restraint, prohibited procedures, criteria for initiation and termination of restraint, procedures for notifying parents, etc.
Parents should be notified as soon as possible following each instance in which restraint or seclusion is used with their child.

Very important so that parents are not surprised by multiple restraint use that they were unaware of.
Policies regarding the use of restraint and seclusion should be reviewed regularly and updated as appropriate.

Issues include: review of data across various groups, accuracy and consistency of data collection, fidelity of implementation of restraint procedures, if procedures actually work in protecting the individual/teachers/peers, review of alignment of school policies with state and local laws.
Policies regarding the use of restraint and seclusion should provide that each incident involving the use of restraint or seclusion should be documented in writing and provide for the collection of specific data that would enable teachers, staff, and other personnel to understand and implement the preceding principles.
15 principles #15

- (1) start and end times of the restraint or seclusion;
- (2) location of the incident;
- (3) persons involved in the restraint or seclusion;
- (4) the time and date the parents were notified;
- (5) possible events that triggered the behavior that led to the restraint or seclusion;
- (6) prevention, redirection, or pre-correction strategies that were used during the incident;
- (7) a description of the restraint or seclusion strategies that were used during the incident;
(8) a description of any injuries or physical damage that occurred during the incident;
(9) how the child was monitored during and after the incident;
(10) the debriefing that occurred with staff following the incident;
(11) the extent to which staff adhered to the procedural implementation guidelines (if established by the State, district, or school)
(12) follow-up that will occur to review or develop the student’s BIP.
Yes, yes I know. These are 15 principals and if you’re a really fast counter you would know that there are only 14 of them, unless you count the Christmas tree in the back row whose school, incidentally, has very low restraint rates.
The guidelines provide some detailed information about behavioral procedures/PBIS.

The guidelines give good information regarding informing parents, data collection and analysis and methods for ensuring fidelity of implementation of both behavioral interventions as well as restraint procedures.
Summary of DOE guidelines

- The guidelines do a very poor job in helping teachers understand when to intervene with restraint.
- Although there are a few examples of what should NOT result in restraint, these non-examples are not particularly helpful (people do not restrain because a student drops the F-Bomb).
- There are NO EXAMPLES, not a single one, of the appropriate use of restraint (e.g., a student drops out of his seat and begins banging his head into floor repeatedly).
There are NO EXAMPLES of what constitutes serious bodily harm.

There are NO EXAMPLES of what constitutes “imminent”.

Regarding “restraining for inappropriate behavior,” this is rarely the case.

Inappropriate behavior (work refusal, cursing) is typically escalated by coercive interactions by staff that is sometimes verbal and sometimes physical (attempts at escorting that turn into restraint).
The problem of focusing on restraint reduction

- Focusing too strongly on restraint reduction (which is a good outcome) takes our attention away from the problem of long-term treatment gains.
- Focusing on restraint reduction as a primary goal allows for too many ways to reduce restraints in ways that might be non-functional, misleading, dangerous, or not in person’s long-term clinical interest.
- Six categories of problems that often lead to high levels of restraint (loose restraint criteria, poorstaff-client interactions, poor client skills in the face of even reasonable interactions, lack of reinforcers, client to client interactions, non-socially-mediated problems).
Sometimes people focus on restraint reduction because the reduction is something that is “tangible.”

We can “order” staff to stop using restraints, but unfortunately, we CANNOT order therapeutic gains for all our clients.

It is far easier to tell staff what not to do than to tell them what to do. We need to de-emphasize proscriptive language in favor of prescriptive language.

Not in all cases, but in a majority of cases, restraint continues because behavior problems continue. Behavior problems continue because of treatment problems, staffing problems, medical problems and administrative problems.
Do we use restraint on people with absolutely no behavior problems? That is, are restraints being used for people with no aggression, even when demands are placed on them?

