Approved: March 22, 2005
Date

MINUTES OF THE SENATE EDUCATION COMMITTEE

The meeting was called to order by Chairman Jean Schodorf at 1:35 p.m. on March 15, 2005, in Room 123-S of the Capitol.

Committee members absent: Barbara Allen- excused
John Vratil- excused

Committee staff present: Carolyn Rampey, Kansas Legislative Research Department
Theresa Kiernan, Revisor of Statutes
Shirley Higgins, Committee Secretary

Conferees appearing before the committee: Rodney Bieker, General Counsel, Kansas State Department of Education
Alexa Posny, Assistant Commissioner of Education
Dr. Earle Knowlton, Department of Special Education, University of Kansas

Senator Schodorf explained that the meeting concerned information concerning the laws, policies, and procedures regarding seclusion and restraints in public schools. She noted that, after the hearing on **SB 241**, members felt further information on the subject was appropriate.

Rodney Bieker, General Counsel, Kansas Department of Education, gave an overview of current law with regard to the time-out or seclusion room. He described the seclusion room and noted that such rooms are authorized in public schools. He noted that there is no state or federal law that directly prescribes standards or guidelines for the use of time-out rooms in public schools. He explained that the few courts that have addressed specific facts about placing students in time-out rooms have uniformly held that the reason for using this measure and the details of the area of isolation must be reasonable. He informed the Committee that all children with disabilities are entitled to a Free Appropriate Public Education (FAPE). These children have an Individualized Education Program (IEP) which addresses their behavior. The IEP team, which includes parents, must develop a Behavioral Intervention Plan (BIP) for the child, and the courts have held that an appropriate BIP for some children may include the use of a time-out room. If concerns later arise about the time-out room, the parents can withdraw their consent to its use. (Attachment 1)

Alexa Posny, Assistant Commissioner of Education, noted that teachers can often use the same disciplinary strategy with any student, yet some students may require varying levels of behavioral intervention as a result of their disability. The issue of the use of time-out as a behavioral intervention comes down to appropriate use. She noted that the appropriate use is for the purpose of removing access to positive reinforcers for a specified period of time. She explained that time-out may be implemented at different levels from least to more exclusionary (observation, exclusion, and seclusion). She noted that there is no one intervention that is appropriate for every child, and the use of any of the time-out methods is subject to safeguards. (Attachment 2)

Senator Apple recalled that pictures of small , wooden time-out boxes were presented by a parent during the hearing on **SB 241**. He asked Ms. Posny if she believed that these type of boxes were often used. Ms. Posney said she was not familiar with the boxes described and that she thought the use of them would be few and far between. She commented that a seclusion room should be well ventilated and used only as a last resort. She noted that, if the use of the boxes described was reported to the State Department of Education, the Department would follow up with an investigation.

Dr. Earle Knowlton, Department of Special Education, University of Kansas (KU), was present to respond to questions from committee members. He informed the Committee that he is part of the KU teacher education program, he teaches undergraduate students courses in special education, and he also participates in the graduate level teacher preparation for adaptive special education enforcement as well as functional special education enforcement.

Senator Schordorf informed Dr. Knowlton that one of the questions raised at the hearing on the bill was how much training teachers in special education receive, especially teachers in behavior disorder, autistic

classrooms. Dr. Knowlton said all teacher education programs in the state strive to use standard space. The standards both in adaptive and functional special education addresses appropriate procedures in classroom management and behavior management. He noted, "We have a lot more challenging behaviors in school now than we did twenty or thirty years ago. So, we have to be very careful to prepare people. It's repulsive to me that we need to legislate probably common sense more than anything else. Certainly, teachers that I have been associated with would not participate in something like that, and they would call attention to the proper authority if they saw the use of plywood boxes and things of that nature. We prepare our students to meet the standards. They must have knowledge of laws, including litigation that gives us very clear guidelines on how we're supposed to manage behavior."

Senator Steineger commented that perhaps there was a way that a survey of the school districts could be done with regard to the frequency of the use of seclusion in public schools. Ms. Posny responded that she checked with the Director of Special Education on the testimony of a parent who said that her child had been secluded 360 times within a very short period of time. The Director informed her that the child was sent to a table and chair in the room in which he already was. She commented, "That's a very different interpretation than what I thought. That's what I call time-out observation."

For the Committee's information, Senator Schordorf distributed copies of completed study on physical restraints in school from the University of Nebraska. (Attachment 3) In addition she distributed a handout entitled, "A Way to Protect Kids with the Use of Seclusion and Restraint in Schools" (Attachment 4) and copies of a prospectus on a study of exclusionary time-out and physical restraint from the University of Nebraska (Attachment 5).

She went on to say that school districts are concerned that **SB 241** is very detailed, yet there are no guidelines, no policies, and no regulations. She commented, "If this is being used, it seems to me that it's safer for the kids and for the school districts to have some policies and some guidelines." Senator Teichman said, "I think this is a very intense, problematic issue we have before us, and I'm not sure we can solve that in just one time. We need to spend some time with this, and I would prefer that you hold on to the bill, because we have it for two years, and study it over the summer." Senator Schodorf replied, "We can hold on to the bill, and I plan to do that. But I'd like to ask the State Board if we need to request that guidelines and policies be drawn up or if there is something else we need to do to get guidelines." Dale Dennis, Deputy Commissioner, State Department of Education, commented, "To be sure we get proper input for policy makers, why don't we develop some guidelines and bring them back to the Legislative Educational Planning Committee (LEPC). That way, you can review them and see if that's what you want. That's just an option."

Senator Lee noted that, first of all, it would be necessary to determine if the seclusion room was appropriate and, if so, the general parameters for the room should be defined. If rules and regulations are decided upon, it should be made clear how they will be enforced.

Senator Teichman moved to direct the State Department of Education to develop policies, rules and/or regulations about the usage of restraints and seclusion rooms, the appropriate use of restraint seclusion time-out rooms, the physical characteristics of such rooms, and appropriate training of teachers and then report to LEPC during the summer of 2005 and to the Education Committee during the 2006 legislative session, seconded by Senator Lee. The motion carried.

The meeting was adjourned at 2:25 p.m.

The next meeting is scheduled for March 16, 2005.

SENATE EDUCATION COMMITTEE
GUEST LIST

DATE: March 15, 2025

NAME	REPRESENTING
Alexa Posny	KS State Dept of Ed
Earle Knowlton	Dept. of Special Education Univ. of Kansas
Glenn Thompson	Stand Up For Ks.
Elaine Frisbie	Division of Budget
Karen Beckerman	JJA
Nancy Lindberg	Ks Children's Campaign
Anna Millham	Sen Petersen intern
LANDON VERMILLION	SEN. PINE INTERN
Doug Bowman	CCECDS
Mark Tallman	KASB
TERRY FORSYTH	KNEA
Josie Torrez	SLCK
Jennifer Schwartz	KACIL
Diane Gjerstad	Wichita Public Schools
Sue Greenbeat	USD #422
Janet West	USD 382
Rafael Rubio	GMF
Miriam Hollstein	German Marshall Fund/Germany
Hans Terlouw	GMF / Netherlands

SENATE EDUCATION COMMITTEE
GUEST LIST

DATE: March 15, 2005

NAME	REPRESENTING
Jaelyn Kettler	Intern - Sen. Steinger
Mikell Smith	German Marshall Fund/Denmark
Dessislava Stoyanova	German Marshall Fund
Bill Brady	SFFF

What is the current law on the use of time-out or seclusion rooms for students in the public schools?

Rodney J. Bieker
KSDE General Counsel
March 15, 2005

1. For purposes of this review, what is a time-out or seclusion room?

   This is a room or area to which a student is sent, or allowed to go, to be isolated from his or her usual classroom setting. Such removals can be used for discipline or as a behavioral intervention strategy to allow a child to calm down and regain his or her composure.

