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RE: Skyler Aldridge, DOB 07/30/2003

Testimony for Kansas Legislature

Seclusion and Restraint in Kansas Schools

January 31, 2012

Today, I bring in a photograph of my grandson, Skyler Aldridge. I adopted my children when they were 13 and 10 years old. They were my husband's children from his first marriage. My background is in working with people with disabilities. I knew when my husband and I began dating; I would face issues I have never seen before.

Our daughter was diagnosed at age 14 with Fetal Alcohol Syndrome, Dysthymia, and Borderline Personality Disorder. Within four years, she was hospitalized over 10 times for suicidal ideations and suicide attempts. I knew if she had children, I would be raising them.

At age 18, Amy emancipated herself from the family with assistance from Community Support Services. She became involved with a young man from CSS, they began a relationship, and she became pregnant in December 2002 with twins. When she told my husband and me this news she still wanted nothing to do with us. She graduated Gardner Edgerton High School in May 2003 and within one week after graduation, her boyfriend/twins' biological father turned violent on her and she finally came home.

She was home for less than 8 weeks when a regular check-up sent her into the hospital. She had preeclampsia and the twins were in distress. She was 4-1/2 weeks from her original due date of September 1. An emergency C-section was performed on Wednesday, July 30, 2003 at 10:50a.m. At 10:52a.m. Skyler came into this world with the umbilical cord wrapped around his neck and body suffocating him. His twin sister, Arianna, was born one minute later with Jaundice.

It was when my daughter was left alone with the twins for the first time, when she overdosed on medications and was hospitalized for a suicide attempt. The twins were 7

weeks old. She left the hospital against medical advice with the twins' biological father and our concern was for the health and welfare of two children. My husband and I received Permanent Legal Guardianship. We are their Permanent Legal Guardians first and them their grandparents.

We knew with medical history of both biological parents, we would have to watch Skyler and Arianna for signs of delays and/or Mental Illnesses. Arianna was the first to meet her developmental milestones even at a slower than normal rate. This, we attributed to prematurity.

Both the twins had Rotavirus and them Chicken Pox immediately after at age 7 months. Our 17 year-old son, had Shingles and Mono was going through his high school at a rapid pace. We still were watching for dominant developmental delays.

When Arianna was meeting her milestones closer to the end of the "normal" range, Skyler always was weeks behind her. They both received Infants and Toddler Services. It was during the toddler years of age 3-5 when Skyler was diagnosed with Global Developmental Delay, ADHD, and PICA.

This began Skyler's special services. He continued to receive special services at age 3 when he entered USD231 and the Early Childhood Disabilities/Special Education classroom. He also attended Head Start which placed him in two half-day programs two weeks after turning 3.

Skyler exhibited behavioral challenges as soon as he started preschool. These challenges followed him through Kindergarten and First Grade. One day in first Grade, Skyler decided to walk home and was caught by a teacher before reaching I-35. Behaviors continued in school and a Positive Behavior Support Plan was created and

put in place. Positive behavioral supports and effective educational practices should be in place throughout the educational program and across all settings (Positive Behavior Supports and Behavioral Interventions, 2008). By the time he was in Second Grade, a new principal was in charge of his elementary school and is a firm believer of Zero Tolerance.

As intervention procedures are considered and selected by IEP teams, careful consideration of **several factors** will help the team **to make appropriate decisions about behavioral intervention procedures:**

1. The first consideration is the **appropriateness of interventions.** The team should evaluate which strategies to select based on the student's developmental level, motor ability, communication mode, and other factors relevant to the student and the disability.
2. Second, **preliminary strategies for positive behavioral supports and effective educational practices should be in place** prior to and during the consideration and use of individual interventions.
3. Third, an **FBA** will assist the team in selecting interventions to be considered for a particular student and a particular behavior. Interventions should target the primary function of the behavior and when appropriate, the teaching of socially appropriate and acceptable replacement behaviors.
4. Finally, the use of **intrusive interventions may be selected** by the IEP team in specific individual cases **where severe behavior threatens the safety of self or others** (Positive Behavior Supports and Behavioral Interventions, 2008).

With a brand new team and new principal, Skyler's IEP team met the day before school started to discuss Positive Behavior Supports and the importance of being

consistent with his IEP. It was day six of Second Grade when I received a phone call from Skyler's school to come in and "deal with his behaviors". A BIP was in place with documented steps to take if or when Skyler's behaviors escalated. This first phone call, Skyler was having a "tantrum" in the office and was causing a disruption. I went to the school and showed Skyler's Inter-related Resource teacher, paraprofessional assigned to him at this time, and the principal on how we deal with Skyler's escalated behaviors at home. He calmed down for me and returned to class.