Do we use restraint for individuals who get an “F” on an exam or simply didn’t do their chores at the group home? Or do we push them to the point of aggression and THEN use restraint?
Restraint is NOT the problem!
Restraint is a *symptom* that is a result of a confluence of variables (treatment, staff, medical, administrative).
There is a tremendous difference between eliminating restraint and eliminating THE NEED for restraint.
Anyone can eliminate restraint, but can you eliminate the need as well?
When talking about restraint, I mean ALL FORMS not simply floor restraint, or standing or walking. I mean the restriction of movement of some part of the individual and they are actively resisting against you.
Holding a child by the hand, who is attempting to run into the street, and pulling away from you IS RESTRAINT! It’s just not what comes to mind with most people.
The “Illusion of Restraint Reduction
If the goal is simply the reduction of restraint, (and no one is actually looking at the frequency of behavior problems, staff and client injuries, and the acquisition and maintenance of critical skills) then there are many, many ways to reduce/eliminate restraint!

How is this accomplished?

- For behavior maintained by attention, provide constant 1:1 staffing.
- For behavior maintained by escape/avoidance eliminate all demands (abdicate educational responsibilities).
- For behavior maintained by access to tangibles, allow access to everything the person wants all the time, e.g., “It’s Chuckie’s CHOICE to eat 5 gallons of ice-cream and stay up until 3 a.m. on a school night.”
Now, these methods actually will reduce behavior problems and therefore reduce the need for restraint, but the method of behavior reduction will NOT produce a long-term therapeutic gain based on skill acquisition and personal growth.

These methods are primarily antecedent manipulations (see my talk at 1:30…) and, as such, they do not teach new skills to staff or clients/students.

There is nothing wrong with a few reasonable antecedent manipulations, but if they are taken too far they can actually make long-term, meaningful behavior change almost impossible.

How else are restraints reduced?

Medication, Medication, Medication!

Everyone is screaming about restraint reduction, but those same individuals should be screaming about the dump trucks full of pharmaceuticals that are being pumped into people with disabilities every year.
Medications may decrease crisis behaviors by altering the person’s response to stimuli that normally produce crisis behaviors (they mess with MOs).

The individual never learns how to “cope” with these events, instead we are creating a chemical AO thus removing the need for learning how to cope with difficulty.

When the medications are removed or lose their efficacy individuals are no better off than they were prior to the initiation of medications and sometimes they are significantly worse.

How else can we reduce restraints?

MORE STRINGENT ADMISSION CRITERIA (cherry picking)

GET RID OF OUR DIFFICULT CLIENTS!!!

Call law enforcement!

Do a room clear!
We can create **prosthetic physical environments**: Lexan instead of glass, stucco interior walls, heavy duty door frames and steel doors (hardened homes).

We can create **prosthetic social environments**: Staff are instructed to tolerate the intolerable. Staff allow clients to hit them, destroy their personal property, destroy the property of the home/classroom and disrupt the entire classroom/treatment milieu all in the name of avoiding restraint.
We can create policy that bans restraint or certain types of restraint. This will in fact reduce restraint (at least it will reduce reports of restraint) but it will in no way affect the need for restraint and is by far the worst way to reduce restraint if the goal is the attainment of a clinically meaningful reduction.

- We can play definition games: “We don’t call it restraint if its less than two minutes” or “We don’t call it restraint if is only an escort.” (DOE)
- We can play data games: “We only count 1 restraint for the entire episode even if the episode was an hour long and the individual was restrained 15 separate times in the hour.”
Six categories of problems that lead to high levels of restraint
These categories are by no means exhaustive, they are more of a six point version of David Letterman’s “TOP TEN.”

Although there are most certainly some topics that cannot be covered in the scope of this presentation, making progress in ANY of these six areas will SIGNIFICANTLY reduce restraint.

Making progress in ALL of the categories will DRAMATICALLY reduce restraint as a result of altering the behavior of staff, the individual, and administrators in meaningful ways.