2. In general terms, are the use of such rooms authorized in the public schools?

   Yes. In 1988, the U.S. Supreme Court, in Honig v. Doe, 484 U.S. 305 (1988), recognized that public schools may use their "normal procedures" for dealing with students who are endangering themselves or others. It said: "Such procedures may include the use of study carrels, time outs, or the restriction of privileges." Id. at 313. (Emphasis added.)

   Also, in Robert H. v. Nixa R-2 School District, 26 IDELR 564 (W.D. Mo. 1997), the Court rejected arguments that the use of a time-out room violated the federal special education law, or civil rights laws barring discrimination on the basis of disability. The Court found that time-out rooms are a standard tool used with emotionally disturbed students. Also, in this case, the Court noted that some of the students voluntarily placed themselves in the time-out room to either calm down or avoid distractions. However, no details about the size or characteristics of the time-out room were given.

3. Is there any Kansas or federal law that directly prescribes standards or guidelines for the use of time-out rooms in the public schools?

   My research reveals no such law.

Senate Education Committee
3-15-05
Attachment 1

4. Are there legal constraints on a public school district's use of such rooms?

There are some legal constraints that are imposed by constitutional provisions prohibiting unreasonable seizures of persons by government officials. The few courts that have addressed specific facts about placing students in time-out rooms have uniformly held that the reason for using this measure and the details of the area of isolation must be reasonable. See Rasmus v. State of Arizona, 939 F. Supp. 709 (D. Ariz. 1996); and Wallace v. Bryant School Dist., 46 F. Supp.2d 863 (E.D. Ark. 1999).

5. Are there any provisions in the special education laws that related to this matter?

Yes. All children with disabilities are entitled to a Free Appropriate Public Education (FAPE). They receive a FAPE if the procedural requirements of the law are met and they have an Individualized Education Program (IEP) in place that is reasonably calculated to provide them meaningful educational benefit. Also, they must be provided education in the Least Restrictive Educational setting (LRE).

In developing an appropriate IEP for any child with a disability whose behavior is impeding the child's learning or that of others, the law requires that the child's IEP team consider strategies and supports, including positive behavioral interventions, to address the child's behavior, and to include those strategies and interventions in the child's IEP. In common education parlance, the IEP team, which includes the child's parents, must develop a Behavioral Intervention Plan (BIP) for the child. As previously noted, the courts have held that an appropriate BIP for some children may include the use of a time-out room. If included in a BIP, the child's parents must consent to this strategy before it may be employed with a child. If concerns later arise about the time-out room, the parents can withdraw their consent to its use.

So, yes, there are special education laws that relate to time-out rooms, although they do not prescribe conditions for their use or require specific characteristics.

Kansas state department of Education
leadership and support for student learning

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To: Senate Education Committee
From: Alexa Posny, Assistant Commissioner of Education
Date: March 15, 2005
Subject: Appropriate Use of Time-Out

Maintaining appropriate behavior of some students can be difficult yet it is often necessary to ensure students are provided educational benefit; e.g., learning to high standards. This task becomes more complex when it involves students with disabilities. Teachers can often use the same disciplinary strategy with any student, yet some students may require varying levels of behavioral intervention as a result of their disability.

The use of time-out as a behavioral intervention has been well researched with appropriate guidance and training readily available. The appropriate use of time-out—the separation of a student from his/her classmates—is for the purpose of removing access to positive reinforcers for a specified period of time. This is often used to reduce the future occurrence of an undesired behavior while teaching the desirable behavior.

Time-out may be implemented at different levels from least to more exclusionary:

Observation: The child is moved within the classroom to another location and no longer participates in the group activities; time is usually 30 to 60 seconds.

Exclusion: The child is moved into a corner or behind a partition in the classroom and no longer participates in the group activities; time is usually up to two minutes.

Seclusion: The child is isolated or placed in a different room; time is usually no longer than 5 minutes.

The use of any of these time-out methods is subject to safeguards, such as:

- Incorporating the behavioral intervention in the IEP
- Implementing the intervention in accordance with appropriate guidelines
- Limiting it to appropriate durations of time, generally two to ten minutes
- Ensuring monitored and physically safe conditions
- Using it only when less intrusive procedures have proven ineffective
- Not using it when the child sees it as an escape (e.g., the child wants to be removed)

Senate Education Committee
3-15-05
Attachment 2

Physical Restraints in School

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Running head: Physical Restraints In School

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Attachment 3

Abstract

Over the last two centuries the use of physical restraint has typically been associated with psychiatric institutions. Today however, society's emphasis on educating children in the least restrictive environment has resulted in these procedures becoming commonplace across all educational placement settings including public schools. Since their initial use restraints have been and remain controversial procedures. Professionals that utilize physical restraints claim they are necessary to safely manage dangerous behaviors. Child advocates, however, argue that far too many children suffer injury and death from the very staff charged with helping them. This manuscript reviews and provides a brief summary of research literature, legislation and court decisions on topics related to the use of restraints in schools. We also identify position statements and recommended practices from nationally recognized professional organizations and advocacy groups. Lastly, we make recommendations regarding needs for research, policy and procedures for use of physical restraint in schools.

Physical Restraints in School

A headline of the *American Statesman Staff* read that a 14-year old boy died after being restrained in a classroom by his teachers. According to a preliminary autopsy the child succumbed to an intense amount of pressure to his chest (Rodriguez, 2002). Unfortunately newspapers across the nation carry similar stories. The exact number of deaths caused by physical restraints remains in dispute. The *Hartford Courant* a Connecticut newspaper reported 142 restraint-related deaths occurred in the United States over a 10-year period, 33% of which were caused by asphyxia (Weiss, 1998). A more recent investigation by the Government Accounting Office in 1998 stated that an accurate estimate was impossible since only 15 states have established reporting procedures for such incidents. Based on information available, the GAO estimated that there were 24 restraint related deaths in the U.S. among children and adults (USGAO, 1999). More recently the Child Welfare League of America (CWLA) estimated that between 8 and 10 children in the U.S. die each year due to restraints, while numerous others suffer injuries ranging from bites, damaged joints, broken bones and friction burns (CWLA, 2002). There is no precise way to measure the number or extent of the injuries to children and injuries also to staff as a result of the use of restraint.

Purpose

The purpose of this manuscript is to review available research and court decisions related to physical restraints used in school settings. We review and provide a brief summary of research literature, legislation and court decisions on topics related to the use of restraints in schools. We also identify position statements and recommended practices from nationally recognized professional organizations and advocacy groups. Last, we

make recommendations regarding needs for research, policy, and procedures for use of physical restraint in schools.

What is physical restraint?

As a professional term, "restraint" is defined as any physical method of restricting an individual's freedom of movement, physical activity, or normal access to his/her body (International Society of Psychiatric and Mental Health Nurses, 1999). The term "restraint" is sometimes used to address three different types of restraint procedures: (1) mechanical, (2) ambulatory, and (3) chemical. Mechanical restraints entail the use of any device or object (e.g., tape, tie downs, calming blanket, body carrier) to limit an individual's body movement to prevent or manage out-of-control behavior. A second category of physical restraint is sometimes referred to as ambulatory restraint, manual restraint, or "therapeutic holding" (American Academy of Pediatrics Committee on Pediatric Emergency Medicine, 1997). It involves the use of one or more people using their bodies to restrict another individual's body movement as a means for reconstituting behavioral control, and establishing and maintaining safety for the out-of-control client, other clients, and staff (American Academy of Child and Adolescent Psychiatry, 2000). Chemical restraint is a third type of restraint that uses medication to control behavior or restrict a patient's freedom of movement. This type of restraint is typically used only in institutional or hospital programs, and has developed only in the past forty years as a result of developments in psychotropic medications.

Today, restraints are used in numerous professional settings including medical and psychiatric facilities, law enforcement and correctional facilities, and in our schools. These different types of restraint are used both with adults and children in the event of

emergency behavior situations for people who exhibit aggressive, violent or dangerous behavior or as a precaution against such behavior.

