Proposed Resolution – Delaware PTA – "Restraint and Seclusion"

Table of Contents

1 Whereas All students need to be educated in environments which are supportive and free from abuse, assault, injury, trauma and risk to life; and

2 Whereas The use of inappropriate restraint and seclusion methods by untrained school personnel has resulted in the assault, injury, trauma and, in some cases, death of children in public schools; and

3 Whereas Children at risk, in particular children with disabilities, are disproportionately subjected to inappropriate use of restraint and seclusion by untrained school personnel; and

4 Whereas The use of mechanical restraints shall not be practiced by school personnel, shall only be used by trained medical or law enforcement professionals, and school personnel shall be prohibited from using chemical restraints on any student; and

5 Whereas The use of seclusion must include constant direct monitoring of the welfare of the student and the ability for immediate intervention. The facilities used for seclusion must allow self-egress in case of an emergency, must comply with life safety codes for confinement, and must be designed to keep children safe; be it therefore

1 Resolved That National PTA and its constituent associations support legislation, regulations, policies, and programs that emphasize the use of positive or non-aversive interventions thereby limiting the use of restraint and seclusion on students; and be it further

2 Resolved That National PTA and its constituent associations support legislation, regulations, policies, and programs that ensure the safety of children in emergency cases where restraint and seclusion is needed; and be it further

3 Resolved That National PTA and its constituent associations, will seek, via educational literature, programs and projects, to educate the school community and parents about the risks of excessive and/or inappropriate use of restraint and seclusion by untrained school personnel*;* and be it further

4 Resolved That National PTA and its constituent associations support legislation, regulations, policies, and programs providing that the use of restraint and seclusion practices shall be used only as a last resort in emergency* situations, not as a substitute for comprehensive school-wide supports and accommodations; and be it further

5 Resolved That National PTA and its constituent associations will advocate for the engagement of parents of all children who may be subject to restraint and seclusion in the decision making process, not only in an IEP or other education

meeting, but also in every aspect of a student's education with regard to the use of emergency restraint and seclusion.

*Emergency is defined as an unanticipated and already occurring event that is placing the individual or others in imminent danger of physical harm.

Restraint and Seclusion of Children in Schools Resolution Rationale

The safety and education of children has been at the core of PTA's mission since its inception.

Excessive and improper use of restraint and seclusion seriously threatens both of these goals.

By encouraging the utilization of nationally recognized best practices as outlined in the whereas clauses and supporting documents, and implementing and encouraging action by the resolved clauses, PTA will forward the efforts to keep all children safe and provide an appropriate education, particularly for children with disabilities and special health care needs.

Broadly acknowledging that these risks exist is also essential as a prerequisite to implementing broad, locally appropriate solutions.

While some states, local education agencies, and schools have adopted and fully implemented these best practices, the majority have not. Only through education and advocacy at all levels, can this be accomplished. PTA should and needs to be involved in this effort to meet the PTA standard of "Every Child".

Clearly supporting the goals of eliminating the use of mechanical and chemical restraints by educational staff, minimizing the use of restraint and seclusion, and encouraging the individualized supports and accommodations for children at risk of having restraint and seclusion applied to them, involving parents in the decisions related to the use of restraint and seclusion, and ensuring that educational staff are professionally trained when restraint and seclusion must be used, are the first steps in PTA protecting and supporting children at risk for restraint and seclusion.

The second step is advocacy and education, to promote best practices in supporting and protecting this population of at risk children.

Allowing children in our schools to be injured, killed and have their futures diminished, by inaction related to the overuse and improper use of restraint and seclusion is not an option.

Reference Summary

Butler, J. (2009, May). *Unsafe in the schoolhouse: Abuse of children with disabilities*. Retrieved from http://c.ymcdn.com/sites/www.copaa.org/resource/collection/662B1866-952D-41FA-B7F3-D3CF68639918/UnsafeCOPAAMay_27_2009.pdf
[Whereas Clause 2: pg. 7-9; pg. 10-12]
[Whereas Clause 3: pg. 9-10]
[Whereas Clause 4: pg. 10-12]
[Whereas Clause 5: pg. 10-12]

``Developmental Disabilities Assistance and Bill of Rights Act of 2000, H.R. 4920, 106th Cong. § a,5 (2000).
http://www.gpo.gov/fdsys/pkg/PLAW-106publ402/html/PLAW-106publ402.htm
[**Whereas Clause 3: Section 101 a,5]**

