Restraint and Seclusion

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Introduction

For the purposes of this discussion, *Restraint* is defined as physically holding or securing an individual, either for a brief time period to interrupt severe problem behavior or for an extended period of time using physical holds or mechanical devices to prevent dangerous behavior (Vollmer et al., 2011). *Seclusion* is defined as isolating an individual from others to interrupt problem behavior that places others at risk of harm (Vollmer et al.). It is recognized that not all professions or organizations use these terms in the same way, but some guiding and defining characteristics are necessary to present a fruitful discussion. Deviations from such usage will be pointed out as we discuss various position statements and regulations.

Historically, restraint and seclusion were used as methods to either protect individuals from harming themselves or others, or in some cases to punish harmful behavior (Metzner et al., 2007). In more recent times, restraint and seclusion are usually viewed primarily as protective measures designed to keep an individual from doing harm to self or others. It is recognized that restraint and seclusion can at times serve a punishing function (i.e., decrease the probability of the future occurrence of behavior), but that is not usually the primary purpose of contemporary usage. Though the ethical position of most professionals in autism and intellectual disabilities is that these procedures may be necessary at times, it is the role of the professional to protect individuals from misuse of restraint and seclusion. In this chapter we will provide some historical perspective on the use of restraint and seclusion, sample some position statements from various professional organizations that seem to confirm this ethical stance, and examine some state regulations. Finally, we will outline best practices as gleaned from the literature.

History

During the eighteenth and nineteenth centuries, acute and long-term psychiatric hospitals emerged and flourished in Europe and the United States. Throughout this period, institutionalization of individuals with mental illness, intellectual disabilities, or both was regarded as a humane practice that prevented those individuals from posing a danger to themselves or others. Institutionalization became so widespread that overcrowding became a significant concern (Colaizzi, 2005). Restraint and seclusion procedures were routinely used by staff to physically manage patients and as treatments for challenging

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behavior (Steinert et al., 2010). Following some controversial debate over the use of these procedures, the American Psychiatric Association (formerly known as the Association of Medical Superintendents of American Institutions for the Insane; AMSAII) was developed in 1844. They asserted a collective decision to permit the use of restraint in American institutions (Colaizzi, 2005).

Although some doctors, such as French psychiatrist Philippe Pinel, advocated for the use of less intrusive strategies to treat and manage individuals with mental illness, the use of seclusion and physical, mechanical, or chemical restraint (i.e., use of medication that slows behavior in a general manner) was widespread and largely unregulated. In the mid-nineteenth century, John Connolly, a superintendent at a large asylum in Great Britain, developed and popularized the use of padded seclusion rooms as an alternative to restraint (Colaizzi, 2005). Connolly was a major proponent of the "non-restraint" movement, urging that psychiatric patients could receive therapeutic treatment in the absence of (mechanical) restraint.

Not much is known about the history of restraint practices in educational settings. We do know, however, that procedures that involve the removal of students from learning opportunities have been in practice for decades. Some examples include sending students home from school, in-school suspension, and various forms of time-out (including seclusion). Ryan, Peterson, Tetreault, and Van Der Hagan (2008) found that students have been secluded in empty rooms, specially designed time-out booths, closets, and refrigerator boxes.

Throughout the twentieth century, concerns about the conditions in psychiatric hospitals frequently arose in public discourse. Many of the debates about inhumane treatment focused largely around seclusion and restraint practices. For example, in 1998, the Hartford Courant published a series of articles revealing that over a 10-year span, 142 individuals died as a result of restraint or seclusion in psychiatric hospitals, facilities for individuals with disabilities, and group homes in the United States (Weiss, Altimari, Blint, & Megan, 1998). Children under the age of 17 accounted for over 26% of the deaths and the disturbing details in the articles sparked public outrage. Despite the fact that most professionals are generally in agreement that less restrictive procedures should be used primarily, investigations by the US Department of Justice revealed sustained inappropriate use of seclusion and restraint (U.S. Department of Education, 2012), and a period of great scrutiny and regulation of these procedures emerged (Weiss et al., 1998). Over the past 20 years, restraint and seclusion have remained controversial topics at the forefront of much debate. Numerous position statements have been disseminated, wherein the misuse of restrictive procedures and their negative effects have been well established. Sturmey (2009) urged researchers for a "call to action" for more research, acknowledging that while the literature has demonstrated that the excessive use of restrictive procedures is undesirable, we have not yet developed a strong body of literature exemplifying how we can effectively eliminate these procedures.