Two weeks, another phone call was received. Skyler decided to have a "tantrum" between two doorways. This time an Autism Specialist and his IR teacher would not allow me the necessary time to calm him down before taking matters into their own hands. Since this episode occurred at the end of the school day, these two professionals wanted to leave school for the day. Shocked at what I was witnessing and their approach to Skyler's behaviors after meeting and discussing techniques that work, Skyler was physically carried to our car by the two school personnel. This type of situation occurred one more time again within one week later. Again, he was physically carried to our car.

"Physical restraint" means bodily force used to substantially limit a person's movement. A school employee *may* use physical restraint on a child with a disability only if the child's behavior presents an imminent risk of harm to self or others. "Imminent risk of harm" means an immediate and impending threat of a person causing substantial physical injury to self or others. **Restraint should be used only if a student presents a danger of imminent risk of harm to self or others and *only* as a last resort to protect the safety of all involved.** (Physical Restraint/Mechanical Restraint-Use and Restrictions, 2008).

Over the next several months, many meetings took place with me and the school principal on how to best work with Skyler. I also provided additional training techniques that have the best effect on Skyler when his behaviors escalate. I met several times with the principal one-on-one discussing our family dynamics, who Skyler likes to work with in the school, and Positive Behavior Supports.

If the student is agitated or upset, it may prove helpful to teach the student to use a relaxation area, such as a corner with a mat or pillows. Although it will be necessary to teach the student to use such an area, it may prove helpful as an additional coping strategy if consistently used. When the student is aware of appropriate options for escape and appropriate accommodations are in place to allow the student to be successful in school situations and work tasks, the student can be taught strategies to deal with difficult circumstances and encouraged to face more difficult situations rather than choosing to escape (Teaching Coping Skills, 2008). Use the end of the class to comment on positive achievement of all class members. Allow students to comment on good things they saw others doing. Build a classroom spirit around following classroom rules. Use stickers, praise, applause, additional playtime, or edibles as appropriate to reinforce and encourage class-wide positive behavior (Focus on Whole Class Positive Behavior, 2008).

On April 10, 2010, I received a phone call at 9:12am from Skyler's principal. I had to come to the school and bring him home immediately. He was suspended. When I arrived at the school, I noticed the paraprofessional that I knew did not well with Skyler was in the office as well as the principal. The principal told me to take Skyler home and he could not return to school until I met with her to discuss his behaviors.

I received a Daily Data Sheet on what transpired once Skyler stepped foot into the school building at 8:00am. It did not make sense for many reasons. Why was Skyler working with a para that we know does not work well with him? Why, when his behaviors started to escalate was he brought into an open classroom when he has a history of destroying them? Why was he not taken to a "Safe Place" to calm down? And, why was his BIP not followed? An out-of-school suspension paper was given to me before I could ask any of these questions. It was presented, "either you take this paper or I will mail it to you". I was pissed!

As soon as possible after use of the seclusion room or physical restraint, the school employee who used the seclusion room or physical restraint, or an employee who witnessed its use, should document the use of the seclusion room or the physical restraint. This documentation should be completed not later than the school day following the day on which the seclusion room or physical restraint is used, and a copy of the documentation provided to the parent of the child when the documentation is completed (Guideline 5(2). Seclusion Rooms and Physical Restraints, 2008).

Upon leaving the school with Skyler, I dropped him off at home to be with my husband while I tried to figure out what was going on. He is on an IEP and a BIP, so why did he get suspended? I met with the Director of Special Education at our district office who I have known on a personal basis for over 10 years. He stated that he spoke with the principal and backs her on her decision. My question was "why"? Why was my child singled out and suspended? The child is only 7!

Skyler was home for two days crying because he could not be at school and learn. He became more depressed when he saw his twin sister leave for school ad he had to stay behind. He cried all the time at home.

When I met with the principal, she admitted that she reacted to Skyler's behaviors instead of being proactive. An admission, yet I could never get it documented on paper. I still am unable to get this suspension rescinded and off his permanent record.

Since suspension, Skyler has been put in a Seclusion Room or I call the "Padded Room". Skyler calls it the "Blue Room" as it is padded in blue. This room was shown to me at the beginning of the school year and I knew of one occasion that it was used. One! Skyler stated to me several times, the he was placed in the "Blue Room" a few times and the door was completely shut on him. To be an effective behavioral intervention strategy, **seclusion should be used only after the IEP team has carefully considered a continuum of behavior intervention strategies and detailed its use in the IEP or BIP** (Seclusion Rooms-Use and Restrictions, 2008). Upon reviewing this information with the school, they, the school stated the door was partially open where a staff member could keep an eye on Skyler when he was in this particular room. We do not have documentation that this information received is correct.

