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Mini Review

Physical Restraint : A Select Overview of Critical Issues for Individuals with Developmental Disabilities

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Abstract

In this paper, a brief overview of critical issues on restraint of people with developmental disabilities was provided. The literature on restraint in this population is limited. Topical issues were : safety, prevention of restraint, reduction of restraint, and monitoring to ensure proper use. Definitions of specific types of restraint are important because not all physical restraint is dangerous.

Keywords: Physical restraint; Mechanical restraint; Applied behavior analysis

Physical Restraint

Restraint has a long history in psychiatric hospitals, schools, and clinics and is often presented as a form of institutionalized abuse. Concerns have been raised recently about injuries and deaths while in restraint. Nevertheless, little research exists on proper restraint usage and restraint continues to be used a, even when there are review processes meant to reduce restraint, little research documents this outcome [1,2]. The fact is that despite newer and improved drug therapy and advanced applied behavior analysis research, few organizations have reduced restraint significantly or eliminated all restraint; however, while many hope to see an environment that is restraint-free, no one wants to see the consequences of eliminating all restraint and thus experiencing client-to-client assault (e.g., restraint is not used when one patient injured by the physical assault of another). Some facilities have resorted to calling the police or even establishing their own police force to deal with discipline through the courts. Such abdication of responsibility often results in a child or adolescent being charged with felony assault. Then, unless a caring judge has an appropriate alternative, a child is placed in juvenile detention. The schools lose funds, but a child loses what should be an opportunity to receive an education. While getting kids placed in detention rids a school of a child in need of discipline, this is often a misuse of police officers and may not achieve what public education is there for.

Client Characteristics

Virtually all of the research in this paper refers almost entirely to clients with Autism and/or Intellectual Disabilities and in some studies other mental disorders as well. Most organizations will limit the use of restraint to a few individuals; however, organizational indicators showing many of its students or clients are restrained could be a warning sign for excessive dependence. While extremely large individuals may be recommended for alternative approaches. Generally, some clients may be physically restrained excessively because they are smaller and less likely to put up a struggle. Every restraint should be closely followed up on to determine if the criteria for restraint was met. The criteria for restraint should be clear: A person continuing (more than once) aggression toward others or self-injurious behavior with such force that it is likely to result in a serious injury if restraint is not used. The least restrictive restraint should, if possible, be tried first. Generally, physical restraint is last-resort. Anyone who extends the duration of restraint should ensure the agreement of another staff. If no agreement is given, restraint should end. Response-contingent release criteria should be avoided as it can prolong restraint time, creating a higher risk of injury or death.

Types of Restraint and Risks

Restraint may be classified as mechanical (e.g., arm splints, face mask) or physical or personal (eg., hands held to the side). Physical and personal are the same. The goal of restraint is to prevent or to minimize physical injury to clients with dangerous self-injurious behavior or dangerous physical aggression - not to abuse patients or clients. The definition of mechanical restraint - is the application of mechanical devices to control movement [1]. Mechanical restraint devices may include arm splints, splint jackets, helmets (e.g., wrist for 1-3 minutes (simple holding), cross arm basket holds, and takedowns or follow the downs in which both clients and staff contact the floor. Simple holding of wrists is a low-risk procedure if conducted properly, whereas follow downs and basket holds have high-risk potential due to the possibility of improper use (e.g., holding someone down for excessive periods on floors with hard surfaces, placing weight on the diaphragm, which should never be used, using highly dangerous choke holds, which most police no longer use). Deaths due to restraint are always possible if high - risk procedures are used, particularly if professional supervision on-sight is not provided or if supervisory personnel lack authority. Rather than banning all restraint, clinicians should tightly regulate crisis personal restraint and ensure minimal use of this potentially dangerous intervention.

Crisis and Planned Physical Restraint

Prior to the current trend of avoiding programmatic restraint in favor of crisis restraint, the research found programmatic restraint to be much safer than crisis restraint, in fact, emergency physical restraint resulted in injuries 5.73% of the time whereas planned restraint resulted in injuries .25% of the time [3]. Restraint is typically applied as a crisis measure rather than a planned one (i.e., programmatic) because of regulatory or statutory an authorities. Incorporating restraint into a component of a comprehensive treatment program is a recommendation of the leading professional organizations for

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behavior analysts (Association of Professionl Behavior Analysts - APBA - and The Associaton of Behavior Analysis Internaional (ABAI).This gap between professional organizations, research, and laws or rules regulating practice is problematic, and may allow the continued use of excessive restraint by classifying it as "safety plans", The use of restraint more than twice in a week or month is often used in clinical settings as a guideline for conducting a functional analysis to determine the function of problem behaviors. Every organization using restraint should consider developing a number of behavior analyst positions, whose practice is regulated by the Behavior Analyst Certification Board (BACB).

Reducing Restraint

The reduction of restraint has been a topic in recent years, most likely due to concerns about injuries and deaths related to improper or excessive use of physical or personal restraint [1,3,4,5]. Williams listed the following methods for reducing restraint: (1) restraint fading (2) staff training (3) assessment and revision of antecedent conditions (4) revising release criteria for release from restraint (5) successful behavior treatment. An additional method is the use of organizational behavior management OBM) procedure [1,2]. Restraint fading is used for complicated individuals with severe self-injurious behavior (e.g., Oliver, Hall, Hales, Murphy, and Watts) [6] Staff training typically is used to teach alternative skills [7]. Williams and Grossett used an OBM procedure targeting individuals with large numbers in restraint with hand mittens for healing of wounds [2]. Behavior programs were increased significantly as alternatives to restraint. Large declines in restraint occurred as more programs developed.

The publication of a book on restraint reduction is an indication that more attention to reducing restraint is forthcoming [5].

Prevention of Restraint

Restraint may be prevented for some clients/students by simply preventing aggression by providing adequate floor space and avoiding crowds [8]. Restraint may be occasionally necessary for a small number of individuals with dangerous self-injurious behaviors as well as aggressive behavior toward others; however, applied behavior analysis treatment plans and caregiver's training must address what the functions of dangerous behaviors are (i.e., what maintains the behaviors). Research on functional analysis has documented that many dangerous problem behaviors are learned and that Applied Behavior Analysis (ABA) can be used to effectively treat those target behaviors maintained by social mediation as well as automatic reinforcement if function-based treatment is used [9,10]. In addition to the employment of behavior analysts or other professionals with similar training and experience and use of functional analysis, preference assessments to enhance learning, organizations can prevent the use of restraint through leadership based guidance on the use of evidence-based methods for prevention of severe problem behaviors [7,11].

Summary

In this brief paper, definitions of various types of physical restraint were provided. This is important because some types of physical restraint are dangerous and some are not. Prevention and reduction of restraint were noted. The safety of various restraint was discussed. Applied behavior analysts were introduced if a school or institution uses restraint. The admission of one unique, difficult-to-treat person can create bewilderment if no behavior analysts are on the staff. Organizations oriented toward future challenges must anticipate what student/client needs will exist and look at unmet needs periodically. Some will be prepared and some will not.

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