

RESTRICTIVE AND AVERSIVE: CUT AND DRIED OR ARE THEY IN THE EYE OF THE BEHOLDER?

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2 WHAT WE DO

“There is what we *actually* do, and then there is what we CALL what we do. They are seldom the same thing.”
--anon (I’m kidding, it’s me)

3 WHAT WE DO



What do we call what is this guy doing?



What do we call it
if this guy is doing the same thing?

4 A QUIZ: WHAT IS THIS GUY DOING?

- **A. Making a statement about discrimination in our nation**
- **B. Disrespecting the flag and all the sacrifices made by those who fought to protect it**
- **C. Proposing Marriage**
- **D. Kneeling** ✓



5

**I can't figure out why my kids cry
when they get 'time out'
I tried it and I loved it!**



6 EN LOCO PARENTIS

- No it doesn't mean "Crazy Parents"
- Serving in the place of the parent
- I'll come back to this later...

7



Context

8 RESTRICTIVE AND AVERSIVE: FUNCTIONALLY DEFINED OR CULTURALLY DEFINED?

- The concept of restrictiveness or intrusiveness is a longstanding hallmark of modern medicine
- It has also been applied to human services delivery, particularly as it relates to behavioral treatment, placement at a school or facility, and the use of emergency procedures
- The concept of “aversive” is used primarily in behavior analysis, and unlike the concept of restrictiveness, “aversive” is defined functionally whereas “restrictiveness” is typically not well defined at all. Instead, the word restrictive is often applied to procedures that affect the individual’s rights in a legal/moral sense.
- Other times the word restrictive is used when an individual is somehow segregated from the general population in some manner (self-contained classrooms as opposed to general education classrooms). Sometimes a setting is referred to as more restrictive.

9 RESTRICTIVE AND AVERSIVE: FUNCTIONALLY DEFINED OR CULTURALLY DEFINED?

- At times restrictive may also refer to the range of motion that a particular emergency intervention allows
- One problem is that “restrictive” as a term is not functionally defined nor is it a scientific term, but its use as a label for a variety of circumstances is based on a number variables including but not limited to:
 - The speaker’s own history with respect to the subject at hand (is the speaker generally in favor of or against the use of a specific procedure for example)
 - Cultural norms
 - Existing laws that (may) arbitrarily deem something as a “restrictive procedure”

10 RESTRICTIVE AND AVERSIVE: FUNCTIONALLY DEFINED OR CULTURALLY DEFINED?

- One thing that the concept of restrictiveness is NOT based on is the service recipient's perspective. That is, what may be restrictive to the law maker may not be restrictive to the individual and vice-versa.
- The same can be said of the concept of aversive. What is "aversive" in the public eye is not necessarily functionally aversive
- Another problem is that some behavioral procedures are termed "restricted" procedures, as in their use requires special approval or a special level of expertise. Some people may also call these procedures "restrictive."

|| WHICH IS MORE RESTRICTIVE? SECLUSION OR RESTRAINT?

- It is hard to say which procedure is truly more restrictive, as “restrictive” has no agreed upon meaning or characteristics
- It is easy to say which procedure most lawmakers and parents dislike the most: Seclusion, as it is allowed in far fewer facilities than restraint
- Things may be termed restrictive or aversive mostly because the individuals applying the label have a personal aversion to the procedure, **not because aversive or restrictive are some unchangeable quality of a stimulus.**
- As an example, in Florida statutes “water mist” (spraying water in a client’s face) is considered a restricted procedure as it was originally intended to be an aversive consequence for behavior. Is “aversive” a property of water mist? Are mists of water painful? On a very hot day can a mist of water in your face feel good? What makes it aversive? What makes it feel good? It is the context. (Tabasco).



12 WHICH IS MORE RESTRICTIVE? SECLUSION OR RESTRAINT?

- The answer of course is that water mist isn't aversive and it isn't a reinforcer. Until it can be demonstrated how it works with a specific individual's behavior it cannot be classed as having aversive or reinforcing qualities.
- It is easy to say, however, "WE don't want YOU using water mist to ATTEMPT to decelerate behavior because you are being **unnecessarily nasty** to the person.
- It is easy to say WE don't want YOU using seclusion rooms, but people can't easily provide a justification for their position beyond the phrase "we don't like it" therefore we use words like false imprisonment, and social isolation and segregation.
- What is more restrictive? A face down 3 person hold for 15 minutes or being placed in a seclusion room for 15 minutes?

