



Physical Restraint

Resources:

(Listing here does not imply endorsement)

- **Handle With Care**

184 McKinstry Rd., Gardiner, NY
12525; 845-25504031;

<http://www.handlewithcare.com/>

- **Nonviolent Crisis Intervention**

Crisis Prevention Institute, Inc. (CPI)

3315-K North 1245h Street,

Brookfield, WI 53005; 800-558-8976

<http://www.crisisprevention.com>

- **The Mandt System®**

David Mandt & Associates

PO Box 831790

Richardson, TX 75083-1790

972-495-0755; Fax 972-530-2292

<http://www.mandtsystem.com/> or e-

mail comment@mandtsystem.com

- **Professional Assault Response Training (PART)**

6105 Glenhurse Way

Citrus Heights, CA 95621-1720

916-723-3802

- **Therapeutic Crisis Intervention**

(TCI) Residential Child Care Project

Family Life Development Center

College of Human Ecology

Cornell University

Ithaca, NY 14853

607-254-5210; fax 607-255-4837

- **Therapeutic Options®**

Therapeutic Options, Inc.

100 Delaplaine Avenue

Newark, Delaware 19711; 302-753-

7115; <http://www.therops.com/> or e-

mail info@therops.com

- **“Physical Restraint... An**

Emergency Procedure.” A “Tip

Sheet” of the Multi-statewide Outreach

Project, Center for Early Education and

Development, University of Minnesota.

Minneapolis, MN: Univ. of Minnesota

http://ici2.umn.edu/preschoolbehavior/tip_sheets/physrest.pdf

The words “physical restraint” are sometimes used to address three different types of restraint. One is the use of mechanical devices or objects to restrict a person’s movement (mechanical restraint), while the second, chemical restraint uses medication to control behavior. A third type, involves one person holding or physically manipulating another person in order to restrain that person’s movement (manual restraint), and is the type addressed here. It is commonly used in schools as a means for preventing injury to a student or others in the immediate environment when that child loses self-control. Although other types of restraint have been used, they are not appropriate in most school situations for ethical and legal reasons.

What is Physical Restraint?

“Physical restraint is a procedure with which a person uses his or her body to effectively and immediately control or immobilize another” (Physical Restraint, 2001). Typically, training programs in physical restraint, sometimes also called “therapeutic holding” (American Academy of Pediatrics Committee on Pediatric Emergency Medicine, 1997), prepare trainees to employ several takedown procedures and holds, as well as understand the correct circumstances when they are appropriate for use. These might include a form of “basket hold” where an adult holds a child from behind by the wrists with the child’s arms crossed in front of the child. Sometimes it also includes use of the adult’s legs to control the legs of the child. Other holds include a horizontal facedown hold of a child on the floor and numerous others. The overall procedures often also include conflict de-escalation procedures, which might prevent the need for the use of physical restraint altogether, or which might permit the restraint to be ended as soon as possible.

Physical restraint is almost universally viewed as an emergency procedure to protect persons and property, and should only be used as a last resort. It should never be viewed as a primary management or intervention technique (Redl, 1952). Before attempting physical restraint, one should have received specific training and be sure to follow school procedures for its use. Procedures would also include a method to request additional back-up assistance from other adults, and methods for either removing the physically violent student from the classroom, or possibly having others in the environment evacuated from the immediate vicinity.

If physical intervention is used, educators should expect an initial dramatic escalation in aggression (Oestman, 1997), followed by a series of four fairly predictable stages: rage, inadequacy/immaturity, saving face, and return of self-control (Long, Morse, & Newman, 1996). The process must include a gradual and sequential release process as a student calms and is willing to comply with expectations (Oestman, 1997). Finally, a follow-up conversation is held with the student to clarify any distortions regarding the purpose of the student being held (Long, Morse, & Newman, 1996).

Physical restraint has a long history in hospitals and psychiatry, particularly in the clinical treatment of violent persons (Romoff, 1985). The use of physical restraint has also been applied to children with emotional disturbance, at least since the 1950s, and was included in a list of “techniques for the antiseptic manipulation of surface behavior” compiled by Redl & Wineman (1952). They were very explicit that physical restraint should not be used as, nor associated with, physical punishment, and that the loss of control of a child should be viewed as an emergency situation where the educator or clinician should either remove the child from the scene, or prevent him from doing physical damage to others or himself. The person performing the restraint should remain calm, friendly, and affectionate, and as a result maintain a potential relationship with the child, and thereby permit the opportunity for therapeutic progress once the child’s crisis had subsided. This “surface management” of behavior will later build opportunities for other intervention.