In response to the controversy and risk surrounding the use of restraint and seclusion, these procedures are among the most highly regulated in psychiatric treatment settings. Numerous organizations have developed policies to regulate the use of these procedures. Due to the potentially severe risk to the patient, some individuals even advocate for the total elimination of these procedures. However, failing to use restraint and seclusion in emergency situations could also result in adverse outcomes, either to the patient themselves or to others in their environment (Recupero, Price, Garvey, Daly, & Xavier, 2011). Below we discuss samples of the position statements of various organizations on the use of restraint and seclusion in clinical settings.

The Emergence of Position Statements

The Association of Professional Behavior Analysts (APBA) represents the interests of credentialed practitioners of applied behavior analysis.

It is the position of the APBA that advances in behavior analytic assessments and interventions have greatly suppressed the need for restraint and seclusion procedures. They acknowledge that in some cases, however, the severity of behavior may necessitate more restrictive intervention to minimize the risk of harm. Instances in which the use of restraint and seclusion are deemed essential, the APBA outlines a few critical stipulations. First, restraint and seclusion should only be used once less restrictive procedures have failed, or have been determined to be unsafe or insufficient. Second, the APBA states that restraint and seclusion procedures are not designed to be used in isolation. Rather, they should be used simply as a component of a comprehensive behavior plan. Finally, when restraint and seclusion are used, they should be carefully monitored by a supervising behavior analyst and only implemented by individuals specifically trained in implementation of the procedures (APBA, 2010).

The Association for Behavior Analysis International (ABAI) has been the primary organization of the field of behavior analysis since 1974 (representing not only practitioners, but behavioral scientists and theoreticians). ABAI's position on restraint and seclusion functions under three guiding principles: (1) the welfare of the individual served is the highest priority, (2) individuals have a right to choose, and (3) the principle of least restrictiveness. Given these principles, ABAI condemns the *unnecessary* or *inappropriate* use of intrusive measures such as restraint and seclusion. Similar to APBA, they acknowledge there may be instances in which the use of restraint or seclusion is unavoidable. In these cases, they stress the need for oversight and design by a licensed professional. Additionally, a Behavior Intervention Plan (BIP) that includes the use of restraint must be consistent with the current literature base, derived from a functional assessment, include reinforcement-based procedures, and be objectively monitored through data analysis. In regard to seclusion, ABAI states that when used within the context of a BIP, seclusion can function as a protective measure, as well as to facilitate the acquisition of appropriate behavior. While ABAI approves of a predetermined timeout or safety intervention procedure involving seclusion, it must ultimately serve as an evidence-based component of a comprehensive BIP (Vollmer et al., 2011).

The American Psychiatric Association (APA) supports intervention design that minimizes the use of restraint and seclusion. When restrictive procedures are deemed necessary, they should be implemented by trained individuals. In addition to providing guidelines for reactive procedures, APA also outlines proactive measures to prevent the need for seclusion and restraint. Following each instance of seclusion and restraint, a debriefing should be held during which research and clinical information is discussed to determine best practice procedures. Additionally, they support programs to educate practitioners on the minimal and safe use of these restrictive procedures as well as maintaining updated information on the use of pharmacological interventions that may prevent the need for seclusion and restraint (APA, 2003).