I3 WHICH IS MORE RESTRICTIVE? SECLUSION OR RESTRAINT?

- Well, if you asked a physical therapist which is more restrictive they would probably say that the restraint is more restrictive as the individual has temporarily lost most of their range of motion
- If you asked a principal they would probably say seclusion is more restrictive as they are not allowed to use it.
- If you work with a client who uses sign language to communicate, which is more restrictive, seclusion or restraint? Which temporarily **greatly reduces** their ability to communicate?
- What is the range of the individual's choices during restraint and seclusion? In restraint can the person put themselves in any position they like? Sitting? Standing? Laying down? Can the person scratch their nose while in restraint? Can they pace while in restraint?



14 WHICH IS MORE RESTRICTIVE? SECLUSION OR RESTRAINT?

- Certainly one can make the point that restraint restricts access to one's own body and restricts access to the ability to stand or sit in whatever position you would like.
- Seclusion, it can be argued, restricts access to people, places, and objects
- Still, how can you truly say one is more “restrictive” than the other?
- Is it restrictive because the individual is socially isolated or is it restrictive because **he/she doesn't want to be socially isolated at this moment?**
- When you go to the bathroom you are socially isolated as well, but you are choosing the isolation. So it is not the isolation itself that is a problem, but isolation **against the person's will** this provides us with a context. The real issue may not be what you're doing, but how the person “feels” about what you're doing.



15 WHICH IS MORE AVERSIVE? RESTRAINT OR SECLUSION?

- Aversive to whom?
- Clearly, if one looks at current regulations, laws and policies seclusion is more aversive than restraint **TO THE PEOPLE WHO MAKE REGULATIONS, LAWS AND POLICIES!**
- What about the recipients of services? Which is more aversive to them?
- Well that depends on the person!
- What if you love trying to hurt staff when you are angry? What if you love physical contact and horseplay? What if you love lots of attention centered around you?
- If these things were true which would you find more aversive? Seclusion or Restraint?



16 WHICH IS MORE AVERSIVE? RESTRAINT OR SECLUSION?

- What if you have a history of sexual/physical abuse? Which would you find more aversive, unwanted physical contact and not being allowed to move **or** being by yourself where no one can touch you?
- Beauty is in the eye of the beholder. So is Aversive!
- Clearly then, for some people, it could be argued that Seclusion could be less restrictive (in terms of choices available to the person) yet more aversive than restraint
- For others, restraint could be more restrictive in the physical sense yet less aversive
- Still for others, seclusion could be more restrictive from a social aspect (technically restricting access to others) yet it could also be less aversive if the individual hates being held more than anything.



17 WHICH IS MORE AVERSIVE? RESTRAINT OR SECLUSION?

- We haven't even begun a discussion of right to effective treatment but what is clear is that policies made regarding the use of various behavioral procedures for treatment and the use of emergency procedures are not based on clear scientific evidence that suggests one modality over another based on long-term treatment gains or short-term safety .These policies are based on the personal aversions of those groups and individuals responsible for policy creation.
- We could also then ask about the qualities of various procedures and try to determine how they derive their aversive qualities for certain individuals.
- “I’m not against restraint for non-disabled people who “know better” but these individuals have disabilities and should not be treated like everyone else!” (not an actual quote)
- Isn't that a form of discrimination? Or is it merely an accommodation? What's the difference?



18 ACCOMMODATION AND DISCRIMINATION

- Legally, we treat children differently from adults. They have the same basic human rights of course, but legally they are treated quite differently from adults. They are **not allowed** to do things that adults can do freely (drink and drive, but not together) and they are **required** to do things that adults do not have to do (attend school of some kind).
- There is clearly discrepant treatment of children and adults in our society because there **MUST** be discrepant treatment.
- It would be considered cruel by most to make children do all the things adults must do and it would be grossly irresponsible at the very least and criminal at most to allow children to do everything adults are allowed to do
- We also would not want the same consequences for children (minors) and adults
- Most would agree that this discrepant treatment is not motivated by **malice** but was instead designed to aid in the protection of children from great harm.