The primary focus of this manuscript will be on the use of ambulatory or manual restraint as an intervention by educators in schools. There have been numerous instances in which mechanical restraint has also been used in educational settings, but its use will be addressed only in the context of some court decisions and policies that relate to physical restraint. While some might include confinement, such as that which occurs in "time-out rooms" as a form of mechanical restraint, it is beyond our scope to address that controversial issue here. Finally, since chemical restraint is not typically used in schools, it will not be addressed.

History

The use of physical restraint originated in the psychiatric hospitals of France during the late 18th century. Restraint procedures were developed by Philippe Pinel and his assistant Jean Baptiste Pussin for the same intent it is used today, as a means of preventing patients from injuring themselves or others (American Academy of Child and Adolescent Psychiatry, 2000; Fisher, 1994; Weiner, 1992). From their initial usage, mechanical and manual restraint have been and remain controversial procedures. Almost immediately after the procedures became popular, a "non-restraint" movement was started in England in an attempt to prevent physical and often brutally aversive mechanical restraints from being used on psychiatric patients in hospitals (Jones, 1972; Masters, et al., 2002; Scull 1979). In response, a Lunacy Commission was established in 1854 to monitor and regulate the use of seclusion and restraint in asylums. In contrast to England's decreased use of restraints during this time frame, the United States viewed

physical restraint as a form of therapeutic treatment and adopted it as an accepted practice for dealing with violent patients (Masters, et al., 2002; Tomes, 1988).

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). Redl & Wineman stated explicitly that physical restraint should not be used as, nor be associated with physical punishment. They advocated that a child's loss of control should be viewed as an emergency situation where the educator or clinician should either remove the child from the scene, or prevent the individual from doing physical damage to themselves or others. The person performing the restraint should remain calm, friendly, and affectionate, attempting to maintain a positive relationship with the child, thereby providing the opportunity for therapeutic progress once the child's crisis subsides.

Over the past many years, law enforcement and correctional agencies have employed physical restraint and related conflict de-escalation procedures as tools in apprehending and managing the behavior of people they are concerned about. Primarily driven by the needs of law enforcement, and the needs of medical or psychiatric hospitals and their accreditation, over the past 25 years several programs to train and certify staff members in the use of physical restraint procedures have been developed, and are now employed by a variety of child caring agencies and programs as well.

Standards and Guidelines for Using Restraint

In most medical, psychiatric and law enforcement applications, strict guidelines govern the use of physical restraint. Often these standards include accreditation

requirements from governing bodies such as the Joint Commission on Accreditation of Healthcare Organizations or other agencies such as the National Association of Psychiatric Treatment Centers for Children (Cribari, 1996) and the American Academy of Pediatrics (American Academy of Pediatrics, 1997). These requirements have resulted in widespread training and certification for staff in these programs.

Unfortunately, there has been no such accreditation requirement for schools, or many other child caring agencies. The fact that there are not commonly accepted guidelines or accreditation standards for the use of physical restraint in schools makes their use more susceptible to misunderstanding and abuse, let alone improper implementation. To make matters worse, school staff that work with this population are often poorly trained regarding effective behavioral interventions necessary for the prevention of emotional outbursts, typically associated with children who have severe behavioral problems (Moses, 2000). Such interventions are critical in preventing student behavior from escalating to potentially dangerous levels, where restraint may be needed.

Restraint in Education

Once thought of as an exclusive tool of psychiatric institutions, physical restraint has been thrust into the mainstream of public education. This is, in part, due to the Individuals with Disabilities Education Act's (IDEA) concept of serving children with special needs in the least restrictive environment. In the quarter century since the original passage of the law back in 1975, many students with emotional or behavioral problems, regardless of disability label, are now being managed in public school environments, frequently in regular schools and classes. The "Regular Education Initiative" and "inclusion" movements of the 1990s have accelerated this process. Schools are now challenged with educating an increasing number of children who frequently exhibit

challenging and sometimes violent behaviors. As a result, the use of physical restraint has moved from only occurring in hospitals and treatment programs, to now being common in public schools as well. Physical restraint has moved along with the students to the new less restrictive environments.

Recent concern for school violence, may have served as a further impetus for using physical restraint in schools. Schools have been encouraged to take all kinds of actions that might both prevent and deter violence in schools. Implementing procedures that include physical restraint might be one element of an overall plan for managing violence and disruption when they do occur in school (Skiba and Peterson, 2002).

Professional training programs

Today, most training in physical restraint for schools is done by a handful of agencies that specialize in this type of training, usually in conjunction with other strategies for conflict de-escalation and problem solving. (See Table 1 for a list of representative organizations and contact information. No endorsement of programs listed should be implied). Most of these training systems evolved from training programs for staff at residential treatment and psychiatric facilities or from psychiatric hospitals, but these training organizations now offer their training to various agencies including schools.

<Insert Table 1 About Here>

Currently these systems of physical restraint and related conflict de-escalation procedures are used in various professions that deal with the management of violent behavior, including juvenile correctional facilities, group homes and schools.

Research on Restraint

An extensive search was conducted to identify articles related to physical restraint. Computer databases of Education Resource Information Center (ERIC), LEGALTRAC, psychINFO and FindArticles were searched for relevant articles. Keywords used in the computer search included: restraint, physical restraint, therapeutic holding, ambulatory restraint, and mechanical restraint. Second, a hand search of studies published between 1970 - 2002 from the following journals was conducted: The *Journal of Psychosocial Nursing, Journal of Special Education, Journal of Emotional and Behavioral Disorders*, *Behavioral Disorders*, and *Exceptional Children*. Lastly, an ancestral search was performed by checking the citations from relevant studies to determine if any of the articles cited would qualify for inclusion in this review. Literature related to restraint in the field of geriatrics was not reviewed.

After conducting an extensive search 25 articles were identified. There were three articles that reviewed the legal aspects of restraints (Coffin, 1999; Kennedy & Mohr, 2001; and Lohrmann-O'Rourke & Zirkel, 1998), and five articles reviewing the use of physical restraints (Day, 2002; Fisher, 1994; Soloff, Gutheil & Wexler, 1985; and Wright, 1999). While there were 14 experimental research studies investigating the use of restraints with children, only three were conducted in school settings (Grace, et. al., 1994; Ruhl & Hughes, 1985; and Magee & Ellis, 2001). The majority of studies (six) were conducted in either a psychiatric facility or hospital (Barlow, 1989; Hunter, 1989; Miller, Walker & Friedman, 1989; Persi & Pasquali, 1999; Petti, et. al., 2001; and Swett, Michaels & Cole, 1989). The last five studies were conducted with children and adolescents suffering from severe autism or mental retardation attempting to reduce mechanical restraints used for the prevention of self-injurious behaviors (SIB) (Favell,

McGimsey & Jones, 1978; Fisher, et. al., 1997; Luiselli & Waldstein, 1994; Milliken, 1998; and Wallace & Iwata, 1999). Last, there were eight position papers offering guidelines for the proper use of restraints with children (Cribari, 1996; Luiselli, et. al., 1994; Milliken, 1998; Mohr & Anderson, 2001; Ross, 2001; Schloss & Smith, 1987; Selekman & Snyder, 1997; and Stirling & McHugh, 1998).

Prevalence of the Use of Physical Restraint

After an extensive search, no research could be identified indicating how widespread the use of restraint in schools has become. Anecdotal information based on court cases, and legislation would seem to indicate that it has become common at least for larger school systems to have some staff performing physical restraints in public school settings. While studies regarding the prevalence of physical restraint procedures in more restrictive settings was also limited, Day (2002) recently asserted that the use of these procedures in residential settings has become commonplace. A survey of frontline childcare workers from psychiatric facilities found restraints were frequently used, with 34% of staff reporting to have used these procedures more than twice per week (Hunter, 1989). Currently the accreditation of psychiatric hospital programs requires written procedures and training on these topics, presumably meaning that these procedures are commonplace in these settings as well. An early study conducted within an adolescent psychiatric unit found that 23% of the population experienced at least one restraint during an 18-month period. Additional findings of interest included higher occurrences of restraints on Monday and Friday due to what the authors called weekend anxiety. Researchers also reported restraints were more common among younger children potentially due to possessing fewer mechanisms for coping with frustration. Last, the

study found male staff members were more likely to initiate restraints than females (Miller, Walker, & Friedman, 1989).

