Reducing Restraints and Seclusions in Schools

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An alternative approach to crisis prevention, the Collaborative & Proactive Solutions model, has been found to have a meaningful impact on reducing the use of restraint and seclusion in elementary special education classrooms.

AUTHORS' NOTE: The second, third, and fourth authors declare they have no financial interests. The first author is the originator of the Collaborative & Proactive Solutions (CPS) model and founder of the nonprofit Lives in the Balance, which disseminates the model. He receives honoraria and royalties from his speaking engagements and books on the CPS model.

RESTRAINT AND SECLUSION are crisis management strategies that school staff are often trained to use as options of last resort for students whose concerning behavior reaches a threshold of danger to self or others (Villani et al., 2011). Restraint refers to any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a person to freely move their arms, legs, body, or head (Office of Civil Rights, 2012). Seclusion is defined as confining a student alone in a room or area that they are 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. Government Accountability Office [GAO], 2009).

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. However, given inconsistencies in reporting, it is thought that this figure represents an underestimate (U.S. GAO, 2020). One example of this inconsistency in reporting may involve schools' use of what are often referred to as "reset rooms." While these reset rooms may be intended as spaces for sensory breaks, in practice, they are frequently used in a manner that more closely resembles seclusion. As a result, use of these rooms is rarely included within reported seclusion and restraint data.

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 a student having difficulty meeting an expectation, followed by the student exhibiting concerning behaviors, and ending with the use of de-escalation procedures (Greene et al., 2023). An alternate model for working with students with concerning behaviors, Collaborative & Proactive Solutions (CPS), allows adults to work with students both to identify difficulties they are having meeting expectations and to address student and adult concerns related to those unsolved problems. Thus, CPS decreases the likelihood that students will engage in concerning behaviors to signal their difficulty meeting expectations and reduces the need to use seclusion and restraint to address any concerning behaviors.

Assumptions and Facts About Restraint and Seclusion

There are a variety of false assumptions associated with seclusion and restraint that may underlie their continued overuse, including the belief that restraint is therapeutic. The fact that school structures and staff trainings tend to be more strongly oriented toward crisis response than prevention may also be a contributing factor (Sokol et al., 2021).

In addition, research suggests that restraint and seclusion cause harm both to those on the receiving end of such procedures and to those administering them. As noted by Mohr and colleagues (2003), the scant available literature concerning psychological and cognitive effects of physical restraint suggests that it may be perceived as punitive and aversive, with the potential for traumatic effects. Abamu and Manning (2019) reported that 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 in benign, 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.

Unfortunately, the most reliably documented adverse outcome of restraint is death. Holden and Nunno (2019) documented 79 restraint-related fatalities occurring over 26 years across a spectrum of children's out-of-home child welfare, corrections, mental health, and disability services. Similar data have been found for schools, with a recent report from the U.S. GAO (2009) identifying hundreds of cases of alleged abuse and death associated with the use of seclusion and restraint in schools.

Of particular concern are data indicating that restraint and seclusion are disproportionately applied to students with disabilities and those with Black and Brown skin (Gagnon et al., 2017; Westling et al., 2010). Specifically, Katsiyannis et al. (2020) cite recent data indicating that students with disabilities (200%), Black students (almost 200%), and Hispanic students (45%) were significantly more likely than their peers to be restrained or secluded.

In consideration of the above, there have been increased calls for the reduction or total elimination of restraint and seclusion in American public schools (e.g., Council of Parent Attorneys and Advocates, 2020), and numerous examples of legislation at the state and federal levels aimed at mandating these reductions

(e.g., Pulrang, 2021). In addition, NASP's own policy platform calls for preventing and reducing the use of physical restraint in schools and prohibiting the use of seclusion, mechanical restraint, chemical restraint, and dangerous restraints that restrict breathing (NASP, 2024). While these efforts have been met with mixed success, mandating the reduction or elimination of restraint and seclusion does not provide educators with alternatives to these practices. This may explain why many educators working with behaviorally challenging students have been slow to embrace these efforts (Boston, 2023).