19 ACCOMMODATION AND DISCRIMINATION

- When people tend to see any discrepant treatment as warranted, they will often term it making “accommodations” or “exceptions”
- When people tend to see any discrepant treatment as UN-warranted, they will often use the term “discrimination” to denote discrepant treatment that is motivated by malice
- This concept of doing it for someone’s “own good” or doing it out of “malice” also enters into whether or not we may call any practice “acceptable”



20 IS IT **WHAT** YOU'RE DOING THAT LAW-MAKERS DON'T LIKE OR IS IT THE **CONTEXT** IN WHICH YOU'RE DOING IT?

- It really isn't what is being done to our clients/students that has people up in arms. It's the context, that is:
- **Who are we doing it to?** Typically developing children? Typically developing adults? Only those with special needs? Criminals?
- **Who is the Agent (person doing the procedure)?** A Behavior Analyst? A Health Care Worker? A Police Officer? A Paramedic or Fireman? A Teacher? A Staff Member? A Parent?
- **What is the actual motivation for doing the procedure?** That is, what is the motivation on the part of the person doing the procedures. Is it for the client/student's safety? Is it for the safety of the general public? Is it for the safety of staff/teachers/parents? Is it intended to replace treatment? Is it done with an expectation to aid in treatment?

21

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- **What is the perceived motivation for doing the procedure?** Typically, if someone doesn't approve of a procedure there is perceived malicious intent, indifference or ignorance on the part of the practitioner. That is, either you *actively dislike* my child and want to retaliate, or *show no empathy* for my child or you are *unskilled* and this is why you are resorting to these procedures. **Although most people won't actually say it, they perceive very little (if any) benefit from emergency procedures that they personally find aversive and they tend to only see the potential for harm.**
 - The important question is, why do some procedures function as aversive stimuli?