For the most part this type of physical restraint has not been researched as an educational intervention (Selekman, 1997). A review of literature found several journals had published articles regarding restraint, but most articles focused on addressing the controversial nature of the procedure. One of the first research articles on reducing restraints was performed by Swett, Michael and Jonathan (1989), who investigated whether the passage of a Massachusetts' state law addressing restraints effectively reduced the number of chemical restraints and seclusionary procedures used in a juvenile psychiatric facility. The researchers found that while the number of chemical restraints had decreased significantly, the number of physical restraints had actually increased. More recently, Berrios and Jacobowitz (1998) conducted a study in a psychiatric inpatient unit with children ranging in age from 5 to 12 years using therapeutic holds (e.g., ambulatory restraints). The study claimed therapeutic holding only slightly reduced the duration of a child's behavioral episode, but was effective in reducing the number of restraints performed by 15.9%.

A more recent study performed by Persi and Pasquali (1999) tracked the frequency of physical restraints used among 281 children aged 4 to 17 placed in four different types of segregated settings: psychiatric inpatient unit, residential group home, day treatment program, and day treatment program located in community schools. The study found that 107 restraints were performed throughout the year. The incidence of restraints varied among settings, with the group home and day treatment programs in segregated schools utilizing the procedure more frequently than either the community day treatment or inpatient unit. The study also found males were slightly more likely to be

restrained than females, and there was a mild significant relationship between age and restraints. Researchers did not find a linear relationship with age, but noted the onset of adolescence brought about an abrupt increased level of restraints administered. Surprisingly, and in direct contrast to earlier findings, the study found that female staff initiated larger numbers of restraints than their male counterparts. When comparing the use of restraints among placement settings, the study concluded the pattern of physical restraint in actual settings is highly variable and difficult to explain, requiring additional studies.

Situations or Behaviors That Prompt Use of Restraint

Only one study (Petti et. al., 2001) was identified that examined the circumstances of when physical restraints were employed. Researchers debriefed both staff and clients following 81 incidents of restraint in a psychiatric hospital setting. Findings of interest included staff reporting that 65% of restraints were initiated due to a perceived safety threat, while 19% were the direct result of patient noncompliance. An interesting finding from patient interviews was that a staff member threatening time-outs was a causal factor for escalated levels of aggressive behavior. This may suggest that time-outs are perceived by patients as a coercive intervention.

Unfortunately, no similar studies were performed in a school environment. What is known and recognized by the professional community is that physical restraints are widely used protective procedures, often implemented for a variety of reasons including violence prevention, prevention of self-injurious behavior, noncompliance, and injury or property damage due to temper tantrums. However, physical restraint has long been considered to be a behavior management technique appropriate for teachers when crisis behavior occurs (Rizzo & Zabel, 1988; Fagen, 1996), and may be used for a much wider

set of student behaviors such as preventing children from leaving a classroom or school grounds, or from destroying private or school property. One study conducted with teachers of students with motional or behavioral disorders (EBD) in public schools found that many had used restraints as either part of a planned behavioral intervention, or as a spontaneous reaction to aggressive behavior. The study reported 71% of these teachers used physical restraint with their students if they displayed aggression toward others, 40% to prevent self-abuse, and 34% to prevent destruction of property (Ruhl & Hughes, 1985).

Efficacy of Restraint Procedures

Despite the belief that physical restraint is a commonly used procedure in schools serving children with emotional or behavioral disorders, very little is known about its efficacy, due to a lack of research (Persi & Pasquali, 1999). Few of the proponents of physical restraint have claimed the procedure has any therapeutic value in and of itself. However, proponents of therapeutic holding justify restraint procedures through the attachment theory developed during the early to mid 1970s (Bowlby, 1973; Cline, 1979; and Zaslow & Menta, 1975). Day (2002) reviewed these theories, and for the most part concluded that there was very little empirical support for therapeutic benefits to children receiving restraint. Most of the studies located were of poor quality and relied upon "unverifiable, and hence questionable, anecdotal evidence and case reports" (Day, 2002,p. 272). There was also no evidence for any potential side effects of restraint. While some might believe that children diagnosed with emotional and behavioral disorders who are exposed to restraints on a daily basis could be humiliated by such highly aversive procedures, there is no scientific evidence of psychological damage or harm beyond the clear physical danger of injury or death. Instead restraint 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 EBD suggest that physical restraint might be warranted for purposes of safety despite a lack of empirical research supporting such claims.

Summary of Research. Very little research has been conducted on the prevalence, appropriate applications, or efficacy of physical restraint. Almost no research has been conducted on the use of restraint in school settings. We do not know how widely physical restraint is used in the schools, the extent or nature of injuries occurring when it has been used in the schools, or its effectiveness in achieving the desired outcomes.

Policy Related to Restraint

An extensive search was conducted to identify court or hearing officer decisions, as well as legislation related to physical restraint. In order to identify cases which have dealt with restraint, a search of legal data bases was conducted (*Federal Supplement* which lists all Federal Trial Court decisions; *Federal Reporter 3rd Series* listing all Middle Appellate Court decisions; *United States Reports*, the official publication for all U.S. Supreme Court rulings; LEGALTRAC, a database that indexes law reviews and other legal periodicals; and finally, *Individuals with Disabilities Education Law Report* (IDELR), a specialty law reporter that publishes case law specific to special education, including some hearing officer reports). The results of this search are described below.

Legislation

The passage of the Children's Health Act of 2000, P.L. 106-310 established national standards regarding the use of physical restraints with children in psychiatric facilities. Unfortunately, this legislation did not affect schools. Five states

Massachusetts, Colorado, Illinois, Connecticut and Texas have passed legislation over the past several years addressing the use of physical restraint with children in the school environment. Texas is the most recent state to do so (Amendments to 19 TAC Chapter 89, 2002), while one additional state, Maryland, has proposed legislation on this topic. Although state guidelines differ, the legislation typically contains many similar elements including; 1) definitions of terms common to physical restraint; 2) required procedures and training for staff; 3) conditions when physical restraint can and cannot be used; 4) guidelines for the proper administration of physical restraint; and 5) reporting requirements when restraint is employed.

Court and Hearing Officer Decisions

Over the years, parents and advocacy groups have filed numerous litigation and/or grievances against school districts and psychiatric units regarding the use of restraints on children. Plaintiffs have typically argued that restraints violate an individual's rights under the Eighth Amendment, which prohibits administering cruel or unusual punishment, and the Fourteenth Amendment, which provides for an individual's liberty interests in freedom of movement and personal security (Kennedy & Mohr, 2001). Cases resulting from these complaints have been lodged through state education agency hearings (e.g., under the Individuals with Disabilities Education Act, or state school disciplinary laws), with the U.S. Office for Civil Rights, and through state and federal court cases.

While the Constitutional issues mentioned earlier can be brought directly in federal court, other options exist as well. The Office for Civil Rights (OCR) in the U.S. Department of Education serves as the primary administrative enforcement mechanism for Section 504, and the Americans with Disabilities Act (ADA) in relation to schools

(Lohrmann-O'Rourke & Zirkel, 1998). Additionally, educational cases are frequently handled by the State Education Agency (SEA), which resolves disputes regarding the Individuals with Disabilities Education Act (IDEA) using a system of impartial due process hearings, and at the state's option, a second-tier impartial administrative review. All OCR and SEA Hearing Officer Reports may also be appealed to federal court.

