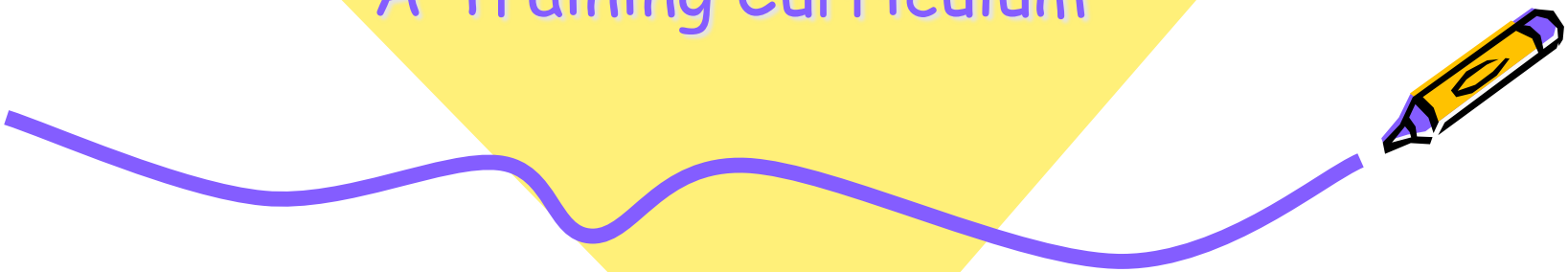
Shouldn't School Be Safe?

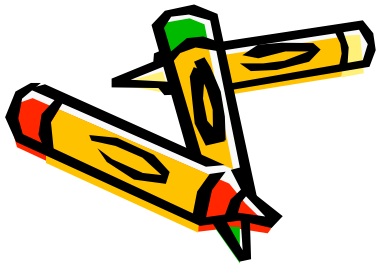
A Training Curriculum



OVERVIEW

The Restraint and Seclusion of School Children

- What are the issues?
- What is happening in schools?
- How can we take a Positive Approach?



What are they?

- RESTRAINT - forced bodily restriction or immobilization (physical/manual, mechanical, chemical) contingent on a certain behavior
- SECLUSION - forced isolation in a place from which the person cannot readily exit
- AVERSIVES - deliberate infliction of physical and/or emotional pain for the purpose of changing or suppressing behavior; restraint and seclusion are generally considered to be types of aversives

Restraint & Seclusion as **Aversives**

Strictly defined, "physical punishment consists of infliction of pain on the human body, as well as painful confinement of a person as a penalty for an offense."

Hyman, I. A. (1995). Corporal punishment, psychological maltreatment, violence, and punitiveness in America. Research, advocacy, and public policy. *Applied & Preventive Psychology, 4*, 113-130.
Hyman, I. A. (1996). Corporal punishment. In T. Fagan, & P. Wardon (Eds.), *Historical Encyclopedia of School Psychology* (pp. 92-93). Westport, CT: Greenwood.

The involuntary overpowering, isolation, application and maintenance of a person in restraints is an aversive event from both the standpoint of logic and from that of the victim.

Miller, D. E. (1986). The management of misbehavior by seclusion. *Residential Treatment for Children and Youth,* 4, 63-73.
Mohr W. K., & Anderson, J. A. (2001). Faulty assumptions associated with the use of restraints with children. *Journal of Child and Adolescent Psychiatric Nursing, 14*, 141-151.

What are the issues surrounding the use of ARS?

- **Ethics** of employing high-risk methods of physical management
- **Efficacy** (evidence base) justifying therapeutic, educational, or safety use
- **Human rights, civil rights**, and legal implications

Rationales for using ARS

- Safety
- Treatment
- Education/Training
- Punishment/Retribution
  - sometimes considered a form of "Education/Training"

About "safety"…

- In rare cases, brief restraint may be called for in an extreme emergency to prevent serious, immediate harm to a person (not to property)
- Permission not required in a legitimate emergency
  - a person who CAN intervene to save another without unreasonable danger to self is obligated to do so
- Is seclusion a legitimate emergency response?
  - lends itself to longer use than necessary
  - usually combined with restraint to get child to seclusion room
- Other aversives not considered a legitimate response to an emergency

Do restraint and seclusion promote student safety?

The evidence base

Effects of RS: injuries and deaths

- RS-related deaths may be 1-3 per week
- Causes of death reported as asphyxia, cardiac complications, drug overdoses and interactions, blunt trauma, strangulation or choking, aspiration, neglect
- Injuries reported as coma, broken bones, bruises, cuts requiring stitches, facial damage
- Consensus in health care and MH field: RS never "safe"
  - Nursing homes
  - Medical facilities
  - Mental health facilities and programs

Do aversives, restraint and seclusion have value as treatment?

The evidence base

- Coercive techniques mask the underlying medical, emotional, or social cause of a behavior, which goes unresolved and can worsen.
- "Attachment therapy" to the contrary, restraint and seclusion do NOT restore calm or emotional stability.
- *"Restraints (are) an intervention in search of a research foundation."*

- - Kennedy, S. S., & Mohr, W. K. (2001). A prolegomenon on restraint of children: Implicating constitutional rights. *American Journal of Orthopsychiatry, 77*(1), 26-37.

Cortisol!

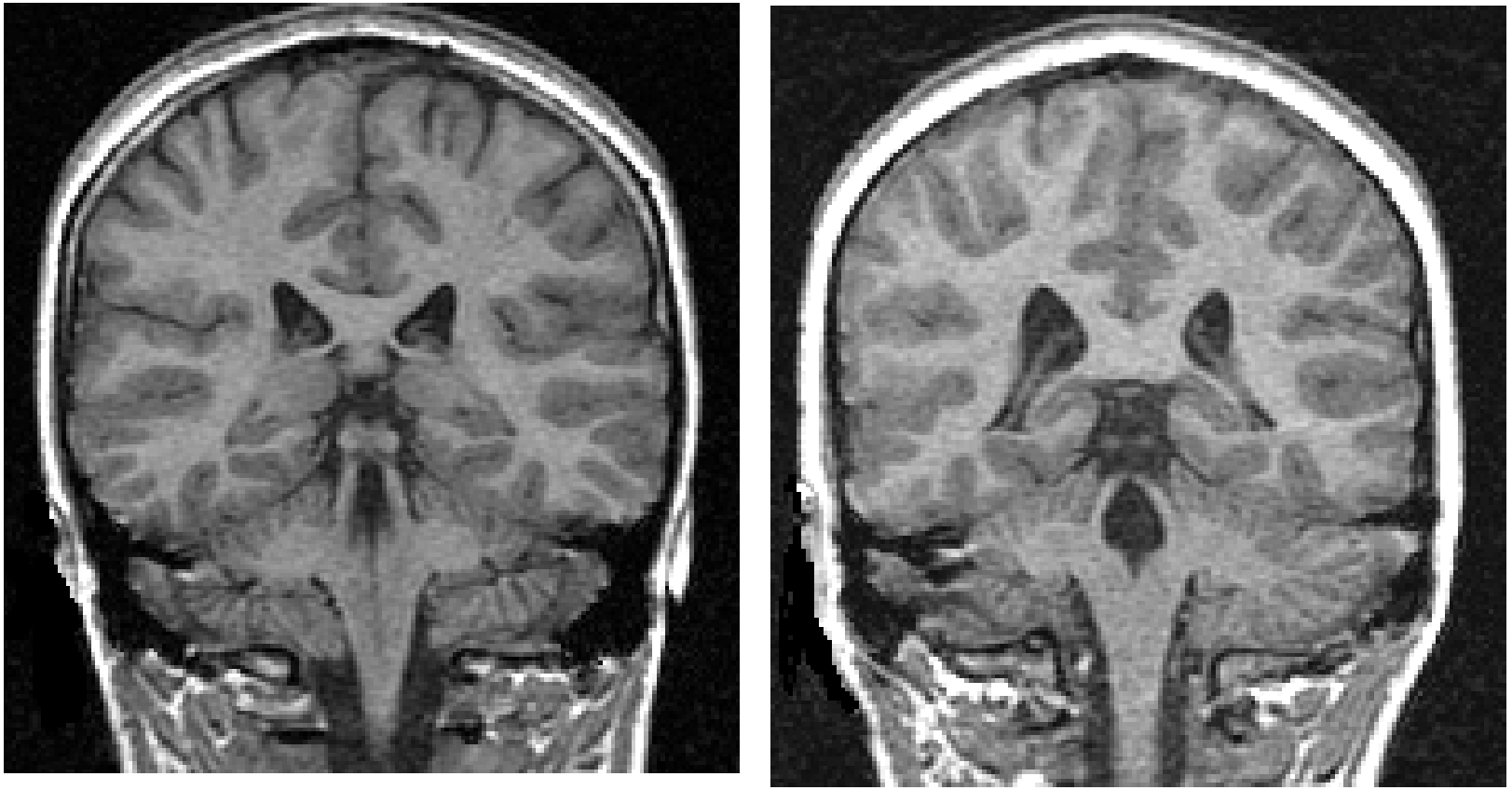
- The body's primary stress hormone
- Released by adrenal glands into the blood
- Helps the body regulate blood sugar levels and blood pressure in response to danger
- Anti-inflammatory, anti-allergic agent, and suppresses the actions of the immune system