The American Academy of Pediatrics (AAP) acknowledges that "restraint" can be considered both chemical and physical. However, their position statement focused solely on the use of physical restraint, specifically for children or adolescents in the acute care setting. They also distinguish between restraint, and mechanisms typically used during transport or medical procedures. Devices used to protect the patient, to support the patient in a specific position, or to assist in the maintenance of normal body functions are not considered restraint interventions in the view of AAP. They note that beyond these customarily used procedures, restraint may sometimes be necessary for severe behavior to keep the individual from injuring themselves or others. When restraint is required under these circumstances, AAP notes specific procedures for safe application, documentation, reassessment, as well as criteria that such a restrictive procedure should only be used after consideration of alternative methods. AAP makes additional notice that verbal interventions and "therapeutic holding" have been used for children and adolescents in psychiatric facilities to avoid the use of restraint or seclusion. AAP defines therapeutic holding as the

"physical restraint of a child by at least two people to assist the child who has lost control of behavior to regain control of strong emotions" (AAP, 1997).

The largest professional membership organization committed to psychiatric-mental health nursing is the American Psychiatric Nurses Association (APNA). In a statement on the topic of restraint and seclusion, they express a commitment to the reduction and ultimate elimination of these restrictive procedures. APNA advocates for further development of empirically based practices for the management and (ideally) complete prevention of behavioral emergencies. While complete elimination of such procedures may seem like a daunting task, APNA is committed to working toward that goal via collaboration with other disciplines and professionals. Until that time, however, they state a few critical specifications should restraint and seclusion be deemed necessary. First, these restrictive procedures should only be used (a) when less restrictive measures have failed and (b) for the minimal time necessary to ensure the safety of both the individual and others in their immediate environment. Additionally, they affirm that individuals who are restrained must be permitted to move as much as possible while still maintaining the safety of others. To ensure their safety, the individual must be monitored continuously throughout implementation of the procedure. The APNA also comments on intent, urging that restraint or seclusion should never be used as a means of convenience, punishment, or coercion (APNA, Updated 2014).

The Cochrane Library is a collection of independent, high-quality evidence to help inform healthcare decision-making. Of a search yielding 2155 citations, no controlled RCT studies evaluating the use of seclusion and restraint were identified. Given the lack of controlled research studies evaluating the effectiveness of these procedures, Cochrane Library states that no official recommendation can be made in regard to the effectiveness, benefit, or harmfulness of seclusion or restraint. However, they do note some qualitative data that suggest these procedures may have serious adverse effects (Fisher, 1994). Although the data are minimal, it is their view that until further analysis is completed, the clinical use of these procedures should be minimized. Until further empirical evidence is gathered, Cochrane Library expressed a need for identifying alternative techniques to replace these restrictive procedures (Sailas & Fenton, 2000).

Restraint and seclusion are of critical concern across a multitude of practitioners and their respective disciplines. The National Association of Psychiatric Healthy Systems (NAPHS) collaborated with the APA, the APNA, with support from the American Hospital Association to compile recommendations to the Board of Trustees of the APA. Among these recommendations, four priority areas were targeted for reform. One of these high-priority areas consisted of seclusion and restraint. The organizations acknowledge that, when used properly, restraint and seclusion can function as injury-sparing and even life-saving measures. Within this compilation, they provide detailed information on specific case studies in which restraint or seclusion may have resulted in unnecessary harm to the individual. They then provide a few regulations surrounding implementation of these procedures. Most notably, they specify that a debriefing should follow each episode of seclusion or restraint. The debriefing should include an assessment of the factors leading to the use of these techniques, steps to reduce their need in the future, and the clinical impact of the intervention on the patient (NAPHS, 2003).