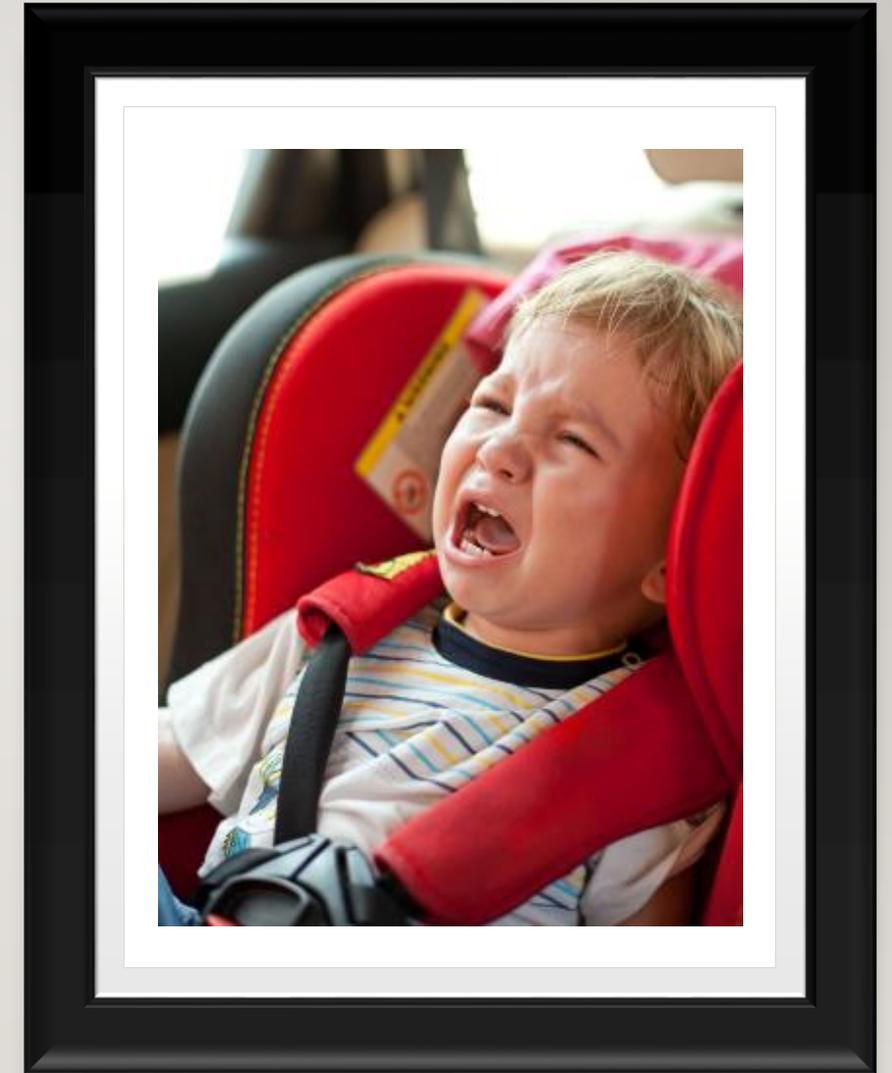
22 RESTRAINT

- **Agent of restraint: Police**
- **Type of intervention: Handcuffs**
- **Population: Person (typically developing) committing battery**
- **Motivation: To protect citizens in general and enforce the law**



23 RESTRAINT

- **Agent of restraint: Parent**
- **Type of intervention: Car Seat**
- **Population: Young Children**
- **Motivation: To protect child from harm/To comply with laws**



24 RESTRAINT

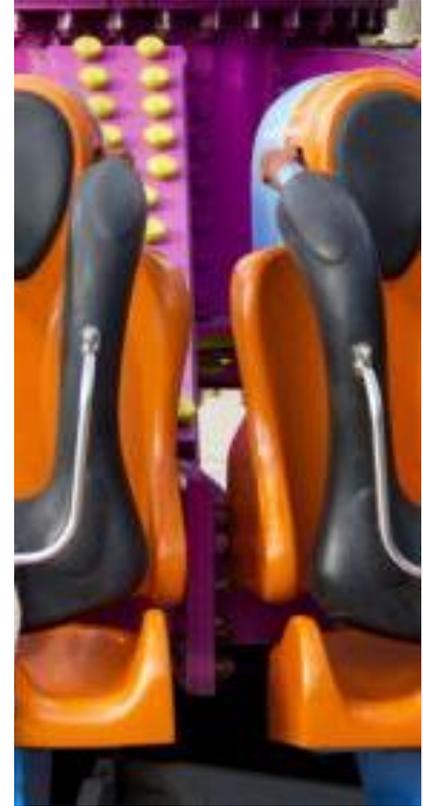
- **Agent of restraint: Physician**
- **Type of intervention: Posey mechanical restraints**
- **Population: Child with special needs**
- **Motivation: To protect the nonverbal child from pulling out his stitches**



25 RE

- Agent of
- Type of Restraint
- Popular
- Motiva

You Must Be This Tall To Be Restrained!



26 RESTRAINT

- **Agent: parent**
- **Type of intervention: Swaddling (blanket mechanical)**
- **Population: infant**
- **Function: To calm the child when agitated**



**Requires Level III LRC
Approval in Florida
and Functional
Replacement for
Flailing limbs**

27 RESTRAINT

- **Agent of restraint: Behavior Analyst**
- **Type of intervention: Physical holding**
- **Population: High-functioning child with special needs and fighting skills (knows how to punch and kick effectively)**
- **Motivation: To protect the child from injuring other students/staff**



