Reducing Restraints and Seclusions in Schools: Implementation of Collaborative & Proactive Solutions in One School System

Ross W. Greene
Department of Psychology, Virginia Tech, Blacksburg, Virginia
Faculty of Science, University of Technology Sydney, Sydney, Australia

Amy Hall
Director of Student Services, MSAD75, Topsham, Maine

Heidi O'Leary
Superintendent, MSAD75, Topsham, Maine

UNDER REVIEW…DO NOT CITE WITHOUT AUTHORS' PERMISSION

Introduction

Restraint and seclusion are crisis management strategies often trained to school staff as the option of last resort for students whose concerning behavior reaches a threshold of dangerousness to self or others. Restraint refers to any manual method, 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 (Office of Civil rights, 2012). Seclusion is defined as confining a student alone in a room or area that he or she is not permitted to leave. This includes scenarios in which the door is locked, blocked by an object, blocked by a person, or held closed (U.S. GAO, 2009).

While restraint and seclusion have at times been referred to as crisis *prevention* strategies, they are not: these procedures occur most often at the *end* of a sequence of events that begins with an expectation a student is having difficulty meeting, followed by concerning behavior, then followed by de-escalation procedures (Greene, Jones, & Munson, 2023).

In American public schools, the most recent data from the U.S. Department of Education Office of Civil Rights database indicate that there are approximately 100,000 restraints and seclusions annually. Given inconsistencies in reporting, it is thought that this figure represents an underestimate (U.S. GAO, 2020).

Mohr and Anderson (2001) have suggested that there are a variety of false assumptions associated with restraint that may underlie its continued overuse, including the belief that it is therapeutic and the belief that there is research supporting the use of these practices, The fact that school structures and staff trainings tend to be more strongly oriented toward crisis management than crisis prevention may also be a contributing factor.

Research also suggests that restraint and seclusion cause harm both to those on the receiving end of such procedures and those administering them. As noted by Mohr, Petti, and Mohr (2003), the scant literature concerning psychological and cognitive effects of physical restraint suggests that it may be perceived as punitive and aversive, with the potential for traumatic sequelae. Children and adolescents who had been restrained during psychiatric hospitalization reported nightmares, intrusive thoughts, and avoidance responses resulting from their restraint experiences, as well as marked startle responses associated with being held in benign and nonthreatening situations. They also reported painful memories and fearfulness at seeing or hearing others being restrained. Five years later, they continued to experience intrusive thoughts, recurrent nightmares, avoidance behaviors, startle responses, and mistrust (Abamu & Manning, 2019).

Unfortunately, the best-documented adverse outcome of restraint is death. Researchers have documented 79 restraint-related fatalities occurred over a 26-year study period across a spectrum of children's out-of-home child welfare, corrections, mental health and disability services, and similar concerning data has been found for schools U.S. GAO, 2009; Holden & Nunno, 2019).

Of equal concern are data indicating that restraint and seclusion are disproportionately applied to students with disabilities and those with Black and Brown skin (Westling, Trader, Smith, & Marshall, 2010; Gagnon, Mattingly, & Connelly, 2017).

In consideration of the above, there have been increased calls for the dramatic reduction or total elimination of restraint and seclusion in American public schools (e.g.,

COPAA, 2020), and numerous examples of legislation at the state and federal level aimed at mandating these reductions (e.g., Pulrang, 2021). While these efforts have met with mixed success, mandating reduction or elimination of restraint and seclusion does not provide educators with alternatives to the use of these practices. This may explain why many educators working with behaviorally challenging students have been slow to embrace these efforts.

Collaborative & Proactive Solutions (CPS) is an evidence-based (see Greene & Winkler, 2019) psychosocial treatment model for youth with concerning behaviors first articulated in published form in 1998 in the book *The Explosive Child* (Greene, 1998). Over the past 30 years, the CPS model has been applied and studied in a diverse array of settings, including families, general and special education schools, inpatient psychiatry units, and residential and juvenile detention facilities. Its effectiveness at reducing or eliminating restraint and seclusion in inpatient psychiatric facilities is well-documented (references here). While similar findings in schools have been noted anecdotally, formal documentation of these findings has been lacking.

The CPS approach emanates from the same broad social learning theoretical foundations as other well-established forms of psychosocial intervention for concerning behaviors. However, CPS represents a significant departure from these procedures and practices. The CPS model relies heavily on the vast findings in neuropsychology delineating the skills frequently found lagging in youth with social, emotional, and behavioral challenges. Rather than focusing on overt behavior, the model centers on the specific conditions in which concerning behaviors occur. An important premise of the CPS model is that concerning behavior occurs when individuals lack the skills to respond to problems and frustrations adaptively, including flexibility/adaptability, frustration tolerance, problem solving, and emotion regulation (Greene, 2018). These frustration responses are said to occur in conditions in which individuals are having difficulty meeting specific expectations. In the CPS model these unmet expectations are referred to as "unsolved problems." The goal of intervention is to help caregivers and kids engage in collaborative and proactive efforts to solve those problems, thereby reducing or eliminating the concerning behavior that is the byproduct of those problems (Greene, 2018).