While many groups described above have taken a more neutral position, offering guidelines and parameters for the use of such procedures, some organizations have taken a firm stance on one side or the other. For example, the Autism National Committee (AUTOCOM) has taken a position of complete opposition to the use of physical restraint or seclusion. They believe that these procedures are in direct violation of the civil and human rights of individuals with disabilities. AUTOCOM feels that physical restraint is simply evidence of treatment failure, and should not be used under any circumstance (1999). We will

return to this point shortly, in an effort to point out that this position may be extreme and potentially impossible to adopt as policy (see section under "summary: best practices"). Along similar lines, The Autism Society supports legislation on the federal regulation of restraint, and that restraint only be used in situations of imminent danger and always implemented by trained individuals. Conversely, the American Association of School Administrators (AASA) released a statement in strong opposition of this sentiment. AASA argues that restraint and seclusion are sometimes necessary to maintain safety in public schools. Without the option of these procedures during emergency situations, some students would not be able to sustain placement in public school settings (Pudelski, 2012).

In a recently published article, Scheuermann, Peterson, Ryan, and Billingsley (2015) used nonfictional case examples to provoke discussion surrounding the professional use of seclusion and restraint. Although some previous reports described circumstances in which seclusion or restraint were misused, Pudelski (2012) argues that the acts committed by those wrongful individuals are not representative of the majority of personnel that utilize seclusion or restraint procedures in schools. However, Scheuermann et al. (2015) stress that those violations should not be so easily dismissed as isolated events, but rather, as an indication of a more severe foundational issue that warrants exploration. Six categories of professional and ethical concerns surrounding the use of restraint or seclusion were identified. These were: (a) potential for death or injury, (b) failure to use the least intrusive intervention and evidence-based practices, (c) inappropriate restrictions on liberty and access to education, (d) programming failures, (e) disproportionate use with certain minority groups, and (f) insufficient training, supervision, and monitoring. In conclusion, the authors acknowledge that although various professionals have differences of opinion, all seek to maximize the benefits of intervention while minimizing the risk to our clients (or students). With that said, they felt that a call-to-action is necessary both on the individual and group level to maximize the "beneficence" to clients. Legislation concerning the use of restraint and seclusion with individuals with disabilities ranges from nonexistent to comprehensive across various levels of the U.S. government. At federal, state, and local levels, there are laws, guidelines, and policies about the use of these procedures in schools, healthcare facilities, and correctional facilities. However, laws, guidelines, and policy documents do not carry the same weight with respect to adoption, implementation, and adherence by individual institutions (Butler, 2016). Laws, of course, are established via the legislative process and are enforced by the judicial system; thus, violations are subject to legal ramifications. Conversely, guidelines and policy documents are merely recommendations (Butler, 2016). There is no legal recourse if individual institutions (schools, healthcare facilities, correctional facilities) choose to develop policies and practices that do not align with federal or state guidelines or policy recommendations.

Guidelines in Educational Settings

According to the U.S. Department of Education's Office for Civil Rights (OCR), students with disabilities make up 12% of the public education student population but account for 67% of the students exposed to restraint or seclusion procedures (OCR, 2016). In 2016, the DOE published a "Dear Colleague Letter" suggesting that the differential rates of restraint and seclusion used on children with disabilities relative to children without disabilities in schools might constitute discrimination and a violation of Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990 (ADA). Over the past decade, there have been a number of high profile allegations of abuse surrounding restraint and seclusion of children in public schools, including a government-issued report in 2009. Taken together, it is not surprising that there has been a recent push to establish standards for the use of restraint and seclusion in schools.

Federal

At the time of this publication, there is no federal legislation concerning the use of restraint or seclusion in public schools (U.S. Department of Education, 2017). From here forward, the term public schools will be used to refer to educational placements that receive federal, state, or local funding, or some combination (elementary, middle, and high schools, special education schools, charter schools, residential schools). Since 2010, several legislative bills have been introduced to the U.S. Congress. One bill, "Keeping All Students Safe Act" seeks to establish federal laws governing the use of restraint and seclusion in public schools. The bill has undergone a series of revisions and has been introduced to the U.S. House of Representatives and U.S. Senate multiple times, but no versions of the bill have been enacted.