This is your brain on cortisol

- Hypervigilance
- Difficulty taking in information
- Misinterpreting actions and intent of others
- Language impairment
- Cognitive impairment
- Loss of self-control and executive function
- Rigidity of thought and action
- Distrust and anger

- *A prolegomenon on restraint of children: implicating constitutional rights*, by Sheila Kennedy and Wanda Mohr Online: http://sheilakennedy.net/2001/04/a-prolegomenon-on-restraint-of-children-implicating-constitutional-rights/

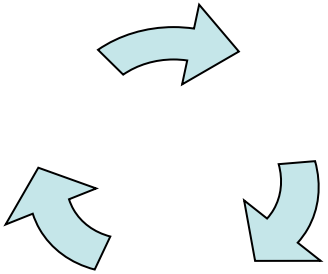
Lateral Ventricles Measures in an 11 Year Old Maltreated Male with Chronic PTSD, Compared with a Healthy, Non-Maltreated Matched Control



(De Bellis et al, 1999)

These trauma responses can be misinterpreted as:

- Symptoms of the person's original disability
- Worsening of the person's original disability
- "Bad behavior"; willful noncompliance



The result is a vicious cycle of dependence on high-risk interventions.

Do aversives, restraint and seclusion have value as education or training methods?

Coercive interventions undermine positive approaches:

- Effects generalize to unwanted domains
- Teach "might makes right"
- Teach vulnerable people to submit to being grabbed and held, creating easy victims for sexual assault
- Destroy trusting relationships
- Cannot teach desirable, self-directed behavior for long-term use in typical settings

Generalization

- A child subjected to ARS may come to fear and avoid not only the "target behavior" but
  - the classroom itself
  - the teacher
  - the school
  - the learning process in general
  - common places and items that have been used inappropriately, e.g. bathrooms, closets, mats, belts, squirt or spray bottles
- Some students become "homebound"
- Some are placed in increasingly restrictive environments

Users of these control techniques may also change in undesirable ways:

- Values
- Attitudes
- Expectations
- Views about others

What's happening in our schools?

Recent data

Testimony
Before the Committee on Education and Labor,
House of Representatives: May 2009

GAO: **United States Government Accountability Office**

SECLUSIONS AND RESTRAINTS

Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers

Why this report?

- Requested by Committee on Education and Labor, House of Representatives
- GAO asked to (1) provide an overview of seclusions and restraint laws applicable to schools, (2) verify whether allegations of student death and abuse from RS are widespread, and (3) examine facts and circumstances in cases where a student died or suffered abuse from RS

What the GAO Found

- No federal laws restricting the use of seclusion and restraints in public and private schools
- Widely divergent laws at the state level
- Hundreds of cases of alleged abuse and death related to the use of these methods on school children during the past two decades
- No single Web site, federal agency, or other entity that collects information on the use of these methods or the extent of alleged abuse

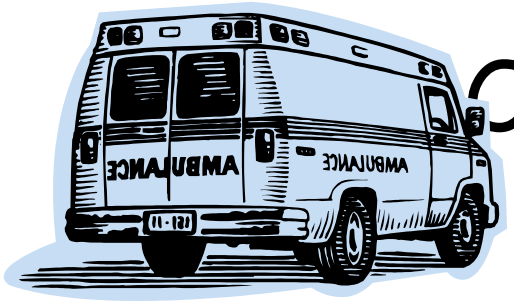
GAO examined 10 restraint and seclusion cases in which there was a criminal conviction, a finding of civil or administrative liability, or a large financial settlement.
These "COMMON THEMES" emerged:

- They involved children with disabilities who were restrained and secluded, often in cases where:
  - they were not physically aggressive, and
  - their parents did not give consent

- Restraints that block air to the lungs can be deadly
- Teachers and staff in the cases were often not trained on the use of seclusions and restraints
- Teachers and staff from at least 5 of the 10 cases continue to be employed as educators

Most frequent targets:

- Although the GAO did not limit the investigation to incidents involving children with disabilities, most of the hundreds of allegations reviewed involved children with disabilities
- 9 of the 10 closed cases involved children with disabilities or a history of "troubled behavior," in particular:
  - autism
  - post traumatic stress disorder (PTSD)
  - attention deficit hyperactivity disorder (ADHD)



GAO also cited findings from 2 related reports:

- Children are subjected to restraint or seclusion at higher rates than adults and are at greater risk of injury
- Even if no physical injury is sustained, individuals can be severely traumatized during restraint
  - *GAO, Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth*, GAO-08-146T (Washington, D.C.: Oct. 10, 2007) and *Residential Programs: Selected Cases of Death, Abuse, and Deceptive Marketing*, GAO-08-713T (Washington, D.C.: Apr. 24, 2008).

Are coercive techniques ever beneficial?

- AVERSIVES
- RESTRAINT
- SECLUSION

Unsafe in the Schoolhouse: May 2009 survey results

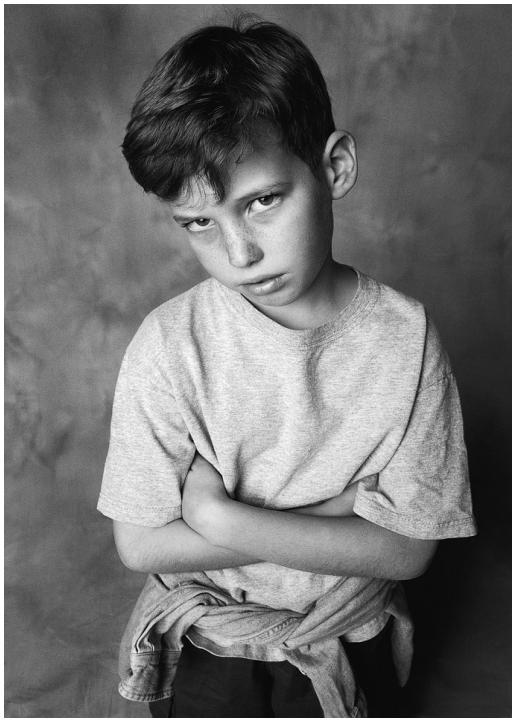
- The Council of Parent Attorneys and Advocates (COPAA) collected reports from parents and advocates about incidents in which children with disabilities were subjected to restraints, seclusion, and the use of aversives.

- Initial report on 188 incidents shows the use of restraints, seclusion, and aversives is extensive, and the consequences immense.