In schools, use of the CPS model involves two primary components: (1) engaging school staff in the process of identifying a child's lagging skills and unsolved problems, using an instrument called the Assessment of Lagging Skills and Unsolved Problems (ALSUP) and then (2) having school staff and kids engage in efforts to solve those problems collaboratively and proactively. Another important premise of the model is that the person in the best position to solve a problem with a student is the person whose expectation the child is having difficulty meeting. If a student is having Difficulty completing the double-digit division problems on the worksheet in math, then the ideal person to solve that problem with the student is the math teacher. If a student is having Difficulty agreeing on the rules of the four-square game with Billy during recess, then the person who monitors recess is ideally suited to facilitate a solution to that problem. If those unsolved problems are causing concerning behavior and the student is simply sent to the office or to a school counselor or psychologist -- who may know little about those problems and are therefore ill-equipped to solve them -- then the problems will remain unsolved and the concerning behaviors being caused by those problems will persist.

The ALSUP (see Appendix A) is a neither a behavior checklist nor a rating scale but is instead used as a discussion guide. It is intended to help adults shift their explanations for concerning behavior (from lagging motivation to lagging skills). There is another advantage to the ALSUP: because caregivers are identifying unsolved problems proactively, those problems become highly predictable and can therefore be prioritized and solved proactively. Thus, the CPS model helps schools move away from intervention that is primarily reactive toward intervention that is primarily proactive, thereby reducing the need for punitive interventions that occur as reactions to concerning behavior.
The problem-solving process -- known as Plan B -- involves three steps:

- the Empathy step, in which caregivers gather information from the student about the factors making it difficult for them to meet a particular expectation
- the Define Adult Concerns step, in which caregivers articulate why they feel it's important that the expectation be met
- the Invitation step, in which the child and caregivers collaboratively arrive at a solution that addresses the concerns of both parties

Implementation in One School System

MSAD75 is a school system in Maine serving the towns of Bowdoin, Bowdoinham, Harspwell, and Topsham. The use of restraint and seclusion in MSAD was confined to three special elementary education classrooms with a total of 27 students. As depicted in Figure 1, during the 2017-18 school year, there were 120 restraints and seclusions in these three classrooms, and 140 during the ensuing school year. This led to unfavorable news coverage and a coinciding effort to bring those numbers down dramatically. The CPS model was implemented during the 2019-20 school year, and staff have continued to implement the model for the ensuing three years. Existing school data collection systems were used to track restraints and seclusions, which are also reported annually to the state of Maine Department of Education. Lead teachers and associated staff in each classroom were trained in the underpinnings of the CPS approach, which was then modeled for staff with individual students. Staff were then provided with direct coaching in their use of the CPS model as they applied it to individual students.

Results

Figure 1 depicts the number of restraints and seclusions in consecutive school years beginning in 2017-18 and ending in 2022-23. Again, implementation of the CPS model began at the outset of the 2019-20 school year. Dramatic reductions in both restraint and seclusion occurred in the first year of implementation and have been maintained during the ensuing three years. This suggests that the effectiveness of the CPS model in reducing restraint and seclusion is durable.