A potentially powerful but underutilized tool for protecting the civil rights of confined or detained youth is the Civil Rights of Institutionalized Persons Act (CRIPA). Established by Congress in 1980, CRIPA provides the Civil Rights Division of the Department of Justice (DOJ) the authority to bring legal action against state and local governments for violating the civil rights of persons institutionalized in publicly operated facilities. Under CRIPA the Civil Rights Division of DOJ protects detained or incarcerated juveniles in prisons, jails, psychiatric hospitals, and other publicly operated facilities from dangerous conditions and unsafe practices of confinement (Puritz & Scali, 1998). The Office for Civil Rights has verified that CRIPA would apply to students in school settings (Complaints can be directed to: Special Litigation Section, Civil Rights Division, U.S. Department of Justice, P.O. Box 66400, Washington, DC 20035-6400. 202-514-6255). However, no records of CRIPA's use related to the use of restraints in schools were located.

Findings. Court rulings can be grouped into four general categories pertaining to the use of physical restraints: 1) decisions affecting the use of mechanical restraints; 2) decisions affecting the use of ambulatory or manual restraints; 3) professional training pertaining to staff who perform restraints; and 4) individual rights related to the Eighth and Fourteenth Amendments, Section 504, and the American with Disabilities Act (ADA).

Mechanical & Ambulatory Restraints. The preponderance of rulings by the Courts, State Education Agencies (SEAs) and the Office for Civil Rights (OCR) found the use of any type of mechanical restraint other than a time out or tray chair to be unacceptable, and in clear violation of a student's individual rights. Specific rulings by each agency are shown below in table 1. In contrast, the Courts, SEAs, and OCR have consistently found ambulatory restraints may be used without violating an individual's rights or threatening their safety. Specific rulings by each agency are shown below in table 2.

<Insert Table 2 and Table 3 About Here>

Professional Training. In *Wyatt v. King* (1992), the U.S. Circuit Court determined that staff working with the mentally ill required specific training regarding interventions germane to their unique care. The Court stated that training should include psychopharmacology, psychopathology, psychotherapeutic interventions, as well as interviewing and assessment procedures for determining a patient's mental status. These findings have since been supported by national training prevention programs which advertise that intensive staff training in schools reduced assaultive incidences by 80%, and resulted in a 77% reduction in disruptive incidents (Crisis Prevention Institute, 2002). Similarly, the states of Pennsylvania and Delaware experienced a 90% reduction in the

use of physical restraints in their state's mental health facilities after instituting intensive staff training programs. Training included crisis management and crisis prevention procedures for staff, as well as extensive training on methods for determining when and how to conduct physical restraints. Texas legislation now requires school personnel who use restraint to be trained and its supporting technical assistance materials have identified critical components for training programs (Amendments to 19 TAC Chapter 89, 2002). Courts, hearing officers and legislation strongly support adequate training before these procedures are employed.

Individual Rights. Numerous court cases have addressed patient rights. This section provides a synopsis of all decisions pertaining to an individual's rights regarding the Eighth and Fourteenth Amendments, Section 504 and ADA. In essence, the Courts have ruled that institutions must take into account a patient's rights at all times, and that any restrictions to individual liberties must be in their best interest. Specific rulings by each agency are shown below in table 2. Perhaps the most influential decision regarding the use of restraint came form the Supreme Court decision *Youngberg v. Romeo* (1982). The court emphasized its concern that the judicial system should not invade the province of those whose job it is to make medical and custodial decisions. This case was critical in establishing a precedent for the establishment of procedures used to determine if the use of physical restraint was considered reasonable, and hinged on whether staff exercised professional judgment. Professional judgment, the court ruled was to be considered presumptively valid. This presumption effectively shifted the burden of proof from the caretaker to the individual alleging that the imposition of restraint was unreasonable. However, to ensure the use of restraints were not being improperly used, the Courts determined in *Converse v. Nelson* (1995) that inappropriate behavioral programs that

constitute punishment disguised as treatment should be subject to analysis under Eighth Amendment standards. Last, as described earlier, CRIPA may also provide a vehicle for advocacy and protection related to the use of restraints.

<Insert Table 4 About Here>

Summary. A review of state and federal policies regarding the use of physical restraint in schools has resulted in several findings: 1) limited forms of mechanical restraints are permitted, 2) ambulatory restraints performed with trained personnel are authorized, and 3) any agency, including schools, that uses restraints needs to provide professional training for staff that perform these procedures.

Advocacy Statements

While professional organizations and advocacy groups frequently hold differing opinions regarding specific issues, it is important to recognize areas of agreement to promote standardization and policy. Position statements regarding the use of physical restraint from nationally recognized advocacy groups and professional organizations were reviewed and summarized.

Professional Organizations

In 1998 the American Medical Association (AMA) reviewed existing restraint guidelines and attempted to coordinate the development of updated national guidelines for the safe and clinically appropriate use of restraint techniques for children and adolescents. In a 1999 report, the AMA supported the development and use of guidelines currently issued by the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics (AACAP), and the American Psychiatric Association (APA) regarding restraint, while encouraging future empirical studies on physical

restraint with children and adolescents across all settings (American Medical Association, 2001).

AACAP's policy statement suggests institutions that use physical restraints establish procedures and policies addressing the circumstances in which restraints are permissible. AACAP also calls for documentation procedures, and in-service training requirements for all staff. Last, they recommend physical restraints be used only as an emergency intervention to maintain safety, and be implemented in a manner sensitive to the child's particular developmental level, specific vulnerabilities, and overall treatment goals (American Association of Child and Adolescent Psychiatry, 2000). The American Psychiatric Association (APA) policy statement is similar to AACAP's, but expressed concerns regarding P.L. 310-106 terminology. The APA believes this legislation defined physical restraint so broadly it essentially encompassed any unwanted touching that might reduce an individual's ability to move freely (American Psychiatric Association, 2002). This definition would classify commonly used escort procedures as a type of physical restraint.

Finally, the position statement by the International Society of Psychiatric-Mental Health Nurses (ISPN) claims restraints should be used as a last resort and only when less restrictive alternatives have failed. ISPN recommends family members be informed immediately after the use of a restraint, and that the child receive a debriefing from their caregivers in clear words that they can understand. The organization claimed the debriefing process is necessary to minimize negative effects related to patients' experiences of being restrained. ISPN also advocates training all staff members on the cycle of aggression, verbal intervention skills, and critical thinking strategies designed to

select the least restrictive intervention that is best suited to the presenting needs of the child (International Society, 1999).

Advocacy Groups

Parents and advocacy groups have argued for the outright banishment of physical restraints, claiming its usage unfit for man, woman, or beast (Williams & Finch, 1997). Many nationally recognized advocacy groups have posted position statements regarding the use of physical restraint on their World Wide Web sites. The National Alliance for the Mentally Ill recently posted a position statement supporting P.L. 310-106 regarding the use of physical restraints, and proposed similar standards be established for schools (National Alliance, 2001). Another professional and advocacy group, the Child Welfare League of America, called for a minimum national standard of training in behavior management techniques, especially in the area of de-escalation. In addition, it called for future research to develop a better understanding of what crisis prevention models work best for specific situations (Child Welfare League, 2002). More recently, the Autism National Committee has called upon Congress and state legislatures to limit the use of restraints on children with disabilities to brief, emergency situations involving serious threat of injury to the person with disabilities or to others. They are also asking for standardized reporting procedures following a restraint, with an investigation of circumstances leading to the incident to develop supports and accommodations for the prevention of future restraints (Autism National Committee, 2000).

Recommendations for Use of Physical Restraint in School Settings

After reviewing the compilation of research, legislation, case law and position statements regarding the use of physical restraint, it would appear that extreme caution should be used by schools when the use of physical restraint procedures is being

contemplated. The following recommendations regarding restraint procedures, staff training, notification and monitoring seem to combine the best practices emerging from our review, and would be advisable for any school that would employ these procedures.