Let’s take a look, shall we?
“Danger to self and others” or “Imminent danger of serious physical harm” can easily lead to overuse of restraint.

Restraint is often used as a consequence of non-compliance (specifically escorts) when there is (initially) absolutely no danger is involved, e.g., a student refuses to get on the school bus or a client refuses to get on the van when the day treatment program is over.

Noncompliance is definitely a problem, but it is seldom dangerous (a client refuses to move from the middle of a busy highway). Inappropriate physical prompting (pulling someone) in these cases could turn noncompliance into crisis that may result in restraint!

Noncompliance should be dealt with programmatically and proactively, (more on this later) and not through the continued use of physical procedures.

We at PCMA use the criteria of continuous aggression/self-injury/high magnitude disruption (CASH). However there are still situations in which judgments must made. No guideline can accommodate all situations.

Non-continuous behaviors may be dangerous, but do not require restraint as they have already ended.
Individualized criteria for restraint will **always** be superior to general criteria, but must be based on data collection and analysis of the problem behavior. General criteria are good for unpredictable emergencies.

Individualized criteria can prevent both the **overutilization** of restraint and the **underutilization** of restraint.

Individualized criteria are based on recurrent, predictable behavior with which staff have a great deal of experience. Individualized criteria should be part of an individualized program. This is NOT the same as the “programmatic use” of restraint (restraint after each instance of behavior for a certain duration used to punish behavior).

The behavior may not be completely predictable in the sense of “the behavior will occur in 3, 2, 1…run away!!!”

It may be predictable, however, in the sense that we expect that it will happen again and we know some of the circumstances that make it more/less likely.
There are two broad categories of crisis:

- Those that come and find you...you were in the wrong place at the wrong time...
- Those that YOU produce yourself! Shame on you!

In many instances, crisis behaviors are produced through coercive interactions.

Coercion means forcing someone to do something they don’t want to do, in a particularly nasty way. This does not mean that the client has NO part in contributing to the problem. Most of us do not attack people and destroy things simply because we get “chewed out” by our bosses (a coercive interaction).

People with disabilities, however, (in most instances) do not have the same skill sets for dealing with coercive interactions, or any sort of aversive for that matter.

In the PCMA BehaviorTools Training, we focus on eliminating 12 different forms of coercive interactions. The focus here is on changing staff behavior (which is sometimes harder than changing our client’s behavior).
You can have the best staff/teachers in the world and they may be non-coercive and they may use positive reinforcement in their interactions with all your clients/students but there still remains the problem of client to client interactions.

Individuals with behavior problems can also cause behavior problems in their peers who ALSO have behavior problems and that’s a big problem!

Sometimes a person’s behavior problem is that he specifically seeks out opportunities to cause behavior problems in his peers, and that too is a problem!

If the individuals cannot be placed in different classrooms/treatment environments then there are three general avenues of action we can take:

We can increase the “reinforcement value” that each individual sees in the other by making strong reinforcers contingent on cooperative tasks (they see each other as more useful).
Sometimes one individual can be taught how to use a “non-reactive” response to another individual’s “junk behavior.”

Sometimes we can teach social skills to the individual who likes to “set off” other clients.

Ultimately there must be an analysis of the interactions between the two individuals to formulate a specific treatment plan, but the interactions must be addressed as well as the need for socially-related skill acquisition.
With almost all behavior problems, we usually know what the behavior is, but *not* the REAL problem!

Problems usually involve some sort of skill deficit.

Why is it that when we are denied access to reinforcers or have to do difficult work that we don’t punch people and destroy the room? (well most of us don’t).

We have numerous skills to help us get our needs met, and if one doesn’t work we have a variety of others to choose from.

If skill deficits are not addressed, there will be an over-reliance on *antecedent manipulations* and some of those can be detrimental in the long run.

