

# Issue Brief



## Preventing the Use of Restraint and Seclusion with Young Children: *The Role of Effective, Positive Practices*

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In recent years, there have been major concerns expressed regarding the use of restraint and seclusion to control the behavior of children with disabilities and/or challenging behavior. In May of 2009, for example, the US Government Accountability Office (GAO) released findings regarding a number of cases in which seclusion and restraint were abused to the point that children were physically and psychologically injured. Some children even died while being restrained. The great potential for abuse and injury has led many school districts, state agencies, and state governments to issue policies, regulations and laws that limit the use of restraint and seclusion. Many of these regulations and statutes effectively prohibit the use of restraint and seclusion except in cases of orthopedic necessity and obvious emergencies in which a child is in imminent danger. Still, there remains uncertainty about what constitutes restraint and seclusion and what should be done as an alternative. The purpose of this document is to review these issues and discuss positive strategies that can be used to prevent behaviors that could lead to considerations of these invasive and potentially-dangerous practices.

### WHAT IS SECLUSION?

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Seclusion refers to the involuntary confinement of a child **alone in a room** or **isolated area** from which **the child is prevented from leaving**. Seclusion may include having a door locked or blocked with the child being alone, or having a child placed away from peers and caregivers for a period of time with no access to social interaction or social activities.

Seclusion can be confused with “time out” (as in “closed door time out”), however time out is defined simply as an intervention that involves removing or limiting the amount of reinforcement or attention that is available to a child for a brief period of time. Time out can be used as a component of an approved behavior support plan when it involves removing a child from an activity, taking materials or interactions away, or having the child sit out of an activity away from attention or interactions. It is important to emphasize that time out does not require or imply seclusion. For more information about time out, readers are referred to “What Works Brief #14” at [www.vanderbilt.edu/csefel/resources/what\\_works](http://www.vanderbilt.edu/csefel/resources/what_works).

Seclusion (involuntary confinement) is an extreme procedure that is not developmentally appropriate and should serve no purpose as an intervention with young children. In the authors’ opinion, young children must never be alone in a room or isolated completely from social interaction.

### WHAT IS RESTRAINT?

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Restraint is the use of physical force (e.g., holding a child), a mechanical device (e.g., a chair with straps to hold the child) or chemicals (e.g., tranquilizers) to immobilize a child and to prevent the child from engaging in freedom of movement. Mechanical and physical restraints are most relevant for the current discussion. Mechanical restraint is defined as the use of any device or equipment to restrict a child’s freedom of movement. However, the term is not applied when devices are used



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or prescribed by trained medical or related services personnel for the purposes for which the devices were designed. These include: (a) adaptive devices to achieve proper body position or alignment to allow improved mobility, (b) orthopedically prescribed devices, such as protective helmets, that permit a child to participate in activities without risk of harm, (c) restraints for medical immobilization, and (d) the use of safety restraint belts when being transported in a vehicle or to prevent a child from falling out of bed or a chair.

Physical restraint is defined as a personal restriction that immobilizes or reduces the ability of the child to freely move his or her torso, arms, legs, or head. The term does not include a physical escort involving a temporary touching or holding for the purpose of inducing or guiding a child to walk to a safe location. There are other forms of physical contact that do not constitute restraint. Brief physical guidance, instructional prompting, physical support, and comforting are not instances of restraint. Young children often wish to be held and holding and soothing young children is not considered restraint.

Restraint has been used at times when a child is judged to be “out of control,” and at risk of causing injury. Restraint is evident if a child is resisting and protesting the physical contact, and if physical immobilization is used to control disruptive, unruly or undesirable behavior. Common forms of restraint are basket holds and 2 or 4-point prone restraints (i.e., putting child on floor on their stomach and holding down their limbs). Physical restraint has become very controversial due to reports of overuse and abuse of the procedures and the real risk of physical and psychological injury.

## **PROBLEMS ASSOCIATED WITH SECLUSION AND RESTRAINT**

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Both seclusion and restraint are reactive procedures that tend to be used when teachers or other caregivers do not know what else to do. They are associated with a number of significant problems and, therefore, it is vital to understand and implement approaches for maintaining a positive and orderly environment in which prosocial, desirable behaviors are encouraged and challenging (and out-of-control) behaviors are minimized. Preventive strategies that reduce or eliminate the behavioral circumstances that might lead to the use of restraint or seclusion constitute the main messages of this article. However, before describing these positive approaches, it is useful to briefly review some of the primary problems associated with seclusion and restraint.