In the most recent version, introduced to the 114th House of Representatives, the bill directs the U.S. Department of Education (DOE) to establish minimum standards about the use of restraint and seclusion in public schools (H.R. 927, 114th Cong., 2015a). Notable sections of the bill include: (a) prohibiting mechanical and chemical restraint, (b) banning restraint that restricts a student's breathing, (c) barring the use of restraint and seclusion under any circumstances except when a student poses an imminent danger of injury to themselves and others, (d) requiring Local Educational Agencies (LEAs) to ensure that school personnel undergo state-approved crisis intervention training, (e) prohibiting restraint and seclusion from being written into a student's education/safety/behavior plan, (f) mandating that schools notify parents in a timely manner if their child is restrained or secluded at school, and (g) directing the DOE to conduct a national assessment of the Act's effectiveness. The bill also authorizes the delivery of federal grant money to LEAs that demonstrate adherence to the items outlined in the bill, collect data on restraint and seclusion, and utilize school-wide positive behavior interventions. At the time of this publication, Keeping Students Safe has not been introduced to the current (115th) U.S. Congress.

In 2015, President Barack Obama passed the "Every Student Succeeds Act" (a reauthorization of the Elementary and Secondary Education Act). Every Student Succeeds calls for a reduction in "the use of aversive behavior interventions that compromise student health and safety" (S. 1177, 114th Cong., 2015b). However, the term "aversive behavior interventions" is not defined. Thus, although this terminology could be interpreted as including restraint and seclusion procedures, this act merely calls for a reduction in aversive behavioral procedures and does not explicitly regulate or prohibit the use of restraint or seclusion in public schools.

Perhaps in lieu of federal legislation, the DOE issued a Resource Document in 2012 outlining 15 guiding principles that LEAs should use when developing restraint and seclusion policies (DOE, 2012). The 15 guiding principles can be found in the bulleted listing below. Although the publication of the Resource Document appears to have influenced the laws and guidelines in some states (Freeman & Sugai, 2013), there is no legal recourse at the federal level if states fail to adhere to the guiding principles:

- Every effort should be made to prevent the need for the use of restraint and for the use of seclusion.
- 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).
- 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; in cases where restraint and seclusion are used, they should be discontinued as soon as imminent danger of serious physical harm to self or others has dissipated.

- Policies restricting the use of restraint and seclusion should apply to all children, not just children with disabilities.
- Any behavioral intervention must be consistent with the child's rights to be treated with dignity and free from abuse.
- Restraint or seclusion should never be used as punishment or discipline (e.g., placing in seclusion for out-of-seat behavior), as a means of coercion or retaliation, or as a convenience.
- Restraint or seclusion should never be used in a manner that restricts a child's breathing or harms the child.
- 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, revision of strategies currently in place to address dangerous behavior; if positive behavioral strategies are not in place, staff should consider developing them.
- 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.
- 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.
- Every instance in which restraint or seclusion is used should be carefully and continuously visually monitored to ensure the appropriateness of its use and safety of the child, other children, teachers, and other personnel.
- 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.
- Parents should be notified as soon as possible following each instance in which restraint or seclusion is used with their child.
- Policies regarding the use of restraint and seclusion should be reviewed regularly and updated as appropriate.
- Policies regarding the use of restraint and seclusion should provide that each incident involving the use of restraint or seclusion be documented in writing and provided for the collection of specific data that would enable teachers, staff, and other personnel to understand and implement the preceding principles.

State

At the state level, the laws, guidelines, and policies related to restraint and seclusion practices vary. In 2009, the U.S. Government Accountability Office (GAO) published a report on restraint and seclusion in schools. The report contained a review of federal and state legislation concerning the use of restraint and seclusion in educational settings. In addition, the GAO report examined 10 cases of restraint and seclusion of school-aged children that resulted in a criminal conviction, a finding of liability, or a large financial settlement. Almost all of the children in these cases were diagnosed with an intellectual or developmental disability. The accounts of these cases contained within the GAO report contain graphic descriptions and disturbing allegations. For example, in 2002, a 14-year-old boy in a Texas public school died as a result of his trunk being compressed after being placed in a prone restraint by a special education teacher almost twice his size because the student refused to remain seated. At the time of the GAO report, 19 states had no legislation related to the use of seclusions or restraints in schools (GAO, 2009).