Restraint Procedures

Restraints should never be performed as a means of punishment or to force compliance from a student. In addition, physical restraint procedures should never be performed with untrained personnel. The courts have established through numerous rulings that very limited forms of mechanical restraints are permissible with students in a school setting, and that physical or ambulatory restraints should be administered only when the safety of the student, peers, or staff members are at-risk.

When physical restraints are administered, staff must use the safest method available using the minimal amount of force necessary to protect the student and others from physical injury or harm. Once a restraint is performed, its use should be discontinued as soon as possible. In addition, no restraint should be administered in such a manner that prevents a student from breathing or speaking. The student's physical status including respiration and skin color should be continuously monitored throughout the restraint procedure.

Professional Training

All staff members who work with students with emotional and behavioral disorders should be required to receive specialized training in conflict de-escalation, crisis prevention and behavior management techniques. At least a core team of these staff members should receive specialized training in the use of physical restraint before any such procedures are used. Physical restraint should never be used unless the person doing it is trained specifically in the particular technique to be used. Training should

include recognition of the various phases of the cycle of aggression, verbal de-escalation strategies, as well as restraint and counseling procedures. An initial training period should be required, followed by yearly refresher sessions. Staff should also receive certification in First Aid and cardio pulmonary resuscitation in the event of an emergency related to restraint.

Reporting and parent notification

Procedures for reporting and notification should be in place. Following the administration of a physical restraint, a staff member who administered the restraint should verbally notify an administrator as soon as possible. A written report should be provided to the administrator responsible for maintaining an on-going record of all physical restraints conducted by the school within a 24-hour period. In addition, the administrator should verbally inform the student's parents or guardians of the restraint as soon as possible. Written reports to the parents including a description of the event and staff involved should be postmarked no later than 3 working days following an incident.

Advocacy

It is important to remember that policies, procedures, and legislation, even if noble in intent, are all but meaningless if not enforced. The guidelines for schools regarding the use of physical restraint on children are the result of decades of professional practice, state and federal legislation, case law, and grass roots efforts by advocacy groups all concerned with the safety of children. To ensure empirically based best practices are developed and become common practice among schools, it is incumbent upon these same bodies to monitor and hold school districts across the nation accountable. Organizations such as the National Alliance for the Mentally Ill, American Psychological Association, Academy of Child and Adolescent Psychiatry, Council for

Children with Behavioral Disorders, Child Welfare League of America, Autism National Committee, and many others need to act as watchdog agencies monitoring the compliance of schools across the nation to ensure children are kept out of harm's way.

Recommendations for Research

It is evident that there is a strong need for additional research regarding the use of physical restraint with students across all settings. Areas for future research include:

1. The extent to which schools currently employ physical restraint, and if so, which of the restraint systems are used;
2. The nature of the antecedents or behavior that precipitated the restraint;
3. The Diagnostic and Statistical Manual diagnoses (American Psychiatric Association, 2002), special education category (if applicable) or other characteristics of students who receive restraint;
4. The intended purposes or goals of restraint;
5. The efficacy of restraint procedures in achieving these goals;
6. The potential outcomes or side effects including injuries and fatalities as a result of the use of restraint in schools;
7. The training level of the staff who actually perform restraints;
8. The degree to which procedures for de-escalation of student behavior are used before, during, and after restraint.

Using the data compiled where states require reporting will be very useful in beginning to address some of these issues, and make it more likely that restraint will be used safely.

Conclusion

Due to the current risk of student injuries and the mortality rates associated with the use of physical restraint, immediate action is required to ensure that schools

employing restraint do not jeopardize student safety. Based on the review of case law, legislation, and recommended procedures from both professional organizations and advocacy groups, there is a need for clear standards regarding the use of restraint procedures in schools, as well as mandatory training of staff before they use restraints. Improved and standardized record keeping, and notification of administrators and parents of incidents where restraint occurs are also important. Additional research is needed to define situations where restraint is appropriate in schools, as well as its effectiveness in containing or preventing violent or destructive behavior. Unless these recommendations are heeded and action is taken, headlines will continue to appear across our nation describing these preventable fatalities.

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Table 1.

Representative Training Programs on Ambulatory Restraint*

Program	**Contact Information**
Handle With Care Behavior Management System, Inc.	184 McKinstry Road, Gardiner, NY 12525; 845-255-4031; fax 845-256-0094; http://www.handlewithcare.com
JKM Training, Inc.	36 South Pitt Street; Carlisle, PA 17013; 717-960-0457; fax 717-960-0458; http://www.jkmtraining.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
Nonviolent Crisis Intervention	Crisis Prevention Institute, Inc. (CPI) 3315-K North 1245h Street, Brookfield, WI 53005; 800-558-8976; http://www.crisisprevention.com
Professional Assault Response Training (PART)	6105 Glenhurse Way, Citrus Heights, CA 95621-1720; Phone: 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 Delaplane Avenue, Newark, Delaware 19711; 302- 753-7115;

http://www.therops.com/; info@therops.com

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* These programs are listed as examples. No endorsement of these programs should be implied by their listing here.

Table 2.

Summary of Court, State Education Agency and OCR Rulings on Mechanical Restraint

Federal Court	**Rulings**
Jefferson v. Yselta Independent School District (1987),	Teacher and principal did not have qualified immunity from liability for tying a second grade student to a chair.
Heidemann v. Rother (1996).	Blanket wrapping techniques were not a substantial departure from accepted professional judgments, practice, or standards
Ronnie Lee S. v. Mingo County Board of Education (1997),	Elementary school did not have qualified immunity from liability when restraining a child with autism to chair by means of a vest.
State Education Agency	**Rulings**
Portland (ME) School District (1987)	Teacher's strapping down of a student with profound retardation violated his Sec. 504 rights.
White Settlement Independent School District (1996)	School district acted in accordance with IEP provisions allowing a tray chair for redirection and maintaining attention to task
Office for Civil Rights	**Rulings**
Oakland (CA) Unified School District (1993)	Student's Sec. 504 and Americans with Disabilities Act (ADA) rights had been violated when his mouth was taped shut
Aiken County (SC) School District (1995)	Student's Sec. 504 and Americans with Disabilities Act (ADA) rights had been violated when his mouth was taped shut

Table 3.

Summary of Court, Sate Education Agency & OCR Rulings on Ambulatory Restraint

Federal Court	**Rulings**
Garland Independent School District v. Wilks (1987)	Restraining a child with autism engaged in aggressive and self-injurious behavior was not considered to be excessive or violate the child's constitutional protection from cruel and unusual punishment
State Education Agency	**Rulings**
Florence (SC) County No.1 School District (1987)	Determined school personnel had not violated a student's Section 504 rights while restraining him to prevent harm, despite language in the IEP forbidding corporal punishment.
Office of Civil Rights	**Rulings**
Ohio County Public Schools (1989)	Did not find evidence to support parent's claim that a teacher used excessive force in restraining a student.
Wells-Orgunquit (ME) County Schools (1990)	School district did not violate a student's Sec. 504 rights when using a physical restraint to control violent behavior
Gateway (CA) v. Unified School District (1995)	Determined a student's behavior modification plan permitted the use of physical restraint

Table 4.

Summary of Federal Court and OCR Rulings on Individual Rights

Federal Court	**Rulings**
Jackson v. Bishop (1968)	Interventions not professionally indicated and unnecessarily restrictive may violate a patient's 14th Amendment liberty interest.
Parham v. J.R. (1979)	Supreme Court determined children did not enjoy the same degree of constitutional protection as adults.
Bell v. Wolfish (1979)	Supreme Court stressed that innocent persons have a right to be free from punishment
Youngberg v. Romeo (1982)	Supreme Court ruled persons involuntarily committed to state institutions have a constitutionally protected liberty interest under the due process clause of the 14th Amendment to reasonably safe conditions of confinement, and freedom from unreasonable bodily restraints. These were fundamental liberties that can be limited only by an overriding, non-punitive state interest.
Farmer v. Brennan decision (1994)	Supreme Court ruled restraints violated the prohibition against cruel and unusual punishment when used in a correctional facilities, and that prison official have a duty to provide humane conditions of confinement and can be held liable for acting with deliberate indifference to the health or safety of an inmate.
Converse v. Nelson (1995)	Mass Superior Court ruled inappropriate behavioral programs

	that constitute punishment disguised as treatment should be subject to analysis under Eighth Amendment standards.