1. A first problem is that restraint carries a potential for injury to occur for the child being restrained. As indicated above, there have been cases where serious injury and even death have resulted from a child being restrained in order to address undesired behavior. In

addition, there is the possibility for the adult involved to suffer injury due to the physical contact and confrontation used in restraint procedures.

2. There is also the potential risk of psychological problems, including trauma, among young children who are exposed to restraint and seclusion procedures. Young children can be very frightened, anxious, or nervous because they do not have the skills to understand the procedures and their consequences (what is happening). Furthermore, use of restraint or seclusion involves the real risk that children inadvertently learn that their caregivers are responsible for placing them in ‘scary’ situations, which can impair the development of safe and secure relationships with other adults and peers. There is also the risk that children may learn that classrooms are associated with invasive and traumatic experiences, which may lead to future difficulties in subsequent schooling.
3. As there is a lack of therapeutic benefit in using restraint and seclusion procedures, young children are not learning positive behavioral alternatives. Therefore, children’s behaviors may remain unchanged and teachers may end up resorting to additional and more forceful intrusive behavior-control procedures. The likelihood that circumstances may occur over and over again in the same way is both negative and disturbing for the child, with no positive outcomes.
4. When restraint and seclusion are used to control behavior, there is a risk that such procedures may over time become the “normal” or routine practices in the classroom. Because restraint and seclusion can temporarily curtail the occurrence of disruptive behaviors, teachers may be reinforced for using them and, unintentionally, use them more often and more routinely in the future. With continued implementation of restraint and seclusion, the risk of abuse is dramatically heightened.

## **WHAT SHOULD BE DONE?**

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The use of seclusion and restraint can be reduced most effectively by implementing proactive procedures that prevent serious challenging behaviors from occurring. In this respect, there is widespread agreement that the best way to deal with behavioral challenges is to implement a multi-faceted program for: (a) promoting desirable social-emotional behaviors and (b) preventing the development and occurrence of disruptive, violent and other inappropriate responses. A general framework of prevention that has been adopted by many authors is the tiered prevention and intervention model that has been adopted by multiple disciplines such as public health and educational psychology (Simeonsson, 1991; Walker et al., 1996). A tiered

prevention and intervention model typically involves three levels of interventions or strategies. When used in public health, the universal level is comprised of interventions to promote healthy lifestyles by the entire populations (e.g., reducing smoking or immunizing children against disease). The next level of the model involves targeted interventions designed to prevent an at-risk group from getting the disease or engaging in the risky behavior (e.g., a targeted campaign for teens to not smoke). The highest level is treatment that is directed at those individuals who are already engaging in the behavior or have the disease. A well-developed application of the tiered framework is the “school-wide positive behavior support (SW-PBS)” framework designed to promote positive school cultures and prevent problem behaviors in school settings (Sugai et al., 2000). SW-PBS has been implemented effectively in many thousands of schools (see [www.pbis.org](http://www.pbis.org)).

Tiered models of prevention have also been developed for early childhood programs, and such approaches have been shown to be effective in improving children’s behavior and reducing the need for reactive, behavior management procedures (e.g., Fox, Jack, & Broyles, 2005; Fox & Hemmeter, 2009; Hemmeter, Fox, Jack, Broyles, & Doubet, 2007). The tiered model of prevention and intervention is endorsed as an effective intervention approach for challenging behavior by the leading professional associations in early childhood (e.g., Division for Early Childhood, 2007). Fox and her colleagues (2003) described a tiered prevention framework, the “Pyramid Model”, designed to build social competence and prevent challenging behaviors for young children. The Pyramid Model consists of three tiers of practices with the first tier being comprised of the universal practices applicable for all young children. The second tier addresses the needs of children with social and emotional delays who are at risk for challenging behavior, and the third tier is concerned with children who display persistent, serious challenging behaviors.

The first universal category of practices (tier 1 strategies) concerns the quality of positive relationships developed between the child and the child’s parents, teachers, early education and care professionals, other caring adults and, eventually, peers. These relationships provide the context and the mold from which the child’s future relationships and interactions will emerge, and they serve as the basis for the early guidance and instruction that adults offer for the child. The stronger the positive relationship an adult has with a child, the more effective the adult will be in helping the child acquire social competencies.

The second general category of universal practices at tier 1 involves basic levels of adult-child interactions, guidance and modeling with respect to empathy for others, assistance with problem solving, promotion of skill development, and the provision of comprehensible, predictable and stimulating environments. These practices are manifestations of fundamental guidelines for high quality early education, positive parenting and for arranging the physical environment to promote safety

and orderliness in classroom, child care, and home settings. It is understood that adherence to such guidelines for all children will help promote healthy social-emotional development and reduce the incidence of serious challenging behavior.