"We need to do everything we can to protect schoolchildren from abusive, torturous, and — in some cases — deadly uses of seclusion and restraint and to stop these horrific abuses from going unchecked. (Education Secretary Asks for Seclusion, Restraint Policies, 2009),"

Since Positive Behavior Supports were presented to the school and taught to appropriate personnel, this "Blue Room" became their resource when Skyler's behaviors escalated. Proactive and preventative behavioral interventions should be initiated and on-going to diffuse disruptive and volatile situations. When students are provided appropriate supports, the potential for misbehavior is minimized (Seclusion Rooms-Use and Restrictions, 2008). The school chose to deal with Skyler's behaviors their own way and not the best way for Skyler.

Even though his school believes elsewise, Skyler's behaviors have never been to the degree that presents imminent harm to him or others. Screaming at the top of his voice, does not present imminent danger to any students even if they are taking State assessments. Seclusion is also appropriate for use when the student's behavior presents an imminent risk of harm in order to diffuse the situation, protect all involved and regain a safe, controlled, productive learning environment. "Imminent risk of harm" is defined as an immediate and impending threat of a person causing substantial physical injury to self or others. Violent action that is destructive of property may involve a substantial risk of injury to a person (Seclusion Rooms-Use and Restrictions, 2008).

With Skyler's disabilities the way they are, he became fearful of the dark and started having nightmares. The more he was placed in this room, his fears escalated to the point where it has become a phobia and he is deathly afraid of the dark, cannot go to the bathroom by himself, and has to have someone with him when he leaves a room. A **behavior intervention strategy** is one that is planned to support an individual through a targeted behavior change – not to punish the individual until they comply (Seclusion Rooms-Use and Restrictions, 2008).

Our fears became a reality. Skyler cannot appropriately function on appropriate coping skills because of these continual seclusions. He has had five toileting "accidents" at home and seven "accidents" at school since the first time he was placed in the "Seclusion Room". He states, "I do not have accidents" when my husband and I know he does and the reason behind these accidents. Skyler now HATES going to school!

With the Speech delays, social skills delays, and behaviors Skyler's has exhibited over the years, I knew there were more than Global Developmental Delays going on with him. I requested a Functional Behavior Assessment to be completed on Skyler when we met for his IEP 10 days after his out-of-school suspension. The school IEP team laughed at this request.

When the IEP team met the day before school started this school year, I came in with a plan. After his suspension, I contacted Families Together who referred me to the Disability Rights Council for legal representation. Over the summer months, a DRC attorney and I discussed Skyler in depth regarding the suspension as well as seclusion and restraints that were being used on Skyler without our knowledge.

The day before Third Grade started, I requested and demanded a Functional Behavior Analysis be done on Skyler before accepting his IEP and BIP as they were written and presented to us from his elementary school. What lacked in this FBA was the verification of data analysis. During this stage the IEP team should take time to verify that the expected behavior change is a socially valid one. Will this behavior change, improve or add to the quality of the student's life? The team should also verify that all data collected are reliable (Functional Assessment Process Flowchart, 2008).

Skyler has two targeted Case Managers on his IEP team; one transitioning in and one transitioning out. Both of these Case Managers know how to analyze FBA data and produce correct functions of behaviors. Skyler's elementary school did not allow either of these Case Managers to analyze FBA data with them and, therefore, his behavior functions are that in which his school wants us to believe are true and factual where they are not. IEP team members brainstorm possible interventions tied to the confirmed function of the behavior. At this point the IEP team is encouraged to be open and creative in brainstorming possible interventions being sure to consider a continuum of resources and options available to the student and team (Functional Assessment Process Flowchart, 2008).

Our "plan" for Third Grade was to enter this school year educated and educate the school with everything we possibly can about Skyler's disabilities. Under no circumstances were we going to let Skyler's school belittle us as parents/guardians and do discipline "the school way" Teams should strive to develop behavior intervention strategies that can be implemented across school and home environments and can be monitored for their effectiveness by school personnel and parents (Behavior Support Plans and Behavioral Interventions, 2008).

The principal does not acknowledge me any time I visit my children in the school even though I always make eye contact with her. The principal closes and locks classroom doors on me so I cannot enter my child's classroom without their teacher being present. The principal has spoken with the entire school staff and most of the teachers do not accept me as being a positive influence in my children's own

elementary school. Why? This is because, "I am a distraction" as the principal stated to me in a meeting.