Office of Civil Rights	**Rulings**
Chicago (IL) Public Schools District decision (1993)	Determined a district's failure to monitor and respond to conditions at a private school for students with severe cognitive disabilities violated the student's Section 504 and their ADA rights

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Author's Note

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A Way to Protect Kids with the use of Seclusion and Restraint in Schools.

President Bush's New Freedom Commission Report on Seclusion and Restraint:
Limiting seclusion and restraint and making services "consumer and family-driven" are also key policy objectives of President George W. Bush and the President's New Freedom Commission. The President's report has identified the dangers and concerns of seclusion and restraint and the need for policy changes:

> ". . . It is inappropriate to use seclusion and restraint for the purposes of discipline, coercion, or staff convenience … Seclusion and restraint are safety interventions of last resort; they are not treatment interventions. In light of the potentially serious consequences, seclusion and restraint should be used only when an imminent risk of danger to the individual or others exists and no other safe, effective intervention is possible. It is also inappropriate to use these methods instead of providing adequate levels of staff ..."

We must answer the call of the President's New Freedom Initiative. We must take President Bush's New Freedom policy on seclusion and restraint and apply it to protect the 65,000 students receiving special education in Kansas schools.

Federal Agencies Urge Dramatic Reduction or Elimination of Seclusion and Restraint:
Under President Bush's leadership, the US Department of Health and Human Services (HHS) has set out a detailed action plan to dramatically reduce, and eventually eliminate, the use of seclusion and restraint in all publicly funded treatment programs. HHS is trying to eliminate the need for these invasive tactics because "In addition to the very real risk of death and injury, individuals who have experienced previous physical or sexual abuse can suffer further traumatization when subject to these practices."

Potential Language on Seclusion & Restraint in Schools that would set the Policy, and still let the State Board of Education Adopt the Regulations / Potential Amendment to HB 2331:

Some Legislators have asked how they might scale back the specific, detailed measures in SB 241 & HB 2339 and instead create an effective and consistent state policy on seclusion and restraint in schools that is based on President Bush's New Freedom Initiative; however, the rules and regulations to implement these state policies would be left up to the State Board of Education. This is potential to do that:

"New Section 1. The Kansas State Board of Education shall adopt rules and regulations to ensure the use of seclusion rooms and restraint are interventions of last resort, and are used only when an imminent risk of substantial harm to the individual or others exists and no other safe, effective intervention is possible. Such rules and regulations shall also ensure that:
a. parents are accurately and timely informed regarding the use of seclusion and restraint on their children, including detailing the use of the intervention in the child's individual education plan,
b. these interventions are not used for the purposes of discipline, coercion, or staff convenience,
c. school staff utilizing these interventions receive training on the safest and most effective methods of implementing these techniques, including evidenced-based practices to prevent behaviors that lead to the need for seclusion or restraint, and
d. adequate procedures and safeguards are established regarding the safe use of these interventions.

The Kansas State Board of Education shall provide an annual report and accounting to the Kansas Legislature on the numbers of occurrences, students and frequency of the use of seclusion and restraint in schools, along with recommendations to reduce or eliminate the need for seclusion and restraint. Chemical restraint, mechanical restraint and locked seclusion rooms are not allowed as interventions. All policy directives contained in this section are only for students receiving special education and related services."

Senate Education Committee
3-15-05 Attachment 4

A Study of Exclusionary Time-Out and Physical Restraint

A Prospectus

Over the last two centuries the use of physical restraint has typically been associated with psychiatric institutions. Today however, society's emphasis on educating children in the least restrictive environment has resulted in these procedures becoming commonplace across all educational placement settings including public schools.

Since its initial use restraint has been and remains controversial. Professionals who utilize physical restraint claim it is necessary to safely manage dangerous behaviors. Child advocates, however, argue that far too many children suffer injury and death from the very staff charged with helping them.

The use of time-out (or any procedure taking a student from his or her normal educational environment), particularly seclusionary time out (where the student is placed in a special isolated location or room) has been equally controversial, and in many situations can be related to the use of restraint. There is some question about the safety of time out procedures, particularly in seclusionary time out settings. There is often also concern regarding the degree to which time out might interferes with the child's rights, interferes with access to academic instruction, and concern about its effectiveness in solving the behavior problems it is intended to solve. Exclusion from normal learning environments is an issue which has come under more scrutiny as No Child Left Behind has focused on academic outcomes for all students.

Definitions

Physical restraint is any physical method of restricting an individual's freedom of movement, physical activity or normal access to his/her body. The most common physical restraint and the focus of this study is when one or more people use their bodies to restrict another's movement.

For this study we will define exclusionary time out as any time an individual is sent out of their normal school environment or routine on account of their behavior, and in particular when the are out of sight or earshot of their normal educational setting. Note that for this study we are not limiting the term time out to be associated with "time out from positive reinforcement" which has been the classical "behaviorist" definition of this procedure, but instead are more interested in any and all occasions for which students are excluded from their normal leaning environment regardless of the intention of the adults involved. As a result the study will also address various forms of exclusion students from their normal teaching environment including in-school suspension, think time, problem solving rooms, and various other types of temporary exclusion based on behavior which are imposed on students as a result of behavior, regardless of the term used to describe the nature of this exclusion (numerous euphemisms for this procedure appear to be used in the schools). Thus it can also include formal suspension or expulsion.

Seclusionary time out is any time when an individual is placed in a specially designated room or environment for this time-out period. As with exclusionary time out, the focus of this study will be the nature of the setting rather than the theory or motivation of the adults for sending the youngster to that setting. The nature of and use of seclusionary time out will be a particular emphasis of this study, and the study will attempt to describe the situations and procedures where seclusionary time out is employed in educational settings.

Although each of these interventions can be employed separately, they are being studied together because they many times are linked- physical restraint may be employed in order to place a student in seclusionary time out. They are often used for the same student populations, and they pose potentially similar dangers for these students. They both also may require similar record keeping, training and IEP or treatment plan entries, and may pose similar legal issues for the schools and agencies which employ them.

Senate Education Committee
3-15-05
Attachment 5

Need for Information

In spite of the apparent common use of both of these types of procedures, little is known about how often they are used, the circumstances when they are used, and the level of training of the staff who are employing these procedures. While use of these procedures in hospital or institutional settings require adherence to strict training and procedural guidelines, there are generally no such policy guidelines for the use of these procedures in public school or other educational settings (some states have legislation or other guidelines which regulate their use).

Most recognized training programs which include training on the use of physical restraint, have a heavy emphasis on conflict de-escalation. Nevertheless there is currently no data available on whether conflict de-escalation procedures have been employed when physical restraint procedures or time-out procedures have been used in the public schools.

While many states have implemented state-wide behavioral initiatives related to the prevention of behavioral disorders such as "Positive Behavioral Supports", there has been a sometimes insufficient effort to determine the effects of these efforts on reducing the numbers of crisis situations and chronic behavioral problems. This proposed study might be able to develop data management procedures through time to be able to determine whether the numbers of students in need of the most intensive interventions is diminishing.

Recently the disproportionate identification for special education of certain minorities groups, particularly African-Americans, as well as the disproportionate involvement of the same minority groups in the school discipline system have begun to receive attention. Although some have speculated that a similar disproportionality in the use of time-out and physical restraint may also exist, there is no data to be able to determine that at the present time. This data from this study may determine whether such a disproportionality exists for the use of these procedures.