We should focus on teaching individuals how to get their needs met in safe, appropriate ways, AND we must focus on teaching *coping skills*. 
Coping skills are behaviors we demonstrate when we can’t get what we want, are told something we don’t like, when we are disappointed, when we are exposed to unpleasant but necessary events and what we do to appropriately escape from and avoid unpleasant things that CAN be avoided.

Individuals who learn significant skills that help them get what they need and allow them to handle what they don’t like are just going to have fewer crises.

If there are fewer crises there are fewer restraints.

It’s very easy to reduce restraints in other (less productive) ways yet the individual typically has learned absolutely nothing, and when (and if) that person transitions to a less restrictive setting they will in no way be equipped to deal with this new non-specialized environment.

Remember, just because YOUR staff are non-coercive doesn’t mean someone else’s staff will be non-coercive!
Many crisis behaviors are a direct result of demands. Even being asked to wait for a reinforcer can be seen as a demand. Sometimes, even when staff are taught how make a request in the nicest possible way, some individuals will STILL display behavior problems.

We cannot simply eliminate all reasonable requests, for this results in a person who makes no progress whatsoever. The elimination of all reasonable requests is in itself “unreasonable.”

The motivation to escape plummets when reinforcement rises.

You don’t have to pester someone to do a chore or start her job or begin her schoolwork when you have good reinforcers and when those reinforcers are not (initially) difficult to obtain.

When strong reinforcers are present people WANT to do things and are not doing things simply to make YOU go away!

Naturally, you don’t need such strong reinforcers if you tap into your student’s/client’s interests, you just need to create the proper curriculum/treatment programs.
Even if you find things your clients like, there will always be things you must ask them to do that they will not want to do.

If powerful reinforcers are being used you typically do not have to compel people to do things, instead you can just give a subtle prompt instead of nagging or coercing the individual.

It is true that even powerful reinforcers can cause their own problems, but that too comes back to skill deficits (learning how to give up reinforcers, how to share, how to accept alternatives, how to wait, etc.).
Although perhaps less frequent than socially-mediated problems, these types of behavior problems do in fact occur and, in many instances, can still be addressed through skill acquisition.

People have to learn what to do when something breaks, how to stay calm, and how to make it work again. To do this we MUST contrive mildly to moderately upsetting situations in which things break and quickly show people what to do to fix those things.

People have to learn how ask for alternatives when something is unavailable and/or how to ask for information about when something will arrive and how to wait and what to do while waiting. This is much more challenging with non-verbal individuals, but it’s still important.

Medically-related problems, particularly in non-verbal individuals must be addressed through proper medical assessment and treatment. This can be particularly challenging when diagnosis requires verbal report by the patient (a real problem with medication side-effects).
A word about non-compliance, ok, really several words
Non-compliance

- Noncompliance is a really terrible concept.
- Noncompliance is a really terrible concept.
- It is an attempt to assign a label to a person, based on their unwillingness to do what WE want them to do, e.g., “Johnny is VERY noncompliant!”
- Here’s how to get rid of noncompliance forever…ready?
- Rename it SELF-ADVOCACY! Problem solved!
- Noncompliance is not behavior. It is a description of poor instructional control in which the blame for the lack of said control lies with the student/client.
Non-compliance can result in a crisis depending, in large part, on the method used to prompt compliance!

Student: (making noises)
Teacher: That’s it! You need to go to the office!
Student: “Up yours I’m not going!”
Teacher: (grabs student by arm) “Let’s go”
Student: (attacks teacher)
Teacher: (uses restraint)
Very often, physical prompting, used to overcome noncompliance, escalates behavior.

This is typically more of a problem with younger and/or non-verbal individuals.

Older, higher-functioning individuals may also receive physical prompting or highly coercive verbal prompting.

Noncompliance becomes a non-issue when the individual’s motivation is addressed!
Many government reports refer to restraint as “potentially deadly” without any systematic examination of known fatalities.