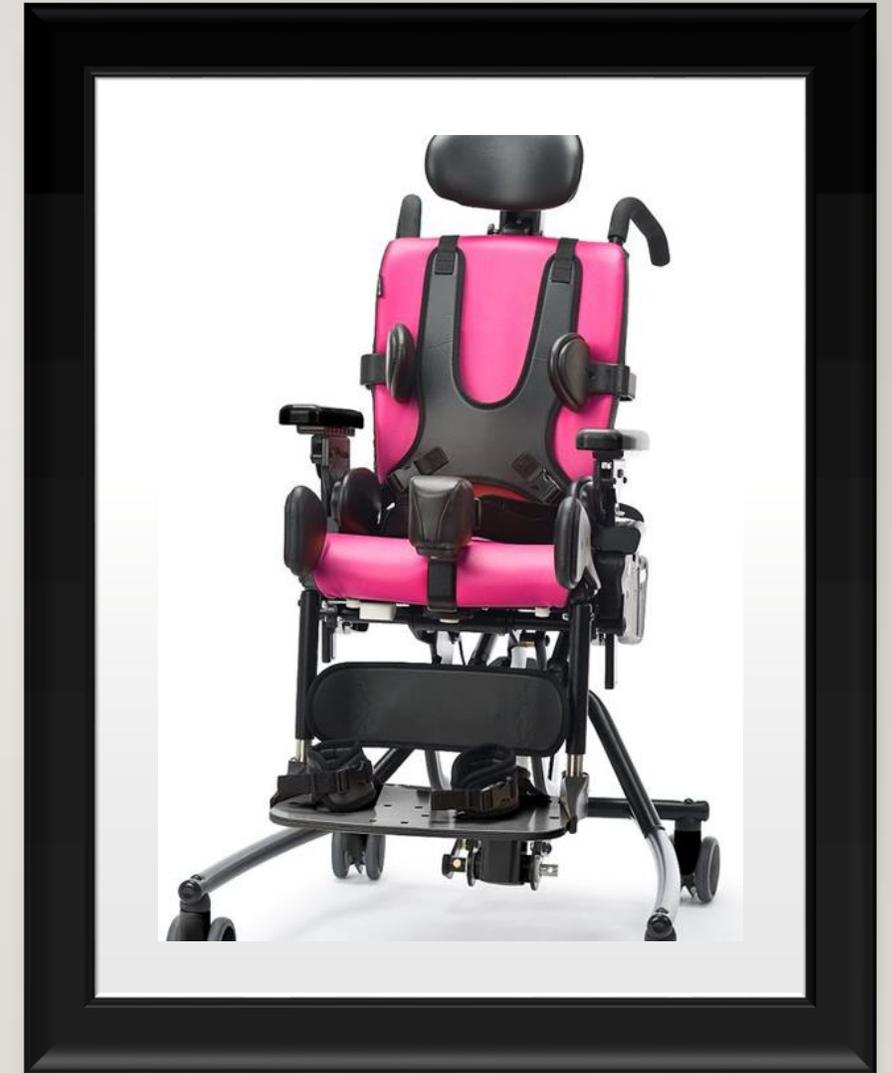
28 RESTRAINT

- **Agent of restraint: Behavior Analyst**
- **Type of intervention: Physical holding**
- **Population: Nonverbal child with special needs (no fighting skills but can injure others causing bruising and bleeding)**
- **Motivation: To protect the child from injuring other students/staff**



29 RESTRAINT

- **Agent of restraint: Physical Therapist**
- **Type of intervention: Seated mechanical restraint**
- **Population: Child with special needs/medically involved**
- **Motivation: To provide proper positioning (not the child's choice)**



30 WHAT IS THE PERCEIVED MOTIVATION?

- **What is the perceived motivation in all these scenarios?**
- **Which scenario are people likely to criticize the most?**
- **In which scenario is it most likely someone will see the motivation (at least partially) as some form of malice? (using it to get even, punish, was done out of anger)**
- **What if instead of handcuffs the police used a taser? What if instead of a taser the police used firearms? How might this change the public perception of malice?**

3 | SECLUSION

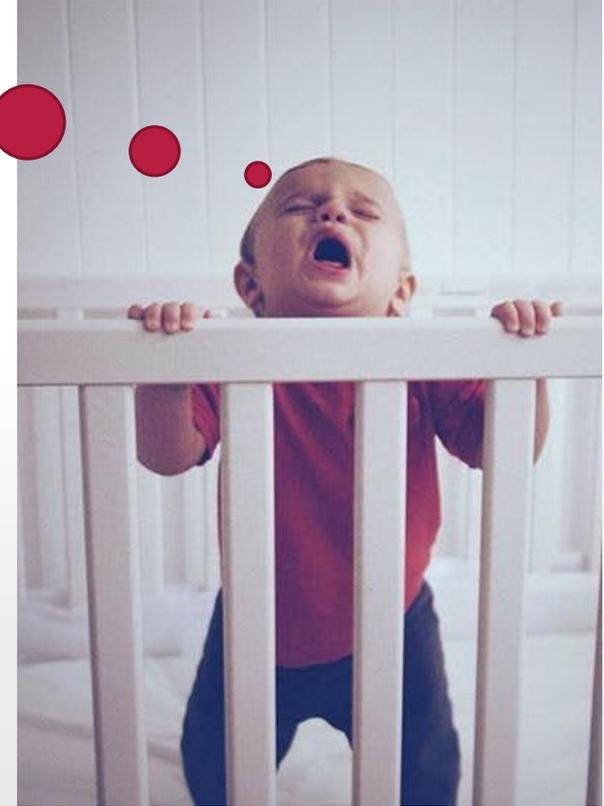
- **Agent of seclusion:**
Physician
- **Type of intervention:**
Medical Quarantine
- **Population:** Patient with highly contagious disease
- **Motivation:** To protect the general population from the spread of infection