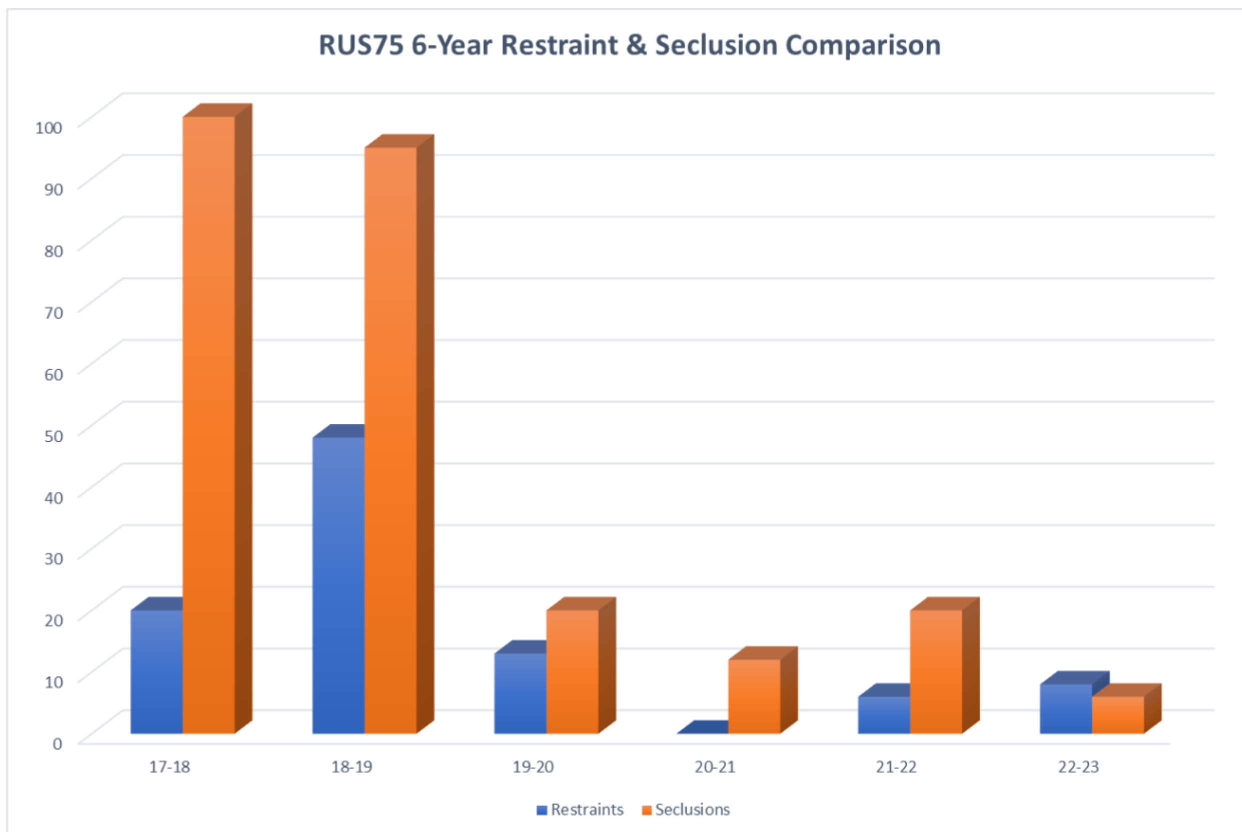

Figure 1: School Discipline Referrals for Four Maine Schools for the Year Prior to CPS Implementation to One-Year Following CPS Implementation

Discussion

In this study, implementation of the Collaborative & Proactive Solutions (CPS model) in three elementary school special education classrooms in which restraint and seclusion were being used was found to dramatically reduce the use of these procedures rapidly and durably. This is encouraging news for school systems committed to reducing or eliminating the use of such restraint and seclusion but unaware of alternatives to existing crisis management programs.

We believe that a major aspect of the CPS model is its effectiveness at completely redefining what is meant by crisis *prevention*. In our experience, many educators still define crisis prevention in terms of actions taken once a student shows signs of escalation. In focusing on proactively identifying the problems that are causing students to escalate (and proactively solving them) – rather than on the concerning behaviors that signal that a student is becoming escalated – the CPS model helps school staff redefine the timeline of prevention and create structures and practices to support this new definition. This requires that staff become skilled at the two key components of the CPS model: the ALSUP and Plan B.

In the process, staff come to recognize that concerning behaviors, and the problems that cause them, are far more predictable than they had imagined. They also come to recognize that once those problems are solved or put on hold (proactively), the frequency

of student escalations decreases dramatically, thereby dramatically reducing the need for restraint and seclusion.

The goal is to eliminate these practices completely. In many similar classrooms, this goal has already been achieved. This will require closer examination of the very few instances in which restraint and seclusion are still being deployed and determining whether these instances could have been prevented as well.

References

Abamu J., & Manning R. (2019). Desperation and broken trust when schools restrain students or lock them in rooms. National Public Radio Morning Edition.

Council of Parent Attorneys and Advocates (2020). The crisis of trauma and abuse in our nation's schools.

Greene, R.W. (2018) Transforming school discipline: Shifting from power and control to collaboration and problem solving, *Childhood Education*, 94:4, 22-27.

Greene, R. W., Jones, B. Y., & Munson, M. (2023). The vast differences between crisis management and true crisis prevention.

Greene, R. W. & Winkler, J. (2019). Collaborative & Proactive Solutions: A review of research findings in families, schools, and treatment facilities. Clinical Child and Family Psychology Review.

Holden M., & Nunno M. (2019). Learning from tragedy: A twenty five-year (1993-2017) survey of the fatal restraints of children and young people in the United States. F.I.C.E. Conference, Tel Aviv, Israel.