Since the publication of that report, 30 states have made changes to their laws or policy documents (Freeman & Sugai, 2013). By 2017, 38 states had legislation and 45 states had policy documents regarding restraint and seclusion (Marx & Baker, 2017). At present time, there are no state laws or policy documents that altogether

prohibit the use of restraint with students with (or without) disabilities in schools. However, there are five states that explicitly prohibit the use of seclusion with students with disabilities (Butler, 2016). There are four states that do not have any laws or policy documents on restraint and seclusion in schools (Idaho, North Dakota, New Jersey, and South Dakota; Butler, 2016).

In their analysis of state laws and policy documents, Freeman and Sugai (2013) found four general trends in terms of content. One trend was the focus on preventive strategies. This included strategies such as de-escalation training, the use of functional behavior assessments, and school-wide positive behavior intervention and supports. For example, in Rhode Island, all school staff must attend annual training on de-escalation strategies. Staff members who are identified as authorized to assist in restraint and crisis situations must also receive advanced training (Rhode Island Department of Elementary and Secondary Education, 2002).

Another trend identified by Freeman and Sugai was the establishment of procedural parameters for restraint and seclusion. In state laws and policy documents, procedural parameters are often preceded by definitions of what constitutes restraint and seclusion. Generally speaking, physical restraint is defined as restricting the physical movement of a student and seclusion is defined as placing a student in an area where they are physically prevented from leaving. Although many of the definitions are similar across states, differences in phrasing can have implications for practice and data collection in a given state. For example, in Colorado, restraint does not include instances in which a student is held for less than 4 min or brief holding of a student by one adult for the purposes of calming or comforting the student (Colorado State Board of Education, 2009). This definition leaves room for subjective interpretation. In other words, a student in Colorado could be physically held by an adult for periods of time longer than 5 min as long as the adult's intention is to calm the child. The definitions of seclusion in state laws and policy documents are often distinguished from time-out procedures. However, depending on the state, the distinction between seclusion and time-out is not always clear.

Two other trends that emerged during their analysis are parental and state notification regarding instances of restraint and seclusion and debriefing staff and students following each instance. Thirty-two states require parents to be notified when their child is restrained or secluded at school (Freeman & Sugai, 2013). Most states have established time frames for notification. For example, in Massachusetts, teachers must inform the student's parents within 1 day or send a written report within 3 days (Massachusetts Department of Elementary and Secondary Education, 2014). In terms of reporting rates of restraint and seclusion to the state, 25 states currently collect data at the state-level for students with disabilities (Butler, 2016).

Freeman and Sugai (2013) outlined three specific procedural parameters in their discussion of trends in state laws and policy documents. The first is the use of restraint or seclusion for punishment. According to Butler (2016), 23 states have laws or policy documents that indicate that restraint and seclusion procedures should only be used in emergency situations in which a student is at risk of physically harming themselves or others. Other states, such as Montana, permit the use of restraint if a student is threatening to damage school property (DOE, 2017). Many state laws and policy documents explicitly state that these procedures should be discontinued when the emergency ends and should not be used for the purposes of punishing students. The second procedural parameter is the use of prone restraints. Prone restraints are physical restraints in which an individual is immobilized on the floor in a face down position. Research has demonstrated that some prone restraint positions produce restriction of lung function (Parkes & Carson, 2008). Given this finding and the number of high profile cases in which students have died during or following prone restraints, the use of prone restraints in schools has been explicitly (by name) or implicitly (by definition/description) banned by 33 states (Butler, 2016). The third procedural parameter is the establishment of time limits for restraint and seclusion. Freeman and

Sugai (2013) found that the time limits for restraint or seclusion found in state laws and policy documents ranged across states but most states limited these procedures to 30 min to 1 h, with a stipulation that an administrator must authorize additional time.