32 SECLUSION

I have to the right to
one phone call!
Somebody contact my
attorney!

- **Agent of seclusion: Parent**
- **Type of intervention: Closed door seclusion/mechanical containment (a crib)**
- **Population: Typically developing toddler**
- **Motivation: To protect the child from the consequences of his or her own behavior when the parent is unable to carefully supervise the child (safety issues).**
- **May be used as a punisher as well with older children in the form of “Time-out.” Even older children child might be “grounded” which is the equivalent of forced social isolation**



33 SECLUSION

- **Agent of seclusion: Behavior Analyst**
- **Type of intervention: Seclusion Room**
- **Population: Special needs child**
- **Motivation: To protect the staff/other students from injury, to remove sources of possible socially-mediated reinforcement (injury to others as a reinforcer)**
- **Yes, seclusion rooms are very different from hospital rooms and a child's own bedroom, but they are similar to the other examples in that the individual is alone against their will in all cases.**

Hey, wait a minute weren't we already on slide 5?

Oh yeah, Merrill definitely phoned this one in.



34 WHERE THERE'S A WILL THERE'S AN OBJECTION...

- As mentioned earlier, it is not simply being alone in a room that advocates/parents/law-makers and some attorneys take issue with. **It is doing so against the person's will** that is the primary problem.
- Sure, if a child hides in a closet for an hour because they don't want to be found (which is a VERY common childhood behavior) then this would not be called seclusion, yet the child is still alone in a closet. It is the **inability to exit** that is the issue and the **reason** there is an inability to exit.
- With children in car seats, patients in quarantine, and toddlers in cribs, many times these things are done **against the person's will** but everyone seems to be just fine with these scenarios as it is "in the best interest" of the child/patient/client or "in the best interest" of society

35 WHERE THERE'S A WILL THERE'S AN OBJECTION...

- **Doing things against a child's will is part of being a parent.** We accept that children must sometimes be subjected to things that are “against their will” just as adults who break societal laws are subjected to things **that are against their will**
- In fact, living in society means **being subjected to things that are against your will on a daily basis!**



36 WHERE THERE'S A WILL THERE'S AN OBJECTION...

- I am frisked **against my will** at airports
- I pay taxes **against my will**
- If I am speeding I may be pulled over **against my will**
- People are forced to wear motorcycle helmets (in some states) **against their will**
- It is clear if you look at our society in general, laws designed for most people may go against the will of some of the people. No law is likely to make 100% of the people happy
- **The more things you do that are against the will of society, the greater the chances that things will be done to you against your will!**

37 WHERE THERE'S A WILL THERE'S AN OBJECTION...

- That seclusion or restraint may be done “against the individual’s will” is largely irrelevant as long as they were engaging in behavior that is against the will of society, as reflected in our laws, norms and values (which includes not letting individuals hurt themselves)



38 WHAT ELSE IS AGAINST THE PERSON'S WILL?

- Any system you have set up in which reinforcers must be earned.
- There is a high probability that our students and clients would rather have free “reinforcers” and you would rather have free money
- It is quite common to see children throw a fit as soon as they find out that they have to earn something rather than being able to start using it immediately.