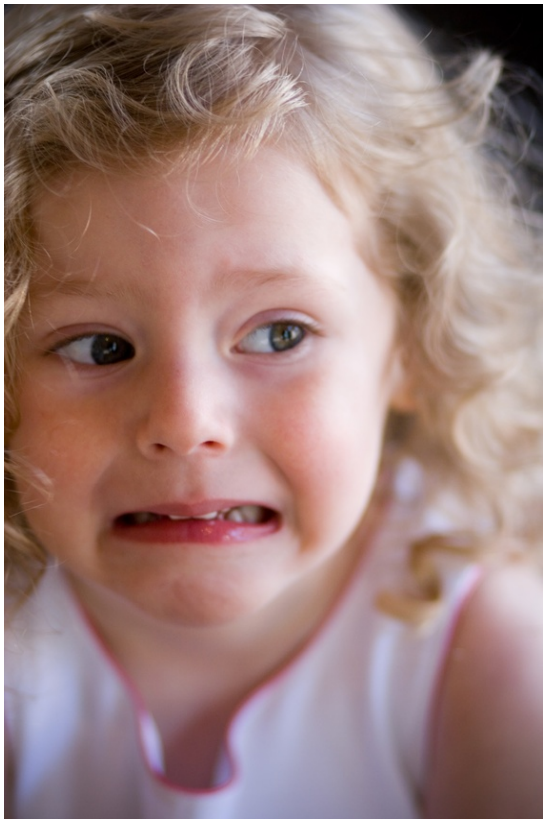
***Unsafe in the Schoolhouse* www.copaa.org**

COPAA: effects on the child

- It is the child who gets the blame.
- May develop new behaviors *(aggression, stereotypical behavior, running away, ripping clothes, self-injury, or tics)*
- Afraid of school
- Afraid of touch
- Terrified of new people who enter their lives because they are afraid of the unknown
- Stripped of their dignity and the essence of who they are or might have been (*71% were children 3-10 years old)*



Effects on other individuals in the classroom or witnessing



- Guilty for not being able to do something to help or protect
- Confused about why a child is subject to abusive treatment

Parents lose jobs or experience economic effects

- Required to pick up child or be in school
- Home schooling
- Must pay for private schooling

"It's a crime I to this day feel I need to observe at least 3-4 times per week, meetings, endless IEPs -- writing letters, you name it, I've done it – including litigation. All for? -- To keep my son safe and educated. Something which most parents take for granted."

Effects on schools and administration

- Retaliation
- Lack of trust
  - parents vs. school
  - school vs. parents and students
    - suspect each other of lying
    - suspect each other of exaggerating
    - students tagged with "severe reputations"
- Relationships irrefutably harmed

- *"Consider living in fear every day of your life because you have to send your child to school."*
- *"The school staff had me convinced for a while that my son would learn in the 'safe room' (closet!) to better anticipate the consequences of his actions.*
- *"What happened to my daughter has brutally and needlessly devastated her life and our family."*
- *"Every breath of air we have, as parents entering this system for the first time, is contingent on not seeing our principal roll her eyes at our son or other children with disabilities in the school or giving us messages, such as when she suspended our son, that we're just not giving him enough consequences."*

Consent and parent involvement

- 71% percent of the parents consented to ARS use
- Of those who indicated that they did consent, many reported that they believed the interventions would only be used under very limited conditions
- COPAA: "Parental consent is not a justification to use abusive measures on a child. But the absence of parental consent tends to show that districts acted unilaterally, ignoring the informed consent requirements in the Individuals with Disabilities Education Act (IDEA). They also ignored the legal requirement that parents as members of the IEP team should fully participate in making decisions about their children's needs and programming."

APRAIS SURVEY

- In 2009, the Alliance to Prevent Restraint, Aversive Interventions and Seclusion conducted a study on the *Use of Restraint, Seclusion, and Aversive Procedures with Students with Disabilities* (APRAIS, 2011); 1,300 parents responded over 2 weeks.

Findings…

In almost all cases (92.9%), the respondents said the treatments resulted in emotional trauma.

To a lesser extent, although still very troubling, the incidents often resulted in physical injury to the child (42.2%) or in obvious signs of pain (33.5%).

If the intent was to calm or reduce inappropriate behavior, quite often an opposite effect occurred with an increase in emotionally-induced challenging behavior such as self-injury, stereotypy, and running away.

Systemic strategies for RS prevention: Education System

- Positive Behavior Supports

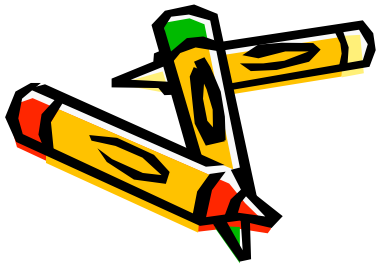
  - Behavior that challenges us seen as symptoms of a problem, not the problem itself
  - Behavior as communication
  - Self-determination and meaningful outcomes
  - Inclusive community settings

Systemic strategies for RS prevention: Mental Health System

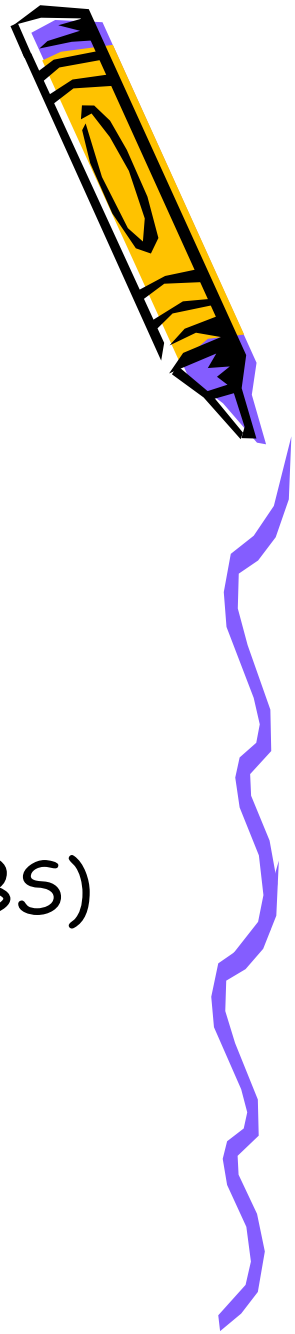
- Trauma-informed care
  - programs, and services based on an understanding of the vulnerabilities and triggers of people who have been marginalized and mistreated
- 6 core strategies
  1. Leadership toward organization change
  2. Use of data to inform practice
  3. Full inclusion of consumers and families
  4. Rigorous debriefing (incident review)
  5. Workforce development
  6. Use of seclusion and restraint prevention tools

ADVOCATING IN THE SCHOOLS:
child by child

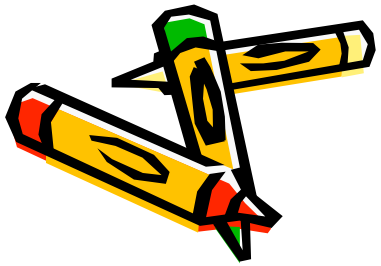
- Prevention
- Vigilance
- Response



PREVENTION



- IEP and BIP
  - Definition
  - Legal status
- Content
  - Positive Behavior Support (PBS)
  - Evidence-based practices
  - NO permission for ARS



Do RS belong in IEPs?

The case against:

- What's wrong with "planned use"
  - Legal considerations
  - Impact on "school culture"

Beware placement of RS in IEPs, 504 plans and behavior plans!

- Conflicts with evidence from MH system that "Restraint is not treatment; restraint is the failure of treatment." How can you "plan" to fail repeatedly?
- Staff may feel that "planned" restraint = "condoned" restraint.
- Leads to belief that child, not system, is having emergencies

Plan failure or "plan followed"?

- You can't say RS are "for emergency use only" AND put them in the IEP. IEPs only work if they are positive plans of action. If they fail so badly that a restraint emergency occurs, everyone needs to be clear that they went outside the plan, the plan failed, and the plan must be fixed.
- Once restraint or seclusion is IN the plan, each use means we FOLLOWED the plan, the CHILD failed, and the CHILD must be fixed by our continued ADHERENCE to the restraint and seclusion plan.

- We cannot make ongoing plan failure an acceptable part of the plan!