Collaborative & Proactive Solutions

CPS is an evidence-based psychosocial treatment model for youth with concerning behaviors (see Greene & Winkler, 2019). The approach was first articulated in published form almost 30 years ago in the book *The Explosive Child* (Greene, 1998). In the decades since, the CPS model has been applied and studied in a diverse array of settings, including families, general and special education schools, inpatient psychiatric units, and residential and juvenile detention facilities. Its effectiveness at reducing or eliminating restraint and seclusion in inpatient psychiatric facilities is well documented (Greene et al., 2006). While similar findings in schools have been noted anecdotally, formal documentation of these findings has been lacking. The current project aimed to begin to fill that gap.

The CPS approach emanates from the same broad social learning theory foundations as other well-established forms of psychosocial intervention for concerning behaviors. However, CPS represents a significant departure from these procedures and practices in that it relies heavily on the vast findings from neuropsychology delineating the skills with which youth with social, emotional, and behavioral challenges have been frequently found to struggle.

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. These skills include flexibility, 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: (a) engaging school staff in the process of identifying skills a child is struggling with, as well as unsolved problems, through the use of an instrument called the Assessment of Skills and Unsolved Problems (ASUP[1]; see https://livesinthebalance.org/cps-materials-paperwork/), and then (b) having school staff and students engage in efforts to solve those problems collaboratively and proactively (referred to as "Plan B").

An 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 the unsolved problem is causing concerning behavior and the student is simply sent to the office or to a school psychologist (who may know little about those problems and thus be ill-equipped to solve them), then the problems will remain unsolved, and the concerning behaviors being caused by the problem will persist.

The ASUP is neither a behavior checklist nor a rating scale; it is a discussion guide. It is intended to help adults shift their explanations for concerning behavior from motivation difficulties to skill difficulties. There is another advantage to the ASUP: Because caregivers are identifying unsolved problems proactively, those problems become highly predictable and can therefore be prioritized and often solved before they begin. Thus, the CPS model helps schools move away from intervention that is primarily reactive toward intervention that is primarily proactive. This reduces the need for punitive interventions that occur as reactions to concerning behavior.

The problem-solving process, known as Plan B, involves three steps:

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

What We Did

MSAD75 is a school system in southern Maine. The use of restraint and seclusion in MSAD75 was confined to three elementary special education classrooms with a total of 27 students. The classrooms were designed to

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[1] In response to feedback from the neurodivergent community, the Assessment of Lagging Skills and Unsolved Problems was recently revised, resulting in the ASUP. The unsolved problems section of the tool remains the same, while the "lagging skills" section has been changed to the "skills" section to address concerns about the implied comparison with neurotypicality that the term "lagging" suggested. The ASUP is available at livesinthebalance.org.

support K–5 students with significant difficulties in self-regulation. Each classroom was staffed with a special education teacher and paraprofessionals at an average ratio of 2:1. In addition, the classrooms had a high level of social work involvement. These classrooms resemble what might in some other school systems be called a therapeutic day program. Students were diagnosed with a range of psychiatric disorders, including ADHD, oppositional defiant disorder, and autism spectrum disorder. As depicted in Figure 1, during the 2017–2018 school year, there were approximately 120 restraints and seclusions in these three classrooms, and approximately 140 during the ensuing school year.

The CPS model was implemented during the 2019–2020 school year, and staff have continued to implement the model in the years since. Existing school data collection systems were used to track restraints and seclusions, which are also reported annually to the Maine Department of Education. Over the course of 4 months during the 2019–2020 school year, 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 provided with direct coaching in their use of the CPS model as they applied it to individual students.

What Happened

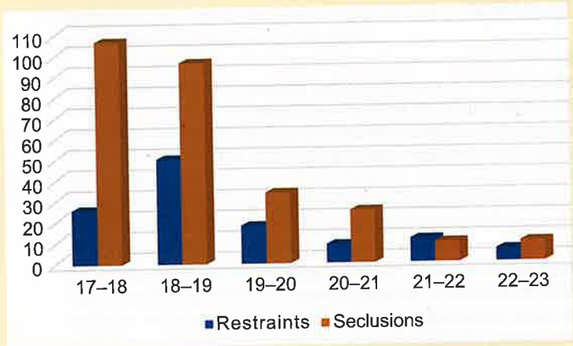
Figure 1 depicts the number of restraints and seclusions in consecutive school years beginning in 2017–2018 and ending in 2022–2023. Dramatic reductions in both restraint and seclusion occurred in the first year of implementation and were maintained during the ensuing 3 years. However, we wanted not only to document the reduction in incidents but also to formally assess the effectiveness of the intervention.