Risks

There are strong risks associated with each of these procedures. The foremost of these is the risk of personal injury or death to the student who is the subject of the procedure - numerous deaths and injuries have been recorded when restraint or time out procedures have been employed without safe environments and appropriate training. Seclusionary time out has been shown to have risk of suicide or injury while in an inappropriately monitored time out environment. Restraint has resulted in numerous deaths and injuries due apparently to a lack of appropriate training and lack of awareness of potential medical problems. Both of these procedures have resulted in numerous court cases challenging their use and have been the focus of various national and state policy initiatives.

Purpose

The purpose of this proposed study is to determine the extent of the use of each of these two procedures in public school settings, and in other specialized settings. It will also determine the circumstances (behavior; situations; staff involved, etc.) in which they are employed, as well as the type of restraint training, the nature of seclusionary time-out locations, type of record keeping, etc. used when these procedures are employed.

Research Questions

The broad research questions to be addressed for <u>both exclusionary time and physical restraints</u> include:

- How often is exclusionary time-out or physical restraint used in educational settings?
- Under what circumstances are these procedures used?
- What are the intended purposes of these procedures?
- What are the behaviors which trigger the use of this procedure?
- Are these procedures used disproportionately with students in certain minority groups?

- Are these interventions paired with other interventions which promote positive behavior? Are they used in the context of "positive behavioral supports"?
- What are the students' DSM diagnosis and/or special education category?
- What is the training of the personnel using this procedure?
- For students with IEPS or Accommodation plans, how many include mention of the possible use of these procedures?
- How does the frequency of use of this procedure in educational settings compare to its use in specialized settings such as in residential treatment or hospital settings?
- What are educators' attitudes about the use of these procedures?
- What is the evidence for the effectiveness of these procedures in accomplishing their objectives? Are they scientifically based interventions?
- Is the rate of use of these procedures different in different states? What might be some reasons for intra or inter-state differences?
- What factors seem to affect variations in the use of these procedures (for example does the level of staff training, age level, severity level of the student disability, etc., affect use?
- What SEA and LEA policies, rules, regulations or guidelines exist to guide the use of exclusionary time-out and physical restraint in U.S. public schools?

Proposed Study Procedures

In order to answer these questions, we are proposing a two tiered study. One tier would be a broad survey. The other would be a more comprehensive study of some of the classrooms and specialized settings which employ these procedures regularly.

In order to determine the prevalence of the use of these procedures in the schools we would propose conducting a survey of special education teachers, building administrators, and special education directors across several states. There would be a somewhat different questionnaire for each group. We would like to survey a significant random sample from among these groups in each state. We would need access to accurate and up-to-date e-mail or mailing labels in order to conduct this survey. The survey form would have respondents identify the frequency with which they employ these procedures, as well as a variety of information about the circumstances, procedures, training, etc. related to their use. The actual questionnaires will be created soon.

The second tier of the study would focus on a number of classrooms and a number of specialized day or residential treatment settings where these procedures are employed. An estimate would be about 15-20 of each type. Actual archived data from these programs' actual use of seclusionary time-out or physical restraint in these settings would be obtained and analyzed, and data would be gathered prospectively for a period of time (perhaps a year) as well in order to detect changes. This study would greatly enhance the ability to compare comparable settings and client behaviors related to the use of these procedures, and would permit a comparison of actual data on the use of these procedures to the survey estimates.

Outcomes Expected

One of the benefits of this study might be that it could create some basis on which to judge whether either or both of these procedures are being over used in some environments or situations at least compared to other locations with similar populations by creating a sufficiently large data base across settings, precipitating behaviors, diagnoses and states. The study will suggest options for states to aggregate their own data in such a way as to maintain oversight over the use of these procedures.

The study may determine whether these procedures are used disproportionately with students of differing ethnicities, diagnoses, ages or other characteristics.

Regardless of the current use of these procedures, most would agree that the use of both of these procedures should be minimized, and that all other alternatives should be employed before these procedures are used. In order to achieve this goal, this study should provide valuable information on how these procedures are currently being used, whether and how they are paired with other positive behavior supports, and might be able to suggest improvements in the procedures and training for their use. The study might also be able to identify what alternative procedures are being used in those locations where time-out and restraint are not employed as frequently.

This study will result the following:

1. Several research journal publications or reports related to the finding in this study.
2. A report specific to the data for each state, if desired by that state.
3. A set of recommendations for policies and procedures for employing these interventions safely and in accord with student rights, in such a way as to minimize their danger and in order to keep their use to the absolute minimum. These policy recommendations would be both at the State and local school level.
4. A set of recommendations for regional or statewide data collection and oversight of these procedures which would include suggestions for the types of data to be routinely gathered and how the data would be handled and aggregated.
5. A set of training guidelines which should support the policy recommendations and ensure appropriate use of these and which will minimize the use of these procedures

Confidentiality

In order for this project to proceed, we would need the following:

1. There will be no disclosure of individually identifying information.
2. There will be no disclosure of information identifying individual programs or schools without their prior approval.
3. This study will be approved by one or more of the Institutional Review Boards at the institutions of the primary researchers. These procedures are intended to insure confidentiality and safety of all human subjects.
4. State reports will be vetted by participating state agencies to insure that state data are reported accurately and that there is no indirect way to identify participating school, agencies or individuals.

Tentative Time Line

There is no fixed time line at this point for this study- study will proceed on the basis if available time and resources. Tentative time frame-

January-March, 2005-	Obtaining preliminary approvals, drafting of survey instruments; drafting of data fields for data from day and residential programs obtaining lists of day and residential treatment facilities; obtaining information about how to access, sample survey populations, and determining funding mechanisms.
March-May	Inviting participation of day and residential treatment programs; preliminary data gathering from these programs; preliminary planning of survey delivery.
June-August,	Gathering of data from participating day and residential treatment facilities; continued planning for survey.
August-December-	Delivery of surveys to special education teachers, building administrators and special education directors; continued data gathering from day and residential treatment facilities; preliminary data analysis.
January-June, 2006-	Continued survey follow up; Finish day and residential treatment data gathering; Data analysis; writing of reports and manuscripts.

June- February, 2007 Writing of reports and manuscripts.

Needed from participating states as soon as possible:

1. Preliminary agreement to participate in the study.
2. Identification of one or two state liaisons/contact persons.
3. A letter of cooperation and support suitable for submission with grant funding requests made to support this research project.
4. A list of the day and residential treatment programs in this state with addresses and contact information. Some states may choose to include juvenile justice facilities or other alternative programs which serve students with behavioral challenges.
5. An estimate of the approximate number of people in that state in each of these categories-
   a. Directors of special education
   b. School building administrators- public and private, K-12
   c. Special education teachers all schools public and private.
6. Preliminary understanding regarding access to mailing labels or e-mail addresses in order to be able to deliver a survey.

Needed during the period from February to May, 2005:

1. A list of all laws, regulations, policies or technical assistance documents related to physical restraint or to time-out for that state, and an indication of how they might be accessed (e.g. website, etc.).
2. An agreement on how the survey might best be delivered and returned within that state.
3. An agreement about the willingness of the state to provide financial or in-kind support to the survey.
4. Discussion and agreement about the nature of the survey instruments.
5. Discussion and agreement about the nature of the data fields for the gathering of the data from day and residential treatment agencies.
6. Discussion and agreement about any state specific data analysis or reports which would be expected from the research.
7. Agreement about authorship and credits in any reports or manuscripts resulting from this study.
8. Note: Grant or other external support for this project will be explored during this period, and may require other support documentation from the participating states.

Needed during the period from August to December, 2005:

1. Actual mailing labels (or e-mail addresses or other delivery methods for surveys) provided/identified.
2. In-kind or financial support provided for this project depending on delivery method.
3. Input and support for preliminary data analysis.

Needed January-March 2006 and beyond:

1. In-kind or financial assistance and support for follow up and data analysis.
2. Assistance in drafting or reviewing reports and manuscripts which are generated as a result of this research project.
3. Assistance in disseminating results of this study to key stakeholders within each participating state.

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There is an open invitation for additional states to join in this study.

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