Plan failure or "plan followed"?
Consequences for data collection

- When RS regulated as emergency interventions, data shows characteristics of schools and districts: which ones are failing students and need help
- When RS regulated as "planned" educational and therapeutic interventions for "dangerous" students, data will focus on characteristics of these students, not of the schools they attend:
  - negative image of students
  - rationale for segregation

IDEA

- Does not specifically allow OR forbid restraint and seclusion
- Presumption in favor of positive behavior support
- Requires evidence-based practices

Time to stop planning to fail and failing to plan!

- RS in IEPs and BIPs has failed for over 35 years. *Why would it work now?*
- But the idea/ideal of deferring to the IEP remains attractive to legislators and policymakers

For "planned" use, informed consent is needed

- In practice, consent is seldom well informed.
- In schools and programs, parents often report that their consent was coerced.

Many parents report:

- Confusion over what is being requested (e.g. "restrictive procedures")
- Lack of discussion of dangers, or of positive alternatives
- Intimidation and coercion (e.g. loss of program)
- Being told that SR must be in IEP for student safety

Is it informed?

- Is the individual, parent or guardian informed of the actual nature of the procedure?
- Are unclear terms like "restrictive procedure" used instead?
- Are risks (trauma, injury, death) discussed?
- Is receipt of services, entry into a program, or placement retention contingent on consent?
- Are positive alternatives fully discussed?

What's in that IEP?

Other names used for RESTRAINT:

- Restrictive procedure
- Restriction of movement
- Limiting movement
- Holds/holding
- Therapeutic holding
- Positioning/postural support
- Pinning
- Patterning
- Containment
- Hands on
- Take down
- Physical support
- Physical intervention
- Physical escort
- Intrusive procedure
- ???

Other names used for SECLUSION:

- Isolation
- Confinement
- Safe room
- Isolation room
- Calming room
- Time out
- Time in
- Time away
- Time alone
- Seclusion time out
- Exclusion
- Separation
- Quiet time
- Break time
- Planned ignoring
- ???

Parental disadvantages

- Don't know dangers, don't know medical background of RS
- Insufficient knowledge of best practices

- NO other children's service system prepares parents for this flaw in special ed: in children's mental health and other health care settings there is no controlling document equivalent to an IEP in which it is lawful to specify or approve the planned use of restraint or seclusion.

What do federal education laws and regulations say?

- IDEA '97 created a presumption in favor of "positive behavioral interventions, strategies and supports"
- When problems arise, a Functional Behavioral Assessment (FBA) is required. The FBA should lead to positive behavioral interventions and supports.
- Under IDEA and No Child Left Behind, practices used by schools must be "evidence based."

May aversives, restraint and seclusion be used as punishment or retribution?

- Federal education law prohibits punishing a child for a manifestation of his/her disability
- Virtually all existing state statutes and regulations also prohibit this use

Corporal Punishment as Aversive

- "Corporal punishment" in public and private schools banned by statute in 29 states.
- *"The American Academy of Pediatrics believes that corporal punishment may affect adversely a student's self-image and school achievement and that it may contribute to disruptive and violent student behavior."* AAP position statement (2000) calls for ban in schools.
- Term "aversives" seldom used in MH system; "punishment" equated with criminalization of mental illness (removal from treatment system to juvenile justice system)

- The 19 states where corporal punishment in schools is currently legal are:

  Alabama, Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Wyoming

Local level protections

- School-wide safety plan
- School district policy
  - Ask for copies!
  - Is there a planning committee you can talk with or join?

Your IEP rights

- IEP written at meeting, not in advance
- Student may attend
- Clarity of language
- When and if to sign: parents have options
- Bringing support person
- Taping, transcription, notes

The IEP is KEY!

- A LEGAL CONTRACT between school and family, required by federal statute
- Must be reviewed and renewed at least annually
- Certain school personnel must attend
- Some students have Section 504 Plan, an "access" plan giving fewer rights

Parent advice

- Meet as a family before the IEP. Include important people from your child's life outside of school, and share observations and ideas for his/her education.
- Get it on paper! The school district will present a "draft IEP." So can the family.
- Consider whether your IEP input would be accepted more readily if it were presented at the meeting by a "credentialed" person (e.g. OT, SLP, MD) who works with your child.

Parents are often worried to see numerous school personnel at the IEP. They fear being "outvoted."

But each IEP gets only 2 votes:

1. **The school's**

2. **The family's**

Due Process

- Required if parents object to SD decision to place RS into an IEP, or to rescind permission for RS use
- Must obtain attorney who knows education law
- Current law places burden of proof on parents to challenge expertise of school district staff
- Parents must hire "expert witnesses" to testify on child's behalf; fees not reimbursable even if case is won

Non-IDEA Court Claims

- In deciding whether school personnel can be held liable for injuring children, courts place great emphasis on the fact that plans approved by parents authorized the techniques.

The legal standard

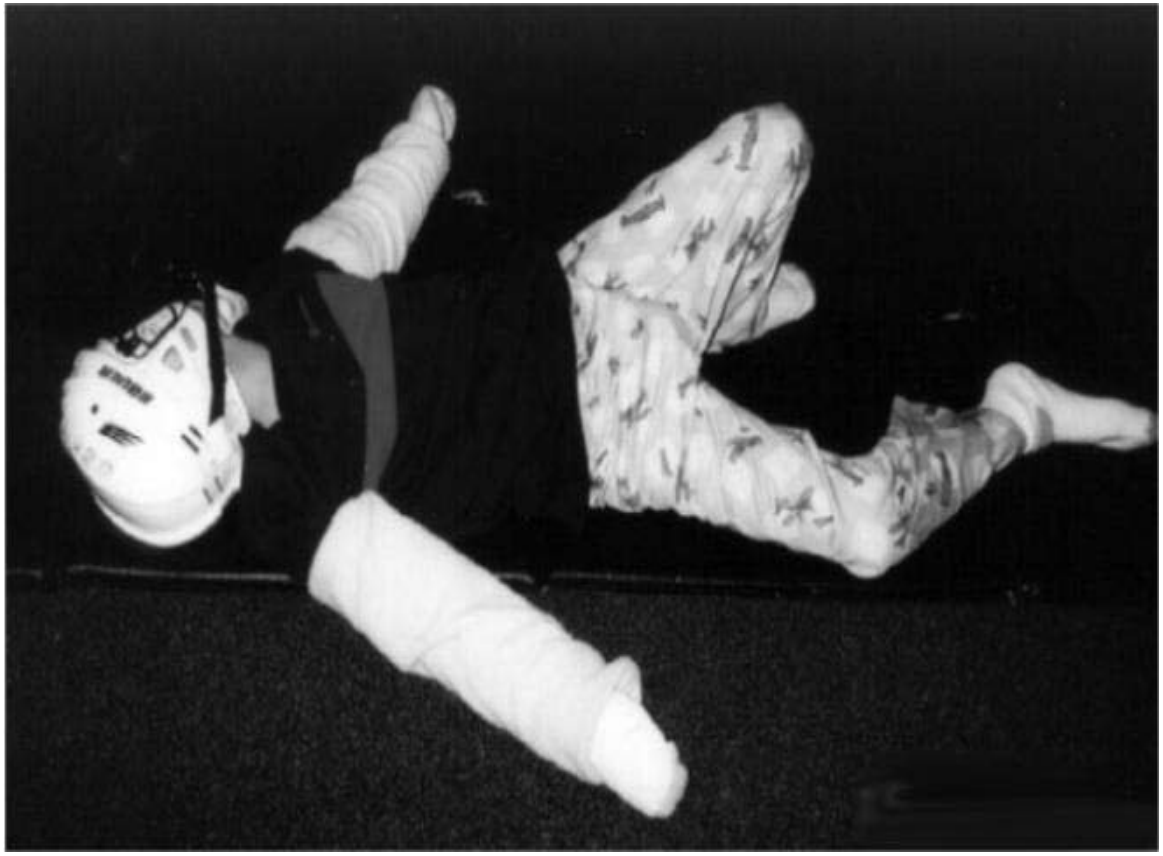
- An authorized professional's treatment of a person with disabilities within the state's care is reasonable if his or her actions are *"not a substantial departure from accepted professional judgment, practice, or standards."* *(Youngberg v. Romeo, 1982)*
- An IEP authorizing the use of RS is generally agreed to set the standard for accepted practice.