Eating a hot dog or fried chicken or getting into a car is also “potentially deadly.”

In N.Y. Soft Drinks of more than 16 oz...

There is no information, provided in any government-sponsored reports on restraint, regarding the incidence or prevalence of restraint-related fatalities in schools.
Deadly restraint in schools!

- Incidence: the number of new occurrences per unit of time (4 deaths per year for example)
- Prevalence: the number of incidents for a given population, e.g., 1 in 90 children have autism
- There are currently no prevalence numbers for restraint-related fatalities, only the incidence and even those numbers are questionable
- “The Government Accounting Office in 1999 stated that an accurate estimate of deaths or injuries due to restraint was impossible since only 15 U.S. states have established reporting procedures for such incidents” (U.S. Government Accounting Office, 1999 p. 5)
Let’s take a shot at calculating the incidence and prevalence of restraint-related fatalities in schools.

On the CAICA website www.caica.org there is a listing of approximately 75 restraint-related fatalities (and supporting documentation in most cases) occurring with children with various disabilities in an 18-year span (1998 to 2006).

Of those fatalities, only 3 occurred in public schools.

The incidence is 3 per 18 years or in terms of per year, .16 children per year.
To get the prevalence we need to know the total population of children with special needs in schools which is approximately 6.4 million. The ratio would be the number of fatalities per year (.16) divided by the total population served multiplied by 100 which equals a mortality rate of .0000026%. A more accurate number might be based on the number of fatalities out of the total number of restraints performed, not simply the population served as not everyone served has to be restrained.
According to the US dept of Education there were approximately 130,000 restraints performed for the 2009-2010 school year.

To find out how many fatalities occurred per student per year we have to take the known incidence (.16 children per year) and the known number of restraints (130,000) and multiply both by 6 so that we can state the incidence in terms of a single child (not .16 child).

This gives a “mortality rate” of 1 child per 790,000 restraints which equals a mortality rate of .00012% per year.
Deadly restraint in schools!

- It is interesting to note, that of those 3 restraint-related fatalities in schools in an 18-year span that all 3 restraints were improper
- One child had a staff member sitting on top of him
- One was being restrained by a staff member from behind when several teenagers jumped on the staff member and then all of them fell on the student
- The third child was suffocated by being rolled in a weighted blanket
- NONE OF THESE RESTRAINTS WERE APPROPRIATE!
- These 3 restraints are what the preceding numbers are based on!
Deadly restraint in schools!

- As you can see, the actual risk of a restraint-related death in schools is incredibly low.
- The PERCEIVED risk, however, is astronomically high!
- Peter Sandman, a risk consultant believes that people’s perceived risk is higher when they are unfamiliar with the subject, have no control over what happens, and when the sense of outrage over the incident is very high (deaths during restraint as opposed to deaths during an auto accident).
Legal issues in restraint use
It is becoming increasingly common to see litigation based on the use of restraint

Typically it is parents suing schools/agencies

Individual staff or teachers are RARELY sued. Individual staff or teachers have to do something truly heinous to be sued directly and then the charges will most likely be criminal, not civil.
Why do people sue?

- Hey, Attorneys have to earn a living too!
- Ok, there are other reasons
- Damages!
- Physical (self-evident)
- Psychological (harder to prove)
- Civil rights violations (difficult to put a dollar value on, often used to punish organizations and create policy change)
- Typically it is alleged that there was negligence or malpractice (typically negligence)
Typically we are talking about a wrongful death or a major injury requiring hospitalization (typically broken bones).