Secondary prevention practices (tier 2 strategies) are geared for children who have social emotional delays or experience circumstances known to increase the risk of social-emotional disorders and the development of challenging behaviors. Such risk factors may include poverty, abuse, neglect, maternal depression, and developmental delays or disabilities in learning or communication. A variety of parent training, social skills and social-emotional curricula, and multi-component intervention programs have been developed to provide assistance for these children (e.g., Walker et al., 1998; Webster-Stratton, 1990; and see Joseph and Strain, 2003).

The tertiary practices (tier 3 strategies) of the pyramid include intervention and support strategies for those relatively few young children who already demonstrate patterns of persistent challenging behavior and who require more concerted and individualized intervention efforts. The challenging behaviors of these children may accompany a developmental delay or disability, though a diagnosis or identified disability is not necessarily present. It is often these children, who may demonstrate violent or other “out of control” behavior, who are subjected to physical restraint or seclusion in efforts to manage their behavioral disturbances. The following section addresses effective strategies for these behaviors.

## **PROCEDURES FOR CHILDREN WITH SERIOUS AND PERSISTENT CHALLENGING BEHAVIORS**

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When confronted by very serious challenging behaviors of young children, there are several important things to keep in mind. First, the frequency and intensity of a child’s challenging behaviors are likely to be much easier to address if the fundamental and inexpensive procedures of universal (primary) and secondary prevention are implemented early and with integrity. Building positive relationships, providing high-quality environments, and assuring a child’s physiological and social-emotional well being can serve to forestall the majority of challenging behaviors. Second, a great deal of research has been conducted on strategies for assessing and intervening with serious challenging behaviors. These strategies have been documented to be effective, even with very persistent and disturbing behaviors, and they do not require invasive techniques or physical confrontation. The strategies are based on scientific principles of behavior analysis and the practical approach of positive behavior support (Dunlap & Fox, 2009).

Many researchers and early childhood professionals endorse the use of individualized positive behavior support (PBS) to address

serious challenging behaviors and, indeed, PBS is the approach indicated for the top level of the Pyramid Model. PBS strategies have been thoroughly explicated in a large number of books (e.g., Bambara & Kern, 2005), articles (e.g., Powell, Dunlap, & Fox, 2006) and web sites (e.g., [www.challengingbehavior.org](http://www.challengingbehavior.org)). In brief, the approach begins with a functional assessment of the behavior. This assessment process yields information related to the function and maintaining consequences of the behavior, along with a detailed description of the antecedent and contextual events that are associated with occurrences and non-occurrences of the behavior. The assessment information leads directly to a behavior support plan. The support plan can be comprised of numerous, individualized components, but should always include strategies for: (a) teaching replacement behaviors, especially functional communication, that can serve as alternatives to the targeted challenging behaviors; (b) changing the consequences for challenging behaviors so that undesirable behaviors are no longer rewarded and so that, instead, prosocial behaviors are strengthened, and; (c) modifying the antecedent and contextual events so that “triggers” for challenging behaviors are eliminated or ameliorated, and stimuli associated with desirable behavior are added and enhanced. It is worth emphasizing this latter element. Considerable research has shown that strategic, assessment-based arrangements of antecedent stimuli can produce very rapid change in behavior (Luiselli, 2006) and, therefore, such procedures can be an efficient and effective alternative to restraint and seclusion.

## WHAT IF SERIOUS “OUT-OF-CONTROL” BEHAVIORS OCCUR?

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The use of thorough preventative strategies, and assessment-based PBS procedures, should make out-of-control behavior very unlikely. However, it is impossible to anticipate every behavior that might happen, and it is inevitable that very serious challenging behavior will occur in some circumstances. In these instances, it is essential to insure the child’s and peers’ safety and to attempt to deescalate the child’s behavior. The following steps can be used to help the child calm down:

1. Approach the child calmly using a quiet and supportive tone of voice. Make eye contact with the child and position yourself to physically block the child from having an escape route to move away from you.
2. Begin by using verbal directions such as direction about what to do next (e.g., “Put the block down”), a direction on how to de-escalate (e.g., “Take a deep breath”), and/or a direction about appropriate behavior (“We’ll ask if you can have a turn next”).
3. It is also effective to provide narrative observations about the child’s emotional state that validates the child’s feelings (e.g., “It looks like you are very

angry”). By validating the child’s emotion, the child understands that his message is being heard and acknowledged by the adult.

4. If verbal strategies are unsuccessful, then use non-intrusive physical interventions such as moving the child, blocking the child’s ability to hurt others or himself (e.g., blocking child from throwing objects at another child or hitting self), interrupting aggressive action with physical guidance (gently guiding the child to put down materials that are being used to hit), or removing materials from the area.
5. If the child’s behavior persists and you have assistance, you might ask another adult to remove other children from the immediate proximity of the child who is engaging in out-of-control behavior. Once the children are removed, you can stay with the child until the child calms down and regains control (i.e., let the tantrum run its course).
6. If the child is persistent in the challenging behavior, the adult should consider removing the request or instruction and waiting until the child deescalates or calms down before offering the child any additional guidance or feedback. When out-of-control behavior is occurring, it is usually not productive to continue to place demands on the child with an expectation of compliance.

If none of the strategies above work to deescalate a child then the teacher can use the LEAD strategy. However, this strategy should be very rarely used and is an intervention of last resort to prevent harm to the child or to others. It should only be used when the challenging behavior is dangerous to the child or others, the behavior is escalating, and all first response strategies have failed. LEAD refers to a four step process presented as a part of the Safety First Curriculum that provides early educators with guidance on preventing escalation of challenging behavior and strategies to address challenging behavior in unsafe situations (Early Intervention Behavior Work Group, 2005). LEAD might be used on the first occasion that a child (who does not have a behavior support plan) displays challenging behavior that compromises his safety or the safety of others and that is unresponsive to other de-escalation approaches. It might also be used when a child who has a behavior support plan engages in escalating challenging behavior that poses unsafe conditions.

The LEAD process should always be implemented calmly and with an empathetic and supportive demeanor. While LEAD will involve helping the child contain her body and calm down, it never involves forcing the child into a prone or supine position.

1. **LABEL** the behavior by acknowledging the child’s emotions (e.g., “You are feeling angry. You are mad at Sally and you want to hurt her”).
2. **ENVELOP** the child in a temporary, supportive restraint to provide protection and to contain and



stabilize the child's disruptions (e.g., "I need to help you be safe"). For example, an adult might do this by standing behind the child, wrapping her arms around the child's chest, walking backwards to a wall, and gently sliding down the wall while holding the child until both adult and child are in a sitting position.

3. **ASSIST** the child to calm down (e.g., "I'll let you go when your body is quiet and you can stop hitting and yelling").
4. **DEBRIEF** and **DIRECT** the child to return to the group in a manner reflecting self control.

LEAD is an emergency procedure that may include restraint ("Envelop") in order to protect the child and facilitate calming. Any instance in which such a procedure is necessary must be immediately followed by a thorough reporting of the incident and by a meeting for the purpose of reviewing, developing and revising the child's behavior support plan. If a detailed plan does not yet exist, a functional assessment should be conducted and a multi-component PBS plan should be constructed and implemented.

## SUMMARY AND RECOMMENDATIONS

Restraint and seclusion are intrusive and highly problematic procedures for controlling children with challenging behaviors. They have been associated with an alarming amount of abuse and physical and psychological injury to children. Restraint and seclusion appear to be used when teachers and other professionals do not know what else to do. This is especially unfortunate because there is a wealth of well-documented strategies that can prevent serious challenging behaviors from occurring, and there is also a solid and well-established set of PBS strategies that can be used effectively for the most serious of disruptive, violent and out-of-control behaviors.

Due to the substantial risk associated with restraint and seclusion, there are ongoing efforts to further restrict or even ban the use of these procedures. Given the availability of effective alternatives, it is strongly recommended that programs serving young children work to eliminate the use of restraint and seclusion. In the authors' opinion, seclusion should not be used with young children under any circumstances. Restraint should also be avoided, although it is acknowledged that a brief instance of supportive restraint may be necessary under emergency circumstances, such as when a child's behavior produces immediate and serious risk of injury to the child or others (e.g., running into traffic; hitting a child with a hard object). Such instances should be followed immediately by reports, meetings, and revised procedures designed to prevent any repetition of the incident.

The good news is that the field has advanced to the point that research-based prevention and intervention strategies are well documented and readily available for professionals and other

practitioners to use in classrooms, child care programs, and all other settings. The conscientious and comprehensive implementation of these strategies will promote the healthy social-emotional development for all children, including those children with or at risk for disabilities and difficult behavior.

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