One practitioner-friendly method for calculating the effectiveness of an intervention when examining progress monitoring data like those available here is the percentage of nonoverlapping data points (PND; see https://www.jimwrightonline.com/php/chartdog_2_0/manual/chartdogman.html). This refers to the percent of data points following implementation of an intervention that do not overlap with baseline data, with higher PND indicating more significant and meaningful change (Faith et al., 1996; Scruggs et al., 1987). Since, in this case, we intended for the target behaviors (restraints and seclusions) to decrease in response to the CPS intervention, we calculated the PND below the range of baseline data points. This resulted in a PND of 100% for both restraints and seclusions.

Scruggs and Mastropieri (1998) assert that interventions should be considered "very effective" if the PND is 90% or greater. It should be noted that, because of to the COVID-19 pandemic, MSAD75 was fully remote from March to June 2020 and on a hybrid schedule for the 2020–2021 school year. This meant that only half of the student population was in the school building on any given day, resulting in much higher staff–student ratios. While this likely impacted behavior data collected during those time periods, at least partially explaining the decrease in use of seclusion and restraint, it should also be noted that these decreases were largely maintained during the 2021–2022 and 2022–2023 school years, when all students returned to the buildings full-time.

FIGURE 1

Restraints and Seclusions: 2017–2023



What This Means for You

Implementation of the CPS model in three elementary school special education classrooms in which restraint and seclusion procedures were being commonly used was found to be very effective in dramatically, rapidly, and durably reducing the use of these procedures. This is encouraging news for school systems committed to reducing or eliminating the use of such restraint and seclusion.

Why is CPS effective at reducing restraint and seclusion? A major strength of the CPS model is 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. Such interventions are more accurately viewed as falling in the realm of crisis *management*. By (a) helping staff conceive of concerning behaviors as frustration responses that are caused by expectations students are having difficulty reliably meeting, (b) focusing on proactively identifying those unsolved problems, and (c) collaboratively solving them, the CPS model reconfigures the timeline of prevention and creates structures and practices to support this new paradigm.

Staff come to recognize that concerning behaviors—and the unsolved problems that cause them—are quite predictable, that those behaviors do not occur out of the blue, and that once those problems are proactively solved or temporarily put on hold, the frequency of student escalations decreases dramatically. This dramatically reduces the need for restraint and seclusion. As such, the goal of eliminating—or dramatically reducing—these practices becomes feasible. In many similar classrooms, this goal has already been achieved (Verret et al., 2019). When restraint and seclusion are eliminated for everyone, they are no longer disproportionately applied to anyone, including marginalized populations of students.

While this study shows that CPS can be effective at dramatically reducing restraints and seclusions in the special education classrooms in which the model was implemented, its application to other populations and school settings warrants additional study. For example, although there is anecdotal evidence suggesting the CPS model is effective for nonspeaking and high-support needs populations—students who are also disproportionately restrained and secluded—there is no published research with these populations.

School psychologists can play several important roles in both the direct implementation of CPS and the training and coaching of others in implementing the model. Given their expertise in

assessment, school psychologists are well-positioned to administer the ASUP as a staff or caregiver interview tool for functional behavior assessments. School psychologists may also play an important role in engaging in Plan B discussions with students regarding the unsolved problems identified through the use of the ASUP. Resources provided on the Lives in the Balance website (https://livesinthebalance.org) highlight that these Plan B discussions are key components of behavior intervention plans informed by CPS.

School psychologists can also play a critical role in building the capacity of others within a school or district to implement CPS, thus facilitating greater systems change. This could involve presenting to or conducting book studies with all staff regarding this model and advocating for access to training to build local expertise and leadership. The Lives in the Balance website provides resources regarding these trainings as well.

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