In 2017, Marx and Baker reviewed the legislation and policy documents for each state and examined their alignment with the 15 guiding principles outlined in the Resource Document published by the DOE (DOE, 2012). For state laws, they found adherence or partial adherence to the principles ranged from 3 to 32 states, depending on the principle. For state policies, they found that adherence or partial adherence to the principles ranged from 4 to 38 states. Both state laws and policies were most likely to be aligned with Principle 3 (physical restraint must only be used when a student poses a danger to themselves or others) and least likely to be aligned with Principle 14 (policies are reviewed regularly and updated, data need to be collected and analyzed based on subgroups, settings, staff, etc.).

Noneducational Settings

Healthcare Facilities

The Code of Federal Regulations regarding restraint and seclusion are outlined in the Center for Medicare and Medicaid Services (CMS) State Operations Manual (Department of Health & Human Services, 2008). Any hospital, healthcare facility, residential, non-medical, or community-based facility that serves adults or children and that receives federal, state, or local funding must abide by these regulations. In other words, to continue receiving public funding, they must maintain the Conditions for Participation outlined in the manual. Facilities are routinely surveyed to ensure that conditions are being met. The CMS manual states, "All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time" (Department of Health & Human Services, 2008). Physical, mechanical, and chemical restraint are all included in the definition of restraint. The CMS manual also states that restraint and seclusion can only be ordered by a physician or other licensed independent practitioner who is authorized by the state. Standing orders and orders for restraint or seclusion on an as-needed basis are prohibited. Patients must be monitored continuously during periods of restraint or seclusion and patients must be examined face-to-face by an authorized physician or nurse within 1 h of the beginning of the procedure. An additional face-to-face assessment by the ordering physician must be conducted if a restraint lasts longer than 1 h for a patient under 10 years old, 2 h for a patient aged 10–18 years old, or 4 h for patients older than 18 (Masters, 2017). CMS mandates that staff be trained in the implementation of restraint and seclusion and requires all healthcare facilities to report deaths associated with the use of these procedures. State laws governing restraint and seclusion vary from state to state. In cases in which state laws are more stringent than federal laws, the state laws supersede federal laws.

The Joint Commission for hospital accreditation has also published regulations on restraint and seclusion. Technically, the Joint Commission is not a part of or affiliated with the federal government; it is an independent nonprofit organization. However, in the realm of healthcare, their accreditation is considered important. The 2017 Joint Commission standards are in the bulleted listing below.

- Uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.
- Uses restraint or seclusion safely.
- Initiates restraint or seclusion based on an individual order.
- Monitors patients who are restrained or secluded.
- Has written policies and procedures that guide the use of restraint or seclusion.
- Evaluates and reevaluates the patient who is restrained or secluded.

- Continually monitors patients who are simultaneously restrained and secluded.
- Documents the use of restraint or seclusion.
- Trains staff to safely implement the use of restraint or seclusion.

Correctional Facilities

According to the U.S. Department of Justice, approximately 2 in 10 prisoners and 3 in 10 jail inmates report having a cognitive disability (U.S. Department of Justice, 2015). Currently, there are no federal laws or guidelines regarding restraint or seclusion in public correctional facilities specific to inmates diagnosed with an intellectual disability. However, there are two laws that are potentially applicable in certain circumstances. First, the eighth Amendment stipulates that the government may not inflict cruel and unusual punishment on U.S. citizens (U.S. Const. amend. VIII). Second, the ADA prohibits discrimination against individuals with disabilities by public entities. In other words, individuals with intellectual disabilities who are sentenced to public correctional facilities are entitled to the protections outlined in the ADA, including "reasonable accommodation" for their needs and access to the services available to inmates without disabilities. A recent investigation by the United States Department of Justice Civil Rights Division reported that a state correctional facility in Pennsylvania exposed half of the prisoners diagnosed with an intellectual disability to three or more continuous months of solitary confinement. This practice was deemed a violation of the eighth amendment and the ADA.