Administrative exhaustion

- Administrative exhaustion requirements of IDEA make direct parental appeals to the court system likely to be dismissed

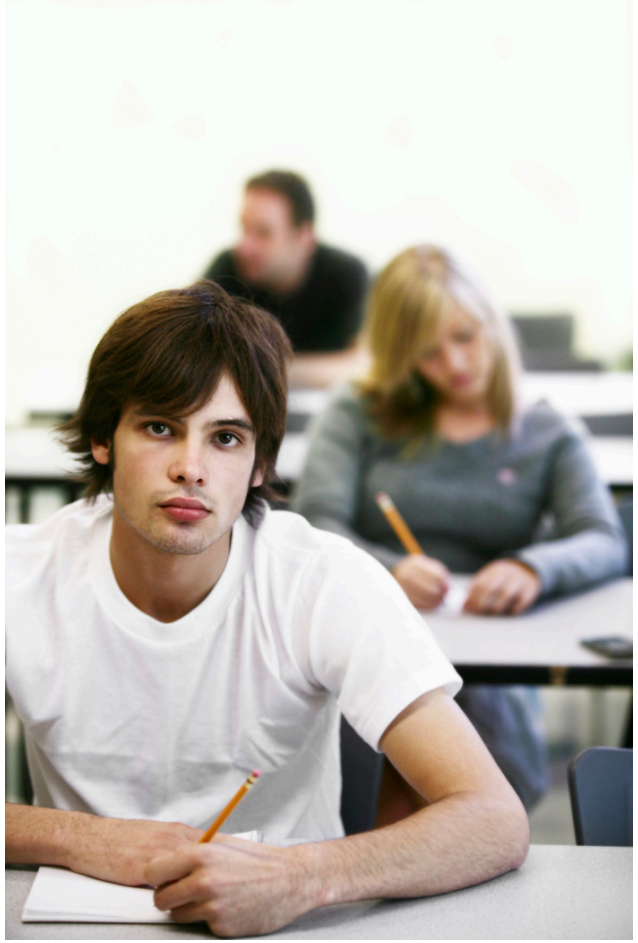
- E.g. recent case involving special ed teacher in PA:
  - allegedly hit, pinched, dragged, and restrained students with autism in Rifton chairs with bungee cords and/or duct tape
  - district court originally did not require exhaustion, but later court ruling held exhaustion required despite abuse allegations

Children have died before administrative exhaustion reached



5 KEY LEGAL ARGUMENTS
against putting RS in an IEP

1. Presumption in favor of positive interventions



Since 1997, the Individuals with Disabilities Education Act (IDEA) has created a presumption in favor of positive behavioral interventions. Congress gave that approach most favored intervention status:

"In the case of a child whose behavior impedes his or her learning or that of others," the IEP team shall "consider, when appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior."

Creating Positive Behavior Supports (PBS)

- Proactive solutions based on communication and context
- Conducting a Functional Behavior Assessment (FBA)
- Preventing ARS

- Behavior that challenges us is a symptom of a problem, not the problem itself.
- It tells us to look closer and listen harder, because something is going wrong.
- Behavior problems are messages about someone's life.

PBS and "Social Validity"

- Developed with, not merely for, the person
- Outcomes that are *meaningful for that person*
- Goals not based on what someone else considers annoying or odd; not a "cosmetic" enterprise

View the results of over 30 years of research on Positive Behavior Supports in the schools, funded by the U.S. Department of Education:

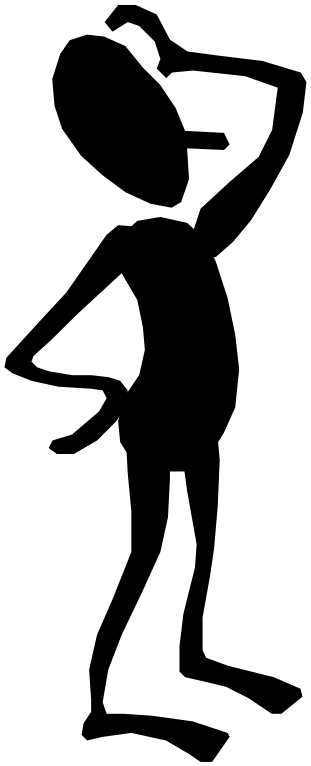
http://www.pbis.org/research/default.aspx

PBS Standards of Practice

- Define aims and content of PBS
- Define content of FBA

- http://www.apbs.org/files/apbs_standards_of_practice.pdf

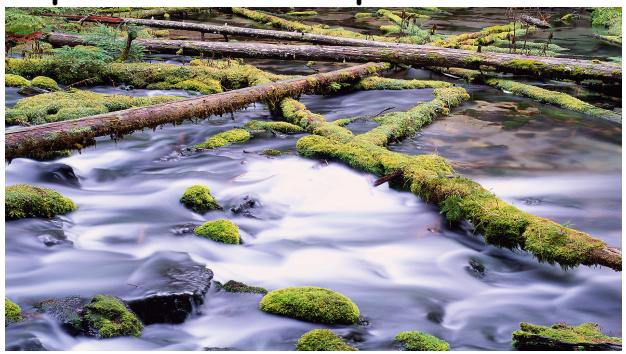
2. Requirement for an FBA



- ✓ A Functional Behavioral Assessment is the type of evaluation used to determine a child's behavior support needs.
- ✓ IDEA specifies that schools must conduct an FBA and develop a behavioral intervention plan for any student with a disability who exhibits severe behavior difficulties and/or who puts peers at risk because of these behaviors.
- ✓ FBA also required when a student with a disability is being considered for serious disciplinary action (e.g., a change in placement, suspension, or expulsion).

No legal standards for the FBA, but practitioners agree it should:

1. interview, include, and respect the person and his/her family
2. be carried out unobtrusively
3. observe a variety of times, places, and situations
4. evaluate the physical environment for stressors
5. explore the impact of things that typically occur before and after the challenging behavior
6. specify needed changes in the behavior of others
7. specify how communication is occurring, and can be improved
8. consider developmental needs and age appropriateness of the person's current situation
9. consider mental and physical health factors
10. consider whether experiences and memories from the past, e.g. of a traumatic event, may be driving responses in the present
11. explore quality of life issues
12. explore nonvolitional behaviors



What are "nonvolitional behaviors" ?

- Not intended; not under direct control
- "My body has a mind of its own."
- Includes anxiety-driven and trauma-driven behavior (basis for "trauma-informed care")

3. Requirement for evidence-based practices

IDEA (2004) requires that the IEP team's choice of special education, related and supplementary services be guided by peer-reviewed research. ESEA/NCLB requires educational programs and practices to be founded on scientifically-based research

"Show me the research":

- Lack of evidence that aversive techniques, restraint or seclusion offer a safe means of teaching desirable, self-directed behavior that a child can maintain over the long term
- Research also shows ARS offer no therapeutic value, can increase problematic behavior, decrease ability to concentrate and learn, and decrease pro-social behavior
- Safe, positive methods of changing and redirecting behavior are well documented

- Evidence-based practices are required under both the IDEA and ESEA/ NCLB.
- Wishful thinking is not enough!

4. State and local prohibitions

- PA Code
- School District policies

PA CODE: § 14.133. Positive behavior support.

- (a) Positive, rather than negative, measures must form the basis of behavior support programs to ensure that all students and eligible young children shall be free from demeaning treatment, the use of aversive techniques and the unreasonable use of restraints. Behavior support programs must include research based practices and techniques to develop and maintain skills that will enhance an individual student's or eligible young child's opportunity for learning and self-fulfillment. Behavior support programs and plans must be based on a functional assessment of behavior and utilize positive behavior techniques. When an intervention is needed to address problem behavior, the types of intervention chosen for a particular student or eligible young child shall be the least intrusive necessary. The use of restraints is considered a measure of last resort, only to be used after other less restrictive measures, including de-escalation techniques, in accord with subsection (c)(2).