I should be able to observe my child any time during his/her school day to watch and learn what strategies work and do not work for my child with a disability. I am watching for cues that Skyler presents and what procedures his teachers use when he tried to communicate his wants and needs in the general education classroom. Active listening involves listening to the student's comments, observing his or her behavior when upset, and letting the student know you are aware that he or she is having a difficult time. Providing opportunities for student success and choice-making while avoiding dramatic reactions to behavior is more likely to maximize a student's ability and willingness to calm and redirect his/her behavior. (Active Listening and De-Escalating techniques, 2008).

Seclusion and restraints in our children's school must end! With introducing Positive Behavior Supports and Interventions and using these every day throughout school environment, every child, no matter if they have a disability or not will love going to school. We must encourage ALL school to be positive and use Positive Behavior Supports to all our children all the time!

REFERENCES

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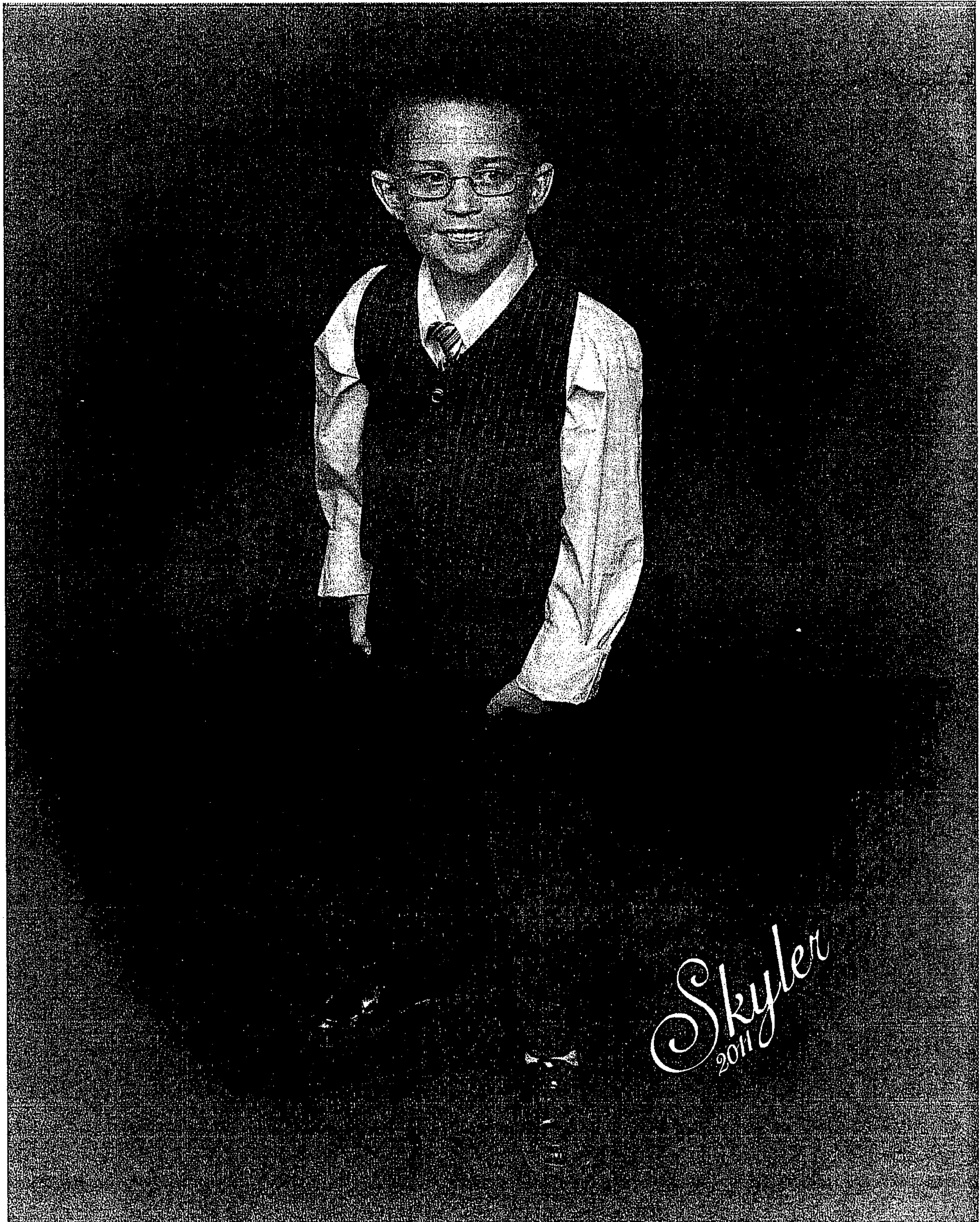
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