In 2007, a Task Force commissioned by the APA issued a Resource Document on the use of restraint and seclusion in correctional mental health (Metzner et al., 2007). The Resource Document reported that correctional facilities use restraint (physical and mechanical) and seclusion as mental health interventions as well as for custody or disciplinary purposes. The Resource Document also noted that rules about restraint and seclusion outlined by the CMS manual do little to regulate the use of these procedures in correctional facilities because so few of them participate in Medicare or Medicaid. Correctional facilities usually seek accreditation from the American Correctional Association (ACA) and the Commission on Accreditation for Corrections (CAC). Both bodies require correctional facilities to have policies for the use of restraint but there are no specific guidelines regarding monitoring, time limits, and documentation (Champion, 2007). The Task Force concluded that correctional mental health facilities have not developed guidelines or procedures that are consistent with community practice. Additionally, the Resource Document suggested that the regulations outlined in the CMS manual should be used as a basis for developing national standards of care for the use of seclusion and restraint in correction facilities (Champion, 2007).

Summary and Best Practices

A simple "thought" problem will demonstrate that nearly all would agree that seclusion or restraint is sometimes necessary. Suppose that an able-bodied adult teacher is walking through a school hallway and a student shouts, "I have a gun and I am going to shoot!" The teacher sees that the student does in fact have a gun, and the student has begun to fire in the direction of other students by pulling the trigger. Probably most anyone would agree that the teacher should restrain the student in whatever way possible if the opportunity to do so should arise. Now suppose the student is not just any student, but is a student known to have an intellectual ability. Should the teacher refrain from restraining due to the disability? Now further suppose that there is no gun, but a student with a disability has just hurt a student and is running toward another student with a closed fist. The point is not to take a position that is pro-seclusion or pro-restraint, but rather to take the position that has been adopted by most entities concerned with abuses of seclusion and restraint: there are times when it is likely necessary or at least safest to use these approaches. Given this likelihood, most entities have chosen

to identify best practices in the use of seclusion and restraint.

Seclusion and restraint should be reserved for cases when a person is posing immediate harm to themselves or others. The procedures should only be used if it is determined that other strategies, such as de-escalation, are ineffective. Staff in facilities and schools should be trained in the use of state or locally approved crisis prevention strategies. If seclusion or restraint is used, the procedures should be carefully monitored by professional staff, and the parents or guardians of the individual should be notified as immediately as possible. If use of these procedures is repeated (i.e., used more than once), future planning should occur and treatment strategies should be adopted and documented based on a functional assessment of the student's behavior. Such a treatment plan should be approved by relevant care providers and especially by parents or guardians. The treatment plan should include strategies for increasing alternative and safe behavior through positive reinforcement and other less intrusive strategies, and decisions about efficacy should be determined by careful monitoring of plan implementation and outcome data for behavior of concern.

It also seems important to further distinguish seclusion from timeout. Seclusion should never be considered a treatment strategy, it is reserved for protection of or from the individual. However, research on timeout shows that periods of restricted access to positive reinforcement can be effective at very short intervals (such as 2 min) and without isolating the individual (e.g., Donaldson, Vollmer, Yakich, & Van Camp, 2013). Thus, whereas timeout could be an acceptable component of a behavioral intervention plan, which would presumably also include reinforcement for alternative behavior, seclusion is not an acceptable treatment component. It is a protection strategy.

To conclude, seclusion and restraint will remain controversial because both procedures are at times misused. Such misuse occurs on a continuum from ignorance, to negligence, to abuse. It stands to reason that such misuses must stop, and that is the purpose of the many position statements, proposed regulations, and standards of use. However, to ignore that the procedures will be used in dangerous circumstances is to in fact set the occasion for terrible misuse. Haphazard use of seclusion and restraint should be avoided at all costs. Understanding implementation of seclusion and restraint should be a priority for staff and care provider training at all levels of care for individuals with intellectual disabilities.

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