PA CODE: § 14.133. Positive behavior support.

- (e) The following aversive techniques of handling behavior are considered inappropriate and may not be used by agencies in educational programs:
- (1) Corporal punishment.
- (2) Punishment for a manifestation of a student's disability.
- (3) Locked rooms, locked boxes or other structures or spaces from which the student cannot readily exit.
- (4) Noxious substances.
- (5) Deprivation of basic human rights, such as withholding meals, water or fresh air.
- (6) Suspensions constituting a pattern under § 14.143(a) (relating to disciplinary placement).
- (7) Treatment of a demeaning nature.
- (8) Electric shock.

5. Requirement that students receive FAPE*

- ARS leads to
  - Loss of time for learning
  - Absenteeism
  - Regression
  - Trauma-related effects that reduce concentration and cognition

**Free and appropriate public education*

LETTERS!

- No Restraint Letter
  - Courtesy of RespectABILITY Law Center
- Health Care Professional's Letter
  - Contraindications to use of RS
- Gebser Letter
  - Named for 1998 Supreme Court decision in *Gebser v. Lago Vista School District:* a letter notifying a school district about discrimination or bullying, paving the way for a Title IX discrimination suit

THE "PARENT REPORT"

A profile for school staff, created by you and your child

- Strengths
- Likes and dislikes; "preferred interests"
- Talents and skills
- Things you child finds challenging, frightening, or upsetting
- Triggers that escalate his or her behavior
- Safe, positive de-escalation methods
- Sensory regulation needs
- Communication strategies and needs
- Positive behavior supports
- How to interpret his/her behavior as communication (e.g. personal "dictionary")
- How to support his/her social skills
- Medical needs
- Medical conditions that contraindicate (rule out) the use of restraint and seclusion, such as asthma, obesity, certain gastrointestinal disorders, heart and pulmonary disorders, etc.
- Instructions on avoiding restraint and seclusion
- Emergency contact information
- A photo of your child

- Ask that your Parent Report be attached to the IEP
- Circulate it to all school staff who interact with your child
- Be sure to include those who may not be familiar with the IEP:
  - substitute teachers,
  - school librarian,
  - school bus driver, etc.

Assuring appropriate data collection: the ABCs

- Place in IEP: "Provide ABC data for ALL problem behavior."

- Antecedent
  - what happened first: where, with whom, under what social and environmental conditions?
  - what else was happening in the area?
- Behavior
  - a clear, nonjudgmental description of the child's actions
- Consequence
  - what happened after the display of problem behavior?
  - what was the consequence or result of the behavior?
  - what was the child's response to that consequence?

- Use the ABCs to consider:
  - Is the action an attempt to communicate (in the absence of other means)?
  - Is it unintentional (e.g. a tic, OCD, PTSD)?
- Is there a good reason for trying to change a behavior, or is it "cosmetic"?

Communication with school

- Daily diary (specify in IEP)
  - What is and isn't working in school
  - Home events that may impact behavior (e.g. parent out of town, loss of pet)
- Parent involvement and volunteering
- Visiting the classroom for observations

Don't assume your child can and will give you needed information!

- *A child may be too young to give parents information directly*
- *A child may not speak due to his/her disability*
- *A child may be embarrassed or afraid to "tell on" adults in authority*
- *A child may assume that his/her parents must already know and approve of what is being done to them*

Communicating with your child ABOUT school

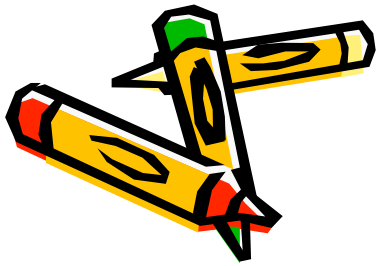
- Try concrete but indirect questions
- Use play (action figures, dolls); role play
- Observe attitudes, emotions

Building your support network

- Afterschool activities
- PTO membership
- Teacher appreciation
- Knowing your school board

VIGILANCE

- Signs of an endangered child
- Healthy vs. dangerous school situations



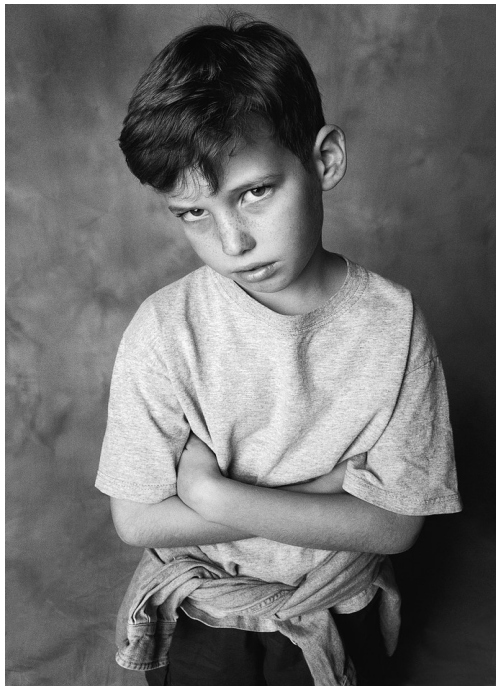
Sudden regressions in behavior or the emergence of new and unexplained behavior problems may indicate psychological distress and offer clues to their origin.

--"In the Name of Treatment," APRAIS

Repeated use of ARS can permanently alter brain development:

- Flashbacks; intrusive memories
- Hypervigilence; "fight, flight, or freeze"
- Repetitive, compulsive activity patterns
- Reduced ability to control emotions
- Permanent changes in brain
- Loss of skills
- Reduced ability to pay attention and learn

Physical signs of possible RS abuse



- Bruising or abraded, reddened skin on arms, wrists, or ankles
- Unusual injuries, such as marks from fingernails, rug burns, "handprints"
- Injuries in unusual places, e.g. hidden under clothing
- Unexpected toileting "accidents"

Emotional/psychological and behavioral signs

- Sleeplessness
- Increased anxiety levels
- Decrease in sociability
- Emergence of a school phobia (especially when the child previously enjoyed attending school) or of a more generalized fear of leaving home
- Emergence of specific fears that may be related to particular ARS (such as fear of spray bottles, seatbelts, or closets)
- Appearance or intensification of self-injury
- Sudden change in weight
- Increased aggression or emotional outbursts

"Abused children show a variety of disturbances in physiology, thinking and behavior. Many have elevated resting heart rates, temperature and blood pressure. After repeated exposures to trauma, the same systems in the brain will be reactivated when the child is merely exposed to reminders of the traumatic event."

A prolegomenon on restraint of children: implicating constitutional rights, by Sheila Kennedy and Wanda Mohr
Online:
http://sheilakennedy.net/2001/04/a-prolegomenon-on-restraint-of-children-implicating-constitutional-rights/

erpret with care and judgment

- *The warning signs of abuse may be attributable to other hidden causes, such as sexual abuse. Such activity can be very difficult to discover, but unlike ARS is illegal in all states.*
- *As with any sudden change in a child's everyday habits and ability to cope, it is important to see a doctor or other professional to rule out other possible causes.*

What *really* makes a school safe?

The overwhelming majority of teachers and aides want to work in schools that are safe, happy, and restraint and seclusion free. Whether they get that wish depends in large part on school leadership and culture. "It takes a village" to safely educate a child.

SAFE SCHOOLS:

"Program culture"

"People who are treated in 'restraint free' facilities will not be restrained... People with similar diagnoses and characteristics who are treated in facilities that seek to control behavior or expect to modify behavior through seclusion and restraint have the potential to be subjected to these interventions."

-- Elizabeth Steel, MSW (1999)

Safe Schools: many good examples of RS reform!