Mattingly, M. J., & Connelly V. J. (2017). The restraint and seclusion of students with a disability: Examining trends in U.S. school districts and their policy implications. *Journal of Disability Policy Studies*, 28(2), 66–76.

Mohr, W., Anderson, K., & Jeffrey, A. (2001) Faulty assumptions associated with the use of restraints with children. Journal of Child and Adolescent Psychiatric Nursing; 14 (3), pg. 141.

Mohr, W.K., Petti, T.A., & Mohr, B.D. (2003). Adverse Effects Associated With Physical Restraint. Canadian Journal of Psychiatry, 48, 330–337.

Nunno, M.A., McCabe, L.A., Izzo, C.V. *et al.* A 26-Year Study of Restraint Fatalities Among Children and Adolescents in the United States: A Failure of Organizational Structures and Processes. Child Youth Care Forum, 51, 661–680 (2022).

Office of Civil Rights (2012). 16 OCR, Restraint and Seclusion: Resource Document.

Pulrang, A. (2021). Three bills that aim to protect disabled students from harm in schools. Forbes.

U.S. Government Accountability Office (2009). Seclusions and restraints: Selected cases of death and abuse at public and private schools and treatment centers.

U.S. Government Accountability Office (2020). K-12 education: Education needs to address significant quality issues with its restraint and seclusion data.

Westling, D. L., Trader B. R., Smith C. A., Marshall D. S. (2010). Use of restraints, seclusion, and aversive procedures on students with disabilities. *Research and Practice for Persons with Severe Disabilities*, 35(3–4), 116–127.

Appendix A. Assessment of Lagging Skills and Unsolved Problems

CHILD'S NAME ____ DATE ______________

The ALSUP is intended for use as a **discussion guide** rather than as a freestanding check-list or rating scale. It should be used to identify specific lagging skills and unsolved problems that pertain to a particular child or adolescent.

LAGGING SKILLS

This section will help you understand why the child is responding so maladaptively to problems and frustrations. Please note that these **lagging skills are not the primary focal point of intervention**. In other words, you won't be discussing the lagging skills with the student, nor will you be teaching most of the skills explicitly. The primary targets of intervention are the unsolved problems you'll be documenting in the next section.

❑	Difficulty maintaining focus	❑	Difficulty seeing "grays"/concrete, literal, black & white, thinking
❑	Difficulty handling transitions, shifting from one mindset or task to another	❑	Difficulty taking into account situational factors that would suggest the need to adjust a plan of action
❑	Difficulty considering the likely outcomes or consequences of actions (impulsive)	❑	Inflexible, inaccurate interpretations/cognitive distortions or biases (e.g., "Everyone's out to get me," "Nobody likes me)"
❑	Difficulty persisting on challenging or tedious tasks	❑	Difficulty attending to or accurately interpreting social cues/ poor perception of social nuances
❑	Difficulty considering a range of solutions to a problem	❑	Difficulty shifting from original idea, plan, or solution
❑	Difficulty expressing concerns, needs, or thoughts in words	❑	Difficulty appreciating how their behavior is affecting others
❑	Difficulty managing emotional response to frustration so as to think rationally	❑	Difficulty starting conversations, entering groups, connecting with people/lacking other basic social skills
❑	Chronic irritability and/or anxiety significantly impede capacity for problem-solving or heighten frustration	❑	Difficulty empathizing with others, appreciating another person's perspective or point of view
❑	Sensory/motor difficulties	❑	Difficulty handling unpredictability, ambiguity, uncertainty, novelty

UNSOLVED PROBLEMS

Unsolved problems are the specific expectations a child is having difficulty meeting. The wording of an unsolved problem will translate directly into the words that you'll be using when you introduce an unsolved problem to the child when it comes time to solve the problem together. Poorly worded unsolved problems often cause the problem-solving process to deteriorate before it even gets started. Please reference the ALSUP Guide for guidance on the four guidelines for writing unsolved problems.

SCHOOL/FACILITY PROMPTS:

Are there specific tasks/expectations the student is having difficulty completing or getting started on?
Are there classmates this student is having difficulty getting along with in specific conditions?
Are there tasks and activities this student is having difficulty moving from or to?
Are there classes/activities the student is having difficulty attending/being on time to?
As you think about the start of the day to the end, are there any other expectations the student has difficulty reliably meeting or that you find yourself frequently reminding the student about?

HOME/CLINIC PROMPTS:

Are there chores//tasks/activities the child is having difficulty completing or getting started on?
Are there siblings/other children the child is having difficulty getting along with in specific conditions?
Are there aspects of hygiene the child is having difficulty completing?
Are there activities the child is having difficulty ending or tasks the child is having difficulty moving on to
As you think about the start of the day to the end, are there any other expectations the child has difficulty reliably meeting or that you find yourself frequently reminding the child about?