39 WHAT ABOUT RIGHTS? DON'T PEOPLE HAVE RIGHTS?

- Yes, people have rights! However...
- When we begin to violate the rights of others or become a danger to ourselves, we begin to put our own rights in jeopardy and we increase the probability that things will be done to us against our will
- If we are concerned about undue violation of the rights of individuals with special needs then we must ask ourselves “are they violating the rights of someone else or posing a threat to themselves?”
- Was the person placed in seclusion because they were being continuously aggressive? Or because they were disrespectful?
- If we do **temporarily** remove one or more of the individual’s rights it is NOT done in the same manner as those who do not have special needs. Furthermore (as with very young children) we very often allow them to violate our rights without affecting theirs.

40 WHAT ABOUT RIGHTS? DON'T PEOPLE HAVE RIGHTS?

- **If an 18 year old non-verbal student with very few skills hits the teacher in the face that teacher will in all probability NOT press charges against the student.**
- **What if the same is done by an 18 year old student who is doing grade-level work and has excellent verbal skills?**
- **We are generally far less likely to restrict the rights of special needs individuals than the general population. Furthermore, when we do restrict those rights it is typically FAR less severe than the restriction we see in the general population.**
- **What would happen if we NEVER restricted the rights of persons with special needs regardless of their behavior?**

4 | WHAT DO WE DO WITH THIS INFORMATION?

- Hopefully, with an understanding of the variables that may cause someone to view a procedure as aversive we can begin to have **meaningful conversations** about the use of restraint and seclusion and any other “restrictive” procedure
- We can **gain an appreciation** for someone else’s point of view and their concerns about the use of procedures that may be against the individual’s will or temporarily remove or limit their rights
- We have to **acknowledge** that sometimes certain people **may act out of malice** but most individuals (I believe) act out of concern for their own safety, the safety of the person in crisis and the safety of society
- We must ask parents/advocates/administrators/law-makers and others to recognize the need for restraint and seclusion in the general population (all forms)
- We must prepare those with special needs, to the greatest extent possible, **to live in society where there are limits on behavior**



42 WHAT DO WE DO WITH THIS INFORMATION?

- We must **acknowledge** that it would be **harmful** to subject persons with special needs to the *same consequences* as legally competent adults. We do not hit people with special needs when they hit us and we don't have them arrested (typically). We are much **less** likely to retaliate or press charges against children or the population of persons with special needs regardless of age
- We must also **acknowledge** that a failure to set *any limits* on behavior, as humanely as possible, **may prevent the individual from functioning independently in society**
- To live a life where someone must follow you everywhere you go is **unquestionably a restriction of freedom and privacy**. To live a life with **no immediate limits** on your behavior will likely cause a **tremendous permanent restriction** of freedom

43 WHAT DO WE DO WITH THIS INFORMATION?

- **Tell** parents/advocates/others that if we carefully, thoughtfully, **temporarily** restrict the rights of person's with special needs we may be able to prevent a **life-long restriction** of the right to live alone, go shopping alone, or even walk down the street by themselves.
- **Remind** parents/advocates/others that, as with their own children, we try to control people verbally, but not everyone responds to verbal commands. It is THEN that we must, as we would with a toddler, resort to some form of physical intervention which could range from a mild physical to prompt to a 3 person hold.

44 WHAT DO WE DO WITH THIS INFORMATION?

- **The big difference** is that most parents can stop using physical interventions (physically stopping them, carrying them, putting them in high chairs to control them) by the time the child is 3 or 4 years old, but practitioners are working with much older, stronger, smarter individuals who are **still not controlled verbally**
- This is why we must use **methods of stopping people that may go well beyond what the typical parent would need** to control his/her own child

45 EN LOCO PARENTIS

- Latin for “In Place of the Parents”
- School teachers, behavior analysts, direct-care staff, teacher’s aides, are ALL working in place of the parent
- No, they do not do all things a parent *would do or be allowed to do* but they are *responsible for the child’s/individual’s wellbeing*.
- These individuals are “trusted” by the parents to look out for their child’s well-being, especially with school-aged individuals.
- Although many of us play the role of “temporary trusted parent” are we truly trusted by the parents? If we are not trusted, we must find out why.