- Centennial School (PA)
- Grafton School (VA)

- The Economic Case

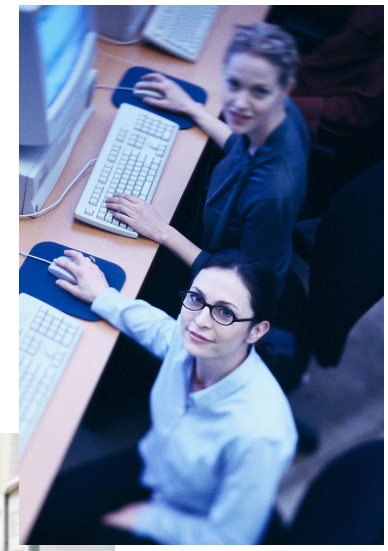
SAFE SCHOOLS:

Leadership from the top

SAFE SCHOOLS:

Serious about staff training

- Quality
- Focused and values-based



Caution…..

- Training not a panacea; by itself, cannot produce systems change
- Training can give teachers false confidence that they can safely enact procedures that are inherently unsafe

SAFE SCHOOLS:

Proactive in preventing bullying

SAFE SCHOOLS:

Inclusive

- Students begin and finish their educational careers in typical age appropriate environments.

- Students receive the necessary instructional and technical supports and services to ensure reasonable success in their learning and development.

The inclusion-bullying prevention connection:

Research shows that in inclusive settings, students <u>without</u> disabilities demonstrate

- improved self-esteem
- positive social behaviors such as kindness and gentleness
- increased collaboration, cooperation, and social competence
- new and valued social relationships
- greater tolerance and fairness

Helmstetter, E., Peck, C. A., & Giangreco, M. F. (1994). "Outcomes of interactions with peers with moderate or severe disabilities: A statewide survey of high school ...ts," in *JASH,* Vol. 19, 263-276.

Hunt, P., Staub, D., Alwell, M., & Goetz, L. (1994). "Achievement by all students within the context of cooperative learning groups," in *JASH,* Vol. 19, pp. 290-301.

Kishi, G. S., & Meyer, L. H. (1994). "What children report and remember: A six-year follow-up of the effects of social contact between peers with and without severe ...abilities, " in *JASH*, Vol. 19, pp. 277-289.

Bogdan, R., and Taylor, S.J, "Relationships with Severely Disabled People: The Social Construction of Humanness," in *Social Problems* (1989): 36,2:135-148.

ARS have longterm negative effects on systems

- "Ripple effects" don't stop with the child and family
- Negative impacts on schools and the people who run them include stress, injury, staff turnover, job dissatisfaction, lack of trust, communication breakdown

Programs that "put a restraint on restraints" report cultural changes:

- Shared vision and goals
- Emergence of trusted leadership
- Students and staff describe program as "a place we want to be" and "a place where we feel safe"
- Improved communication among staff
- Improved communication with parents and children
- Time to plan ahead rather than just react
- Less job stress among staff
- Less stress and reactivity among students
- More rewarding relationships with students/clients

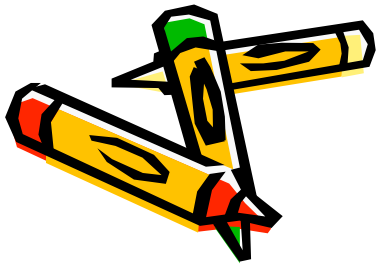
- Less "learned helplessness" and more motivation among students/clients
- More opportunity to model positive behavior and positive responses
- Less "program drift" away from mission and values
- Greater ability for staff to do the work they like – teaching, counseling, etc.
- Better use of staff time
- Ability to attract higher quality staff
- Ability to better retain staff; less turnover
- Fewer injuries among staff and students
- Fewer school days missed by students
- Fewer staff workdays missed; less sick time used
- Less use of replacement staff/substitute teachers

The research base documenting these changes in program culture includes:

- "Reducing the use of seclusion and restraint: A Michigan provider reduced its use of seclusion and restraint by 93% in one year on its child and adolescent unit," by Linda Witte. *Behavioral Healthcare*, April 2008 (online)
- "The Economic Cost of Using Restraint and the Value Added by Restraint Reduction or Elimination," by Janice LeBel, Ed.D. and Robert Goldstein, Ph.D. *Psychiatric Services* 56:1109-1114, Sept. 2005 (online)
- "Establishing and Sustaining Research-Based Practices at Centennial School: A descriptive case study of systemic change," by David C. Miller, Michael George, and Julie B. Fogt. *Psychology in the Schools*, Vol. 42(5), 2005 (online).

3. RESPONSE

- Immediate Steps
- In the next few days
- In the weeks ahead



Your child comes first

- Remain calm; try not to display panic, fear or anger.
- Establish a sense of safety and unconditional support.
- Assure your child he or she has not done something wrong.
- If your child is able to communicate about what happened, gently encourage them to do so. Don't press them if they are not ready.
- Seek support and advice from your child's psychologist or therapist.

Medical attention and documentation

- Go to pediatrician or emergency room
  - Remember: injuries may not be immediately obvious
- Document injuries or signs of trauma in medical records; take and date photos

Contacting the school

- Same day!
- Phone and fax requests
- Ask for full A-B-C account
- Ask for rationale
- Time RS began and ended?
- ID persons involved and witnessing
- Health and safety checks during and after?
- Training and certification of those involved
- Set meeting or debriefing time ASAP

Time to get information while it's fresh -- not the time to confront (or the flow will stop)

Write, tape, document!

Ask for and arrange to get at once:

- a copy of any reporting (i.e., the incident report, mandated reports to the state, etc.)
- the school policy on restraint and seclusion
- nurse's (or other post-RS) health report

When and how should your child return to school?

If child staying home (for now):

- To avoid truancy, get advice from education attorney or advocate
- Have pediatrician send letter to school
- Send parent letter to school
- Consider "homebound instruction"

When child returning to school:

- Work with school to create a re-entry plan
- Teachers must understand "trauma-informed care"
- What new behaviors might occur? How to respond? How to rebuild trust?

Your strategy:

Seek maximum assistance from as many potential supporters as possible.

Remember: Nationwide, lines of power, responsibility, and accountability are not clear.

Contacting protective services

- Law enforcement
- State child protection agency (e.g. "Youth and Family Services")
- State protection and advocacy agency (P&A/DRN)
- Legal assistance (public or private)
  - How to find and choose

Debriefing meeting

- Should your child attend?
- Questions to ask
  - Sample debriefing form
- Reviewing & improving school resources
  - Staff training
  - Schoolwide safety and crisis prevention plan
- Updating child's IEP (or 504) and PBS plan
- Planning for child's re-entry to school
  - Role of trauma-informed care

Remember…

- If ARS techniques are in your child's IEP, BIP, or 504 Plan, now is the time to get them out!

ıould you file an OCR complaint?

- Office for Civil Rights (OCR) in the U.S. Department of Education provides primary administrative enforcement for
  - Section 504 of the Rehabilitation Act
  - The Americans with Disabilities Act (ADA).
- These civil rights statutes address discrimination, equal access, and reasonable accommodations, as applied to schools.

Enlisting support of other stakeholders

School district administration?

- Know and use "chain of command"

State department of education (DOE)?

- Try "hot line" or "help line"

PTO and School Board?

State Parent Training Institute (PTI) and DD Act programs?

- Federally funded; provide training and some advocacy

Legislators?

- Tell your story; have photos
- Share information about legislative efforts: what can they do?
- Ask for help in finding authorities who can step in on your child's behalf

Media?

- Consider carefully:
  - What support do you have?
  - How is the story likely to play?

Parent advocacy groups?

- Local
- State
- National

- Label-based
- Issue-based

- Ask about mission and vision, position statements, services offered, activities the group supports

Advocacy leaders in ARS prevention:

- To get linked up, contact Families Against Restraint and Seclusion (FARS):

  http://familiesagainstrestraintandseclusion.blogspot.com/2011/03/blog-post.html

- If questions remain, a parent-run hotline is available through the grassroots volunteer organization Our Children Left Behind: 877-622-5176.

- TASH has been a national leader on this issue since 1975: www.tash.org

- The Autism National Committee (AutCom) has led the fight for persons on the autism spectrum since 1990: www.autcom.org

TRENDS IN ADVOCACY

"The rising tide has not lifted all boats."