Key issues:
- Was the restraint easily preventable?
- Was the restraint warranted?
- Given that restraint was warranted, was the level of intrusiveness warranted?
- Was the restraint conducted properly by properly trained staff?
- Did the restraint use reflect systemic problems in the school/facility?
These are usually allegations of post-restraint PTSD or at least some form of “trauma”

Very difficult to prove for persons with pre-existing diagnoses/behavior problem

It may be claimed that the person’s skill level has fallen and that behavior problems have worsened subsequent to restraint

Typically the plaintiffs (the individual’s parents/guardians) are vehemently opposed to the use of restraint prior to litigation
“False Imprisonment”
“Cruel and unusual treatment”
“Battery”
“Excessive Force”
“Suffering”
Violations of state/local/federal law (using restraint for staff convenience for example)
A civil rights violation can be a way to circumvent a public school’s “Sovereign Immunity” which puts a monetary cap on damages
Some legal complaints throw in “all of the above” just to be certain that something sticks.
Much less likely in behavior analysis (currently) than in medicine

The argument is that there are repeated restraints over long periods of time (months or even years) and although a plan may be in place, there is no evidence that said plan was altered when it is clear that the behavior problem continued at the same level (hence restraints continued)
It’s clear that it we may not be able to bring all behavior problems to “zero” for every individual, at least not as quickly as everyone might like.

It is, however, necessary to acknowledge that restraint use is showing no downward trend and to document all attempts at revisiting FBAs and BIPs, staffing and any medical issues.

It’s important to get fidelity of implementation measures to demonstrate good faith efforts at providing adequate treatment that falls within the standard of care.
What do we do to protect ourselves?

C.Y.A!
What are Parent/Guardian Expectations/Attitudes towards restraint?
It’s best to clear up any unreasonable/incorrect expectations BEFORE ever using restraint with a client.

What is the parents’ understanding of restraint? Do they see it as necessary, a necessary evil or just evil?

What is the parents’ understanding of the severity of their child’s behavior? Do they under rate it?

Have the alternatives to restraint been explained to the parents?
What are the parents’ understanding of the risks involved in performing restraint?

- Physical (minor injury, major injury, fatality)
- Psychological (traumatization, re-traumatization)

Do the parents understand that there is generally a greater risk of minor injuries than major ones?

Do the parents believe that any injury reflects negligence/incompetence on the part of your organization? Do they know which kinds of injuries occur more frequently and which are rare? Do YOU?
Generally speaking, people are more likely to sue if they feel that their child has been “wronged” in some manner.

It’s important to properly inform parents of the what, why and when of restraint to bring their expectations in line with reality.

If your doctor tells you that a particular surgery could correct a leg problem, but that there is 50% chance you will lose the entire leg, you cannot claim later that you didn’t know about the possibility of limb loss.
Informed Consent

- Being informed does not mean that you “waive your right to sue”

- If you don’t do a proper job of informing, however, people don’t know what to expect

- You must also keep lines of communication open even AFTER consent is given. People can change their minds about things and have misgivings even after giving consent. Many people don’t sue until long after an incident that they seemed “comfortable” with

- You MUST continually check for understanding from parents/guardians to see if their expectations have changed.
If you don’t have all of these...
This will be cooked!
Use a nationally recognized system
Ensure all staff involved are currently certified
Ensure proper supervision
Have clear (and if applicable) individualized criteria for restraint use
Have medical clearance
Get informed consent from parents and set expectations with parents, and keep communication frequent
Have a behavior plan in place that is constantly re-evaluated based on data with careful documentation of all changes, the rationale for such changes and any subsequent improvements in restraint use
Document any and all benefits of using restraint

- Fewer injuries to staff/individual/peers
- Fewer lost treatment/educational days
- Fewer psychotropic medications/lower dosages
- Fewer episodes involving law enforcement
- Shorter episodes using less restrictive forms of restraint
- Increased access to the community (residential) or placement in a less restrictive classroom/school setting
Document, specifically, what was done in an attempt to **minimize** restraint use in *clinically meaningful ways* (trained staff on how to interact better, changed the behavior of peers, addressed medical problems, taught functional coping skills, communication skills, social skills, etc.).
Thank You!

- Don’t forget to check our website www.pcma.com
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- But only if you wanna get a pdf of this presentation!