46 FOR YOU AND YOUR STAFF

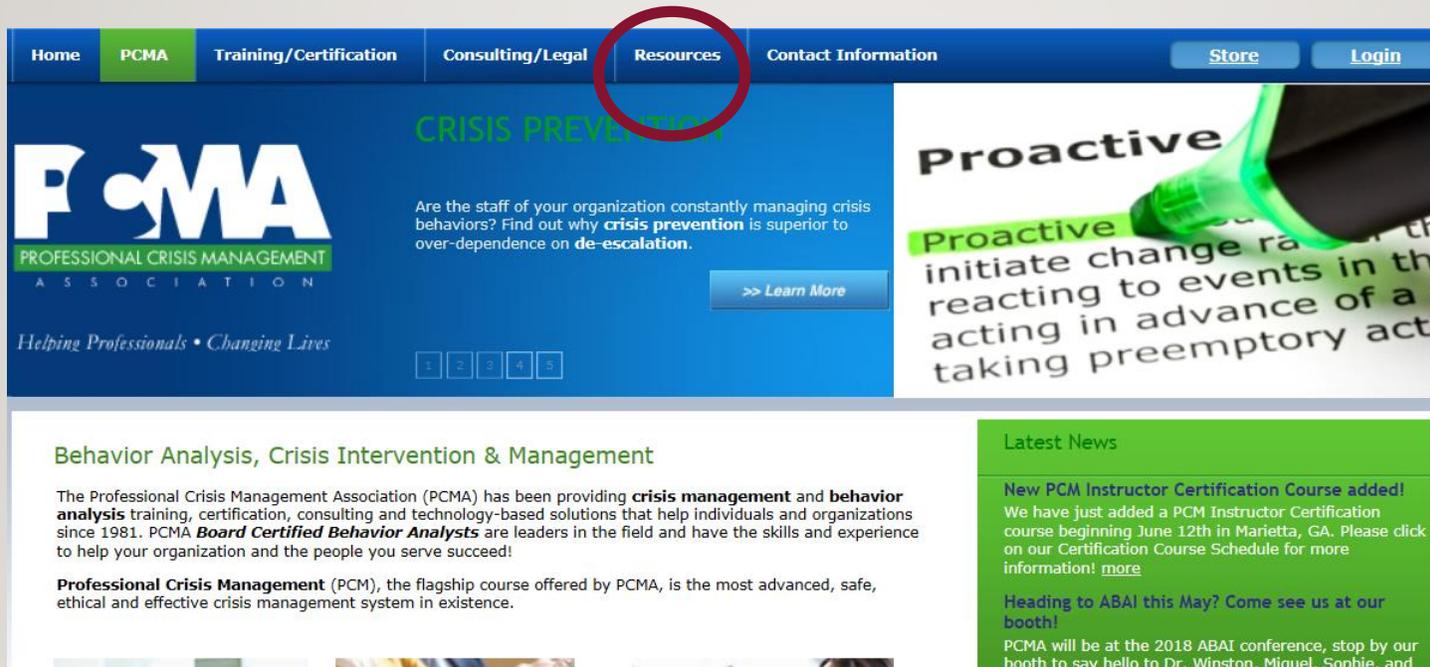
- You all are very special people
- And although those in our field don't put their lives on the line,
- Like all emergency workers,
- In using these “restrictive procedures” you are willing to do what many others are unwilling and/or unable to do.
- Stopping people who are doing dangerous things is something that **MUST** be done in a safe, humane and organized world
- The real issues lie in **how** we stop people and how **others perceive our actions**

47 DISCUSSION? QUESTIONS? COMMENTS?

- **Thank You!**

48 YOU CAN FIND THIS PRESENTATION AT WWW.PCMA.COM NEXT WEEK

Click “resources” then “public downloads”



The screenshot shows the PCMA website homepage. The navigation menu at the top includes Home, PCMA, Training/Certification, Consulting/Legal, Resources (circled in red), and Contact Information. There are also buttons for Store and Login. The main content area features a large blue banner with the PCMA logo and the text "CRISIS PREVENTION". Below the banner, there is a section titled "Behavior Analysis, Crisis Intervention & Management" and a "Latest News" section on the right.

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New PCM Instructor Certification Course added!
We have just added a PCM Instructor Certification course beginning June 12th in Marietta, GA. Please click on our Certification Course Schedule for more information! [more](#)

Heading to ABAI this May? Come see us at our booth!
PCMA will be at the 2018 ABAI conference, stop by our booth to say hello to Dr. Winston, Miguel, Sophie, and