Self-advocacy still in early stages

- "Patient's rights" and "consumer's rights" self-advocates advanced RS reform in medical and mental health services
- Children receiving special ed services and their families not yet adequately heard

- What can YOU do to become a change agent?
- What do you plan to accomplish in your home state?

References and Bibliography

- Alliance to Prevent Restraint, Aversive Interventions, and Seclusion (APRAIS) (2005). *In the Name of Treatment.* Available online.
- Alliance to Prevent Restraint, Aversive Interventions, and Seclusion (APRAIS) (2011). *Use of Restraint, Seclusion, and Aversive Procedures with Students with Disabilities* .
- Bogdan, R., and Taylor, S.J. (1989). "Relationships with Severely Disabled People: The Social Construction of Humanness," in *Social Problems* 36,2:135-148.
- Council of Parent Attorneys and Advocates (COPAA) (2009). *Unsafe in the Schoolhouse.* Available online.
- Hardenstine, B. (2001). *Leading the Way Toward a Seclusion and Restraint-Free Environment.* Commonwealth of Pennsylvania: Department of Public Welfare.
- Harris, S. L., Handleman, J.S., Gill, M. J. & Fong, P. L. (1991). Does Punishment Hurt? The Impact of Aversives on the Clinician. *Research in Developmental Disabilities,* 12, 17-24.
- Helmstetter, E., Peck, C. A., & Giangreco, M. F. (1994). "Outcomes of interactions with peers with moderate or severe disabilities: A statewide survey of high school students," in *JASH,* Vol. 19, 263-276.

- Herman, J .L. (1992). *Trauma and Recovery.* NY: Basic Books.
- Huckshorn, K. A.(2007). *Six Core Strategies for Reducing Seclusion and Restraint Use.* Available online.
- Hunt, P., Staub, D., Alwell, M., & Goetz, L. (1994). "Achievement by all students within the context of cooperative learning groups," in *JASH*, Vol. 19, pp. 290-301.
- Hyman, I. A. (1995). Corporal punishment, psychological maltreatment, violence, and punitiveness in America. Research, advocacy, and public policy. *Applied & Preventive Psychology, 4*, 113-130.
- Hyman, I. A. (1996). Corporal punishment. In T. Fagan, & P. Wardon (Eds.), *Historical Encyclopedia of School Psychology* (pp. 92-93). Westport, CT: Greenwood
- Kennedy, S. S. (2005). Using Restraint: The Legal Context of High Risk Interventions. Presentation at "Examining the Safety of High-Risk Interventions," Cornell University, June 1-4.
- Kennedy, S. S. and Mohr, W. K. (2001). A Prolegomena on Restraint of Children: Implicating constitutional rights. *American Journal of Orthopsychiatry, 71*(1), 26-37.

- Kipnis, D. (1987). Psychology and Behavioral Technology. *American Psychologist,* 42(1), 30-36.
- Kishi, G. S., & Meyer, L. H. (1994). "What children report and remember: A six-year follow-up of the effects of social contact between peers with and without severe disabilities, " in *JASH*, Vol. 19, pp. 277-289
- LeBel, J., and Goldstein, R. (2005). The Economic Cost of Using Restraint and the Value Added by Restraint Reduction or Elimination," by *Psychiatric Services,* 56:1109-1114. Available online.
- Marquis, J., Horner, R., et al. (2000). A Meta-Analysis of Positive Behavior Support. In *Contemporary Special Education Research: Syntheses of the Knowledge Base on Critical Instructional Issues* ed. Russell Gersten, Ellen P. Schiller, and Sharon Vaughn Mahwah, New Jersey and London: Lawrence Erlbaum Associates.
- Miller, D. C., George, M. and Fogt, J.B. (2005). "Establishing and Sustaining Research-Based Practices at Centennial School: A descriptive case study of systemic change," *Psychology in the Schools*, Vol. 42(5). Available online.
- Miller, D. E. (1986). The management of misbehavior by seclusion. *Residential Treatment for Children and Youth,* 4, 63-73.

- Mohr W. K., and Anderson, J. A. (2001). Faulty assumptions associated with the use of restraints with children. *Journal of Child and Adolescent Psychiatric Nursing, 14*, 141- 151.
- Mohr, W. K., Petti, T. A., Mohr, B. D. (2003). Adverse Effects Associated with Physical Restraint. *The Canadian Journal of Psychiatry*, 48, 330-337.
- National Association of State Mental Health Program Directors. (1999). *Reducing the Use of Seclusion and Restraint: Findings, strategies and recommendations.* Alexandria, VA. Available online.
- National Disability Rights Network (NDRN) (2009). *School is not supposed to hurt.* Available online.
- National Disability Rights Network (NDRN) (2010). *School is not supposed to hurt: update on progress in 2009 to prevent and reduce restraint and seclusion in schools .* Available online.
- National Technical Assistance Center for State Mental Health Planning (2002). *Eliminating the Use of Seclusion and Restraint: Special Edition of NTAC Networks.* Alexandria, VA. Available online.

- Perry, B.D. (1997). Incubated in Terror: Neurodevelopmental factors in the "cycle of violence." In J. Osofsky (Ed.), *Children in a Violent Society,* 124-149. New York: Guilford Press.
- Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., and Vigilante, D. (1995). Childhood Trauma, the Neurobiology of Adaptation and Use-dependent Development of the Brain: How states become traits. *Infant Mental Health Journal*, 16, 271-289.
- Pflueger, W. (2002). "Consumer View: Restraint is Not Therapeutic." In *Violence and Coercion in Mental Health Settings: Eliminating the Use of Seclusion and Restraint," a Special Edition of NTAC Networks,* Summer-Fall. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning. Available online.
- Scotti, Joseph, Evans, Ian, Meyer, Luanna, and Walker, Pamela (1991). A Meta-Analysis of Intervention Research with Problem Behavior: Treatment Validity and Standards of Practice. *American Journal on Mental Retardation,* Vol. 96, No. 3, pp. 233-256.
- Steel, E. (1999). *Seclusion and Restraint Practice Standards: A Review and Analysis.* National Mental Health Association Technical Assistance Center (NTAC). Available online.
- Stefan, S. (2006). *Lessons from the Successful Reduction and Elimination of Restraint and Seclusion in Psychiatric Settings.* Presented at TASH Annual Conference 11/8/06, Baltimore, MD.

- TASH (2011). *Shouldn't School Be Safe?* Available online.
- TASH (2011). *The Cost of Waiting: Use of restraints, seclusion, and aversive procedures with students with disabilities.* Available online.
- Turnbull, H. R., Wilcox, B. L., Stowe, M., Raper, C., Hedges, L. P. (2000). Public Policy Foundations for Positive Behavioral Interventions, Strategies, and Supports. *Journal of Positive Behavioral Interventions,* 2 (4).
- Turnbull, H. R., Wilcox, B. L., Turnbull, A. P., Sailor, W., Wickham, D. (2001). The IDEA, Positive Behavioral Supports, and School Safety. *Journal of Law and Education,* 30(3).
- U.S. General Accounting Office (GAO) (1999). *Improper Restraint or Seclusion Use Places People At Risk.* (GAO publication HEH-99-176). Washington, D.C.: USGAO. Available online.
- U.S. General Accounting Office (GAO) (2007). *Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth.* (GAO-08-146T). Washington, D.C.: USGAO. Available online.

- United States Government Accountability Office (GAO) (2008). *Residential Programs: Selected Cases of Death, Abuse, and Deceptive Marketing*, GAO-08-713T Washington, D.C.: USGAO. Available online.
- United States Government Accountability Office (GAO) (2009). *Seclusions and Restraints: Selected Cases of Deaths and Abuse at Public and Private Schools and Treatment Centers*. (GAO-09-719T). Washington, D.C.: USGAO. Available online.
- Witte, L. (2008). "Reducing the use of seclusion and restraint: A Michigan provider reduced its use of seclusion and restraint by 93% in one year on its child and adolescent unit," *Behavioral Healthcare*, April 2008. Available online.