Today, most training in physical restraint is done by a handful of agencies that

specialize in this type of training, usually along with other strategies for conflict de-escalation and problem solving. These include: Nonviolent Crisis Intervention; Therapeutic Options; Therapeutic Crisis Intervention; The Mandt System; and Professional Assault Response Training (See Resources list for contact information). Most of these training systems evolved from training programs for the staff at residential treatment and psychiatric facilities or hospitals. Now they are used by numerous agencies including juvenile corrections settings, group homes, and others.

Techniques apply to both adults and children, and for people with mental retardation, developmental disabilities and mental health concerns, as well as anyone else who might exhibit aggressive, violent, or dangerous behavior.

What We Know About Physical Restraint

According to the website at Cornell University, during the period from 1994-1997 a variety of child caring agencies in Northeastern United States and the United Kingdom participated in a joint evaluation of "Therapeutic Crisis Intervention" training. Results indicated a decrease in physical restraint episodes, fighting incidents, physical assaults, runaways, and verbal threats. Staff also felt more confident in their ability to manage any crisis situation, were more child focused, and increased their knowledge about agency policy and procedures for crisis management.

A search of educational literature could not identify any research which examined the impact of physical restraint on lessening violence or crisis situations in educational settings. For the most part, this intervention has not been addressed in educational research studies (Selekman, 1997). Literature related to adult populations and institutions other than schools, was not searched.

It should be clear that few of the proponents of physical restraint have claimed that it has any therapeutic value in itself. Instead it is usually viewed as a physical safety mechanism that may permit continuation of other therapeutic interventions once the restraint is completed. Most educational textbooks dealing with aggressive or violent behavior, or students with emotional or behavioral disorders suggest that physical restraint might be warranted for purposes of safety in spite of the lack of empirical research support.

Making It Work

It is essential that only thoroughly trained staff attempt physical restraint techniques, only where guidelines for their use are in place, and only when an emergency situation results in serious safety threats. The risks in using physical restraint are high. There is a very strong possibility of injury to the student or staff member conducting the restraint, and possibly others in the environment. Inappropriate use of physical restraint has resulted in serious injury and even death of the student being held (Hartford Curren, 1998; Weiss, 1998), as well as lawsuits being brought against the persons and agencies engaging in the restraint. The use of restraint of any kind has become controversial and is opposed on moral and ethical grounds, except where serious threats to safety are present.

Most programs require extensive initial training, as well as recurrent updates on a regular basis. As a result, implementation of these procedures can be expensive to maintain. In most medical, psychiatric, and law enforcement applications, strict guidelines govern the use of physical restraint. Often these include accreditation requirements such as the Joint Commission on Accreditation of Healthcare Organizations or other groups such as the National Association of Psychiatric Treatment Centers for Children (Cribari, 1996) and the American Academy of Pediatrics (AAP Committee on Pediatric Emergency Medicine, 1997). No similar guidelines for use in schools, makes their use in schools more susceptible to misunderstanding and abuse, let alone improper implementation. Moreover, many states have policies preventing the use of corporal punishment in the schools. While physical restraint properly applied is different from corporal punishment, there have been many lawsuits related to this topic ("Brown by Brown v. Ramsey," 2000). If use of these procedures can be anticipated for specific children, they should be done with parent permission, continued close monitoring, and the circumstances for use included in the student's IEP, Behavior Intervention Plan, or Section 504 Plan.

Summary

Many schools have acknowledged the need for physical restraint procedures as a part of their overall efforts to be prepared to deal with violence and aggression in children at school. Often this entails training one or more staff members in a comprehensive set of procedures to physically restrain students, with related conflict de-escalation training, in order to attempt to prevent injury or property damage in the environment.

Reece L. Peterson, June, 2002

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About the Safe and Responsive Schools Project

The Safe and Responsive Schools Project, funded by the U.S. Department of Education, Office of Special Education Programs, is dedicated to developing prevention-based approaches to school safety, discipline reform and behavior improvement in schools.

Websites: <http://www.indiana.edu/~safeschl/> or <http://www.unl.edu/srs/> Or Contact:

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