National Fire Protection Association: NFPA 101 Life Safety Code. (2006). Retrieved from https://law.resource.org/pub/us/code/ibr/nfpa.101.2006.pdf
[Whereas Clause 5: pg. 41 Section 101-35]

Ryan, J. B., Robbins, K., Peterson, R., & Rozalski, M. (2009). Review of state policies concerning the use of physical restraint procedures in schools. *Education and Treatment of Children*, *32*(3), 487-504. http://www.ode.state.or.us/initiatives/elearning/nasdse/statepolicyphysicalrestraint.pdf
[**Whereas Clause 1: pg. 288]**

School is not supposed to hurt: Investigative Report on Abusive Restraint and Seclusion in Schools. (2009). Retrieved from http://www.ndrn.org/images/Documents/Resources/Publications/Reports/School_is_Not_Supposed_to_Hurt_3_v7.pdf
[Whereas Clause 1: pg. 21]
[Whereas Clause 2: pg. 9-16; 21]
[Whereas Clause 5: pg. 9-16; 21]

United States Government Accountability Office. (2009, May). *Seclusions and restraints: Selected cases of death and abuse at public and private schools and treatment centers* (Report No. GOA-09-719T) (G. D. Kutz, Author). http://www.gao.gov/new.items/d09719t.pdf
[Whereas Clause 3: pg. 5-9]
[Whereas Clause 4: pg. 7-9]

U.S. Department of Education, Restraint and seclusion: Resource Document, Rep., at 1-45 (2012). http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.doc
[**Whereas Clause 1: pg. iii]**
[Whereas Clause 2: pg. 2; pg.12-13]
[Whereas Clause 3: pg. 12-13]

Vollmer, T. R., Hagopin, L. P., Bailey, J. S., Dorsey, M. F., Hanley, G. P., Lennox, D., . . . Spreat, S. (2011). The association for behavior analysis international position statement on restraint and seclusion. *The Behavior Analyst*, *1*(34), 103-110. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3089400/pdf/bhan-34-01-103.pdf
[Where As Clause 4: pg. 106-107]

Background Materials

Vollmer, T. R., Hagopin, L. P., Bailey, J. S., Dorsey, M. F., Hanley, G. P., Lennox, D., . . . Spreat, S. (2011). The association for behavior analysis international position statement on restraint and seclusion. *The Behavior Analyst, 1*(34), 103-110. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3089400/pdf/bhan-34-01-103.pdf [Where As Clause 4: pg. 106-107]

The Necessity for the Use of Emergency Restraint and Seclusion

Emergency restraint involves physically holding or securing a person to protect that person or others from behavior that poses imminent risk of harm. These procedures should be considered only for dangerous or harmful behaviors that occur at unpredictable times, that make the behavior not amenable to less restrictive behavioral treatment interventions, and that place the individual or others at risk for injury, or that will result in significant loss of quality of life. The procedures should be considered only when less intrusive interventions have been attempted and failed or are otherwise determined to be insufficient given adequate empirical documentation to prove this point. When applied for crisis management, restraint or seclusion should be implemented according to well-defined, predetermined criteria; include the use of de-escalation techniques designed to reduce the target behavior without the need for physical intervention; be applied only at the minimum level of physical restrictiveness necessary to safely contain the crisis behavior and prevent injury; and be withdrawn according to precise and mandatory release criteria. Emergency restraint procedures should be limited to those included within a standardized program. Medical professionals should review restraint procedures to ensure their safety. Consideration of emergency restraint should involve weighing the relative benefits and limitations of using these procedures against the risks associated with not using them. Associated risks of failure to use appropriate restraint when necessary include increased risk of injury; excessive use of medication; expulsion from school; placement in more restrictive, less normalized settings; and increased involvement of law enforcement. Crisis management procedures are not a replacement for behavioral treatment and should not be used routinely in the absence of an individualized behavior intervention plan. The best way to eliminate restraint use is to eliminate behavior that invites its use via systematic behavioral treatment procedures. If crisis intervention procedures are used on a repeated basis, a formal written behavior plan should be developed, reviewed by both a peer review committee and human rights committee (when available), and consented to by the individuals served and their parents or legal guardians.

Informed Consent

As members of the treatment team, the individual and parents or guardians must be allowed the opportunity to participate in the development of any behavior plan. Interventions that involve restraint or seclusion should be used only with the full consent of those who are responsible for decision making. Such consent should meet the standards of ‘‘information,’’ ‘‘capacity,’’ and ‘‘voluntary.’’ The individual and his or her guardian must be informed of the methods, risks, and effects of possible intervention procedures, which include the options to both use and not use restraint.

Oversights and Monitoring

Restraint or seclusion (not including brief time-out) for both treatment and emergency situations should be made available for professional review consistent with prevailing practices. The behavior analyst is responsible for ensuring that any plan involving restraint or seclusion conforms to the highest standards of effective and humane treatment, and the behavior analyst is responsible for continued oversight and quality assurance. These {procedures should be implemented only by staff who are fully trained in their use, receive regular in-service training, demonstrate competency using objective measures of performance, and are closely supervised by a Board Certified Behavior Analyst or a similarly trained professional. The use of restraint or seclusion should be monitored on a continuous basis using reliable and valid data collection that permits objective evaluation of its effects. Procedures that involve restraint or seclusion should be continued only if they are demonstrated to be safe and effective; their use should be reduced and eliminated when possible. Efficacy with respect to treatment programs refers to a reduction in the rate of the specified target behavior or reduction in the episodic severity of that behavior. With respect to emergency treatments, efficacy refers only to the time and risk associated with achieving calm.

United States Government Accountability Office. (2009, May). ***Seclusions and restraints: Selected cases of death and abuse at public and private schools and treatment centers*** **(Report No. GOA-09-719T) (G. D. Kutz, Author).**
http://www.gao.gov/new.items/d09719t.pdf
[Whereas Clause 2: pg. 5-9]
[Whereas Clause 3: pg. 5-9]
[Whereas Clause 4: pg. 7-9]

GAO recently testified before the Committee regarding allegations of death and abuse at residential programs for troubled teens. Recent reports indicate that vulnerable children are being abused in other settings. For example, one report on the use of restraints and seclusions in schools documented cases where students were pinned to the floor for hours at a time, handcuffed, locked in closets, and subjected to other acts of violence. In some of these cases, this type of abuse resulted in death.

{Whereas Clauses 2 & 3: Page 5}
Although we could not determine whether allegations of death and abuse were widespread, we did discover hundreds of such allegations at public and private schools across the nation between the years 1990 and 2009.11 Almost all of the allegations we identified involved children with disabilities.
{Whereas Clauses 2 & 3, Page 5}

A 13-year-old boy with attention deficit hyperactivity disorder at an alternative public school hung himself in a seclusion room weeks after threatening to commit suicide, using a cord a teacher reportedly provided him to hold up his pants.

A 7-year-old girl died at a private day treatment center after being held for hours in a face-down, or prone, restraint on the floor by multiple staff members. The staff was allegedly unaware she had stopped breathing until they rolled her limp body over and discovered she had begun to turn blue.

A 9-year-old boy in foster care died at a public charter school after his teacher took him to a "time out" room and restrained him using a "basket hold," which in this case was described as an adult standing behind a child, holding the child's crossed arms and taking him to the floor. Purportedly, the boy began to make a noise like he was vomiting, then slumped over after being released. The teacher testified that she initially thought he was playing dead and joked with other staffers about planning his funeral.

A 17-year-old boy reportedly died from an asthma attack while being restrained by a counselor at a private school for emotionally disturbed teens.

Disabled children as young as 6 years old were allegedly placed in strangleholds, restrained for extended periods of time, confined to dark rooms, prevented from using the restroom causing them to urinate on themselves, and tethered to ropes in one public school district.

A special education teacher at a public school was accused of using bungee cords and duct tape to fasten children as young as 5 years old to chairs designed to support kids with muscular difficulties. According to parents, their children sustained injuries such as broken arms and bloody noses while in this teacher's class. A teacher's aide told investigators that the woman used the restraints on a daily basis to punish the children.

According to the father of an 8-year-old autistic boy, his son suffered from scratches, bruises and a broken nose after being put in a prone restraint by his public school teacher and aide.

A sixth-grade special education student reportedly had his leg broken by the public school teacher who was trying to restrain him.

A 12-year-old girl allegedly had her arm fractured by a special education teacher who put her in a "therapeutic hold," described as being similar to a "bear hug" or hold a student's arms behind their back.

An autistic student at a public school claims he was strapped with his pants pulled down onto a toilet training chair for hours at a time over several days.

{Whereas Clauses #2, 3 & 4, page 7-9}
Children, especially those with disabilities, are reportedly being restrained and secluded in public and private schools and other facilities, sometimes resulting in injury and death. The 10 closed cases we examined illustrate the following themes: (1) children with disabilities were sometimes restrained and secluded even when they did not appear to be physically aggressive and their parents did not give consent; (2) facedown or other restraints that block air to the lungs can be deadly; (3) teachers and staff in these cases were often not trained in the use of restraints and techniques; and (4) teachers and staff from these cases continue to be employed as educators. In addition to the 10 cases we identified for this testimony, 3 cases from our previous testimonies on residential treatment programs for troubled youth also show that face down restraints, or those that impede respiration, can be deadly. For our current investigation, we identified 10 seclusion and restraint cases occurring at public and private schools and selected treatment centers over the past two decades. Common themes related to the cases studies are as follows:

Children with Disabilities: Although we did not specifically limit the scope of our investigation to incidents involving disabled children, most of the hundreds of allegations we identified related to children with disabilities. In addition, 9 of our 10 closed cases involve children with disabilities or a history of troubled behavior. The children in these cases were diagnosed with autism or other conditions, including post-traumatic stress disorder and attention deficit hyperactivity disorder. Although we did not evaluate whether the seclusion and restraint used by the staff in our cases was proper under applicable state laws, we did observe that the children in the cases were restrained or secluded as disciplinary measures, even when their behavior did not appear to be physically aggressive. For example, teachers restrained a 4 year old with cerebral palsy in a device that resembled a miniature electric chair because she was reportedly being "uncooperative." In other cases, we found that teachers and other staff did not have parental consent prior to using restraints and seclusions. For example, an IEP for a 9 year old with learning disabilities specified that placement in a timeout room could be used to correct inappropriate behavior, but only as a last resort. However, teachers confined this child to a small, dirty room 75 times over the course of 6 months for offenses such as whistling, slouching, and hand waving. Parents in another case gave a teacher explicit instructions to stop restraining their 7-year-old child and secluding her for prolonged periods of time. Despite these instructions, the restraints and seclusions continued. In another case, a residential day school implemented a behavior plan, without parental consent, that included confining an 11-year-old autistic child to his room for extended periods of time, restricting his food, and using physical restraints. The child was diagnosed with post-traumatic stress disorder as a result of this treatment. Currently,

thirteen states require schools to obtain consent prior to using foreseeable or non-emergency physical restraints.13

Death from Face Down Restraints or Restraints that Block the Airway: Of the hundreds of allegations we identified, at least 20 involved restraints that resulted in death. Of the 10 closed cases we examined, 4 involved children who died as a result of being restrained. In all 4 cases, staff members used restraint techniques that restricted the flow of air to the child's lungs. In one of these cases, an aide sat on top of a child to prevent him from being disruptive and ultimately smothered him. The other cases related to the use of different types of prone restraints, a technique that typically involves one or more staff members holding a child face down on the floor. Although some of the teachers and staff involved in these cases were trained on the use of prone restraints, the children in their care still died as a result of its use. However, we did not attempt to evaluate the types of training they received or whether they actually implemented the procedure according to the training. Currently, eight states specifically prohibit the use of prone restraints or restraints that impede a child's ability to breathe.14

Untrained Staff: Although we did not evaluate specific training methods, evidence we gathered suggests that the teachers and other staff involved in our 10 closed cases were often not trained in the use of restraints. For example, staff involved in the death of a child in one case acknowledged that they were inadequately trained. A principal in another case testified that she did not know whether a substitute teacher who taped children to their chairs to make them sit still had ever been provided with the school policy on restraint. A local school board in a fourth case was found civilly liable for negligently supervising and training teachers after a 4-year-old girl was strapped to a chair for allegedly being uncooperative. A school district agreed to implement policy changes to improve training in a fifth case as part of a settlement agreement after a teacher repeatedly restrained a frail 7 year old. Lastly, in a sixth case, a volunteer teacher's aide with a history of armed burglary and cocaine possession was allowed to tape first graders to a blackboard and seal their mouths shut; we found no evidence that the school trained this aide or even conducted a background check on her before letting her into the classroom. Currently, seventeen states require that staff receive training before being permitted to restrain children.15

Continued Employment in Education: Although we did not evaluate specific state licensing requirements, we did observe that in at least 5 of our cases, the teachers or other staff involved in the injurious restraint or seclusion of children continued to work with students or had licenses to do so. For example, a 230 pound teacher in Texas who fatally restrained a 129 pound teenage boy face down on a mat currently works as