

Reducing Restraint and Seclusion: The Benefit and Role of Occupational Therapy

Occupational Deprivation and Restraint and Seclusion

Occupational deprivation is the act of prohibiting an individual from participating in a meaningful activity (Wilcock, 1998; Munoz, 2011). Recently, the concept of occupational deprivation has been applied to disenfranchised youth (see for example Bazyk & Bazyk, 2009). When students are chronically restrained or secluded, they may experience occupational deprivation as a result of being kept from their peers and what most would consider typical school activities. Children and youth who endure occupational deprivation at school may experience decreased volition and identify less with the role of student. Occupational therapy practitioners who provide services in settings that habitually use restraint and seclusion may use occupational enrichment as a way to reduce the impact of occupational deprivation to children and youth. *Occupational enrichment* is the process of intentionally adjusting the physical and social environment to provide structured opportunities that promote engagement in meaningful activities that the student would otherwise typically perform (Molineux & Whiteford, 1999; Munoz, 2011). For example, an occupational therapy practitioner working at a therapeutic day school for children with aggressive behaviors may provide students with opportunities that they are missing out on by not attending their general education schools. He or she might focus on creating opportunities for social participation (e.g., playing board games) or help students to assume new roles (e.g., setting up classroom jobs). The practitioner might also work with the educational team to understand the effects of both chronic short-term (e.g., being secluded for a 30-minute period) and long-term (e.g., being removed from a general education school) occupational deprivation.

OCCUPATIONAL THERAPY PRACTITIONERS use meaningful activities to help children and youth participate in what they need and want to do to promote their physical and mental health and well-being. Occupational therapy practitioners focus on the usual occupations of childhood, including participation in education, play, leisure, social activities, activities of daily living (e.g., eating, dressing, bathing), and instrumental activities of daily living (e.g., completing chores, shopping). Task analysis is used by occupational therapy practitioners across a variety of pediatric settings (e.g., schools, community centers, hospitals) to identify factors (e.g., motor, process, communication-interaction, sensory) that restrict or inhibit meaningful participation in the various roles associated with childhood (e.g., student, family member, friend).

ABOUT RESTRAINT AND SECLUSION

The use of restraints and seclusion in schools serves two primary functions. The first function is to limit harmful, aggressive, or negative behaviors; the second function is to deter the use of such behaviors by children and youth in the future (LeBel, Nunno, Mohr, & O'Halloran, 2012). Some children and youth demonstrate aggressive behaviors at school and some educational agencies (e.g., public school districts, private therapeutic day schools, hospital-based school programs) use restraint and seclusion to manage such behaviors. *Restraints* are defined as physical methods that impede an individual's freedom to move or engage in physical activity (Ryan & Peterson, 2004). The common types of restraints that are often used with children and youth in school settings are mechanical restraints and ambulatory restraints.

Mechanical restraints include any type of equipment or device that is applied to a student in an attempt to restrict the student's movement and manage or control his or her negative behaviors (Council for Children with Behavioral Disorders [CCBD], 2009). Examples of mechanical restraints include tape, ropes, and belts (CCBD, 2009). Although sometimes used as a restraint to prevent free movement, devices such as lap belts may also be used to improve postural control. When lap belts or other equipment are used solely for therapeutic purposes rather than to restrict movement, they are not considered to be restraints (LeBel et al., 2012).

Ambulatory restraints—sometimes called *manual restraints*, *physical restraints*, or *holding*—involve using one's own body to forcibly restrict a student's body and/or movement (Ryan & Peterson, 2004; CCBD, 2009). Many educational agencies have attempted to reduce the use of ambulatory or physical restraints due to the eminent risks that they pose to the safety and well-being of children and youth. The risks to children and youth that have been associated with physical restraints include damaged joints, broken bones, skin irritation, and even death (CCBD, 2009). Ambulatory or physical restraints are considered to be corporal punishment by the American Civil Liberties/Human Rights Watch, and the literature suggests that when used in non-emergency situations, ambulatory or physical restraints can lead to increased student aggression and violence (LeBel et al., 2012).

Seclusion is defined as any type of involuntary confinement of a student (LeBel et al., 2012). Seclusions are sometimes referred to as "time outs." A key difference between the time outs that are often given to children by parents (e.g., removed from a situation and asked to sit in a designated area until a timer goes off) and what is considered to be seclusion is that seclusion involves the child being physically (and sometimes forcibly) prevented from leaving the designated area. Ambulatory or manual restraints are sometimes used during seclusion procedures as a means to keep the child from leaving the designated area.

Continued on page 2.

RELEVANCE TO MENTAL HEALTH

Restraints and seclusion should only be used by educational teams as a last resort or in emergency situations to keep children and youth safe in schools. Besides the potential for causing physical injuries, the use of restraints and seclusion has the potential to negatively impact a student's mental health. Children and youth who have been forcibly restrained may experience posttraumatic stress as a result of their treatment. Students may experience nightmares and intrusive or repetitive thoughts related to the restraint experience, and they may develop a tendency to avoid physical contact and/or situations that cause them to remember the restraint experience (Mohr, Petti, & Mohr, 2003). Children and youth who have been restrained may also develop a sense of mistrust of service providers (Mohr et al., 2003). Given the negative impact of restraint and seclusion, it is fortunate that many schools are developing policies and procedures to reduce their use.

OCCUPATIONAL THERAPY PRACTITIONERS can play an important role in helping educational teams to reduce their use of restraints and seclusion. Occupational therapy practitioners can offer a unique contribution to evaluation and intervention planning that addresses the complex challenges posed by students' use of aggressive behaviors in the classroom and other school environments. Occupational therapists can use formal and informal assessment tools to identify the sensory, motor, social-emotional, and cognitive factors that may contribute to a student's aggressive behaviors and help the school team develop positive strategies to decrease the need for restraint and seclusion (LeBel & Champagne, 2010). Occupational therapy practitioners may work with teams to develop student-centered interventions that focus on *establishing pro-social habits and routines, using occupation to enhance and promote self-regulation and relaxation, and developing strategies for managing symptoms (e.g., stress, anger, anxiety) that are associated with the use of aggressive behaviors.*

Occupational therapy practitioners can also serve an important role by evaluating and addressing the environmental factors that contribute to a student's use of aggressive behaviors. Finally, occupational therapy practitioners can apply their unique understanding of the occupational needs of certain populations, such as those children and youth diagnosed with autism spectrum disorder, attention deficit hyperactive disorder, oppositional defiant disorder, bipolar disorder, trauma disorder, and other mental health disorders in order to support their overall participation at school.

LEVELS OF INTERVENTION

Promotion

Occupational therapy practitioners can provide unique contributions to developing school policies and procedures that reduce aggression and the need for restraint, seclusion, and expulsion. Because their services are frequently popular with students, occupational therapy practitioners can promote the use of school-wide efforts to create positive behavior management systems (e.g., incentives-based systems). Occupational therapy practitioners can also promote positive mental health for all students by fostering a culture of respect, citizenship, and stewardship.

Prevention

Occupational therapy practitioners can work with educational teams to prevent students from engaging in aggressive behaviors that warrant restraints or seclusion. Occupational therapy practitioners can educate students and staff regarding the sensory, motor, social-emotional, and cognitive factors contributing to aggressive behavior. Occupational therapy practitioners can educate students and staff on environmental triggers, body triggers, and a variety of coping strategies, including those that are sensory based. In addition, they can set up break areas where students can go to calm themselves down and/or use some calming sensory strategies (Gardner, Dong-Olson, Castronovo, Hess, & Lawless, 2012; Sutton, Wilson, VanKessel, & Vanderpyl, 2013).

Continued on page 3.

CHECK THIS OUT!

- The U.S. Department of Education has developed laws and guidance about seclusion and restraint, including a framework of 15 principles that should be used when establishing policies and procedures <http://www2.ed.gov/policy/seclusion/index.html>
- *CCBD'S Position Summary of The Use of Physical Restraint Procedures in School Settings—Guidelines for teachers and other educational providers* http://c.ygcdn.com/sites/www.copaa.org/resource/collection/662B1866-952D-41FA-B7F3-D3CF68639918/Accepted_CCBD_on_Use_of_Restraint_7-8-09.pdf
- *A Review of Crisis Intervention Training Programs for Schools—Teaching exceptional children* <http://www.maine.gov/education/rulechanges/chapter33/022411dbutlercitreviewofresstraintsinschoolsinschools.pdf>
- *Abuse, Restraints, and Seclusion in School—Legislation and lawsuits related to using seclusion and restraints in school* <http://www.wrightslaw.com/info/abuse.index.htm>
- *AOTA Fact Sheet: Occupational Therapy's role in Restraint Reduction or Elimination* <http://www.aota.org/-/media/Corporate/Files/AboutOT/Professionals/WhatsOT/MH/Facts/Restraint%20fact%20sheet.pdf>

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Occupational therapy practitioners can teach students to ask for a break when they experience triggers, and teach staff to respond to the request for breaks positively. In addition, occupational therapy practitioners can coach students regarding the use of self-regulation, problem solving, and self-calming strategies. Finally, occupational therapy practitioners can consult with teachers to (1) identify alternative strategies to reduce aggression in the classroom, such as using visual supports to teach strategies that accommodate diverse learning styles and reduce stress (particularly for students who are young or have intellectual disabilities); (2) adapt the curriculum to address students' needs; and (3) establish classroom habits and routines that promote the development of self-regulation.

Intensive

Occupational therapy practitioners may also be able to offer intensive supports and services to students who demonstrate aggressive behaviors. Occupational therapy practitioners can work with educational teams to conduct functional analyses of behavior in order to identify the meaning of a student's aggressive behavior, as well as the behavior's causes (i.e., antecedents), environmental setting events (e.g., crowding), and outcomes (i.e., consequences) (Murray-Slutsky & Paris, 2005). Occupational therapy practitioners may also provide group and individual occupational therapy services to help reduce physical aggression and the need for restraint and seclusion.

After careful assessment, occupational therapy practitioners can work with students and teachers to develop environmental adaptations and individualized coping strategies that support the student's participation and help him or her to remain calm (Gardner et al., 2012; Sutton et al., 2013). Group and individual intervention allows for in-depth understanding and identification of students' unique goals, their academic and participation baselines, environmental triggers, body triggers, and coping strategies to reduce aggression. Occupational therapy services can include individualized environmental adaptations (e.g., seat placement and positioning, use of adaptive pencil grips to make writing easier, assignment modifications), the development and implementation of emotional regulation strategies (e.g., self-identifying arousal level, environmental triggers, body triggers, and coping strategies), and the identification of optimal curriculum modifications (e.g., optimally stable seating close to the teacher, movement breaks, mindfulness activities, adjustments of teaching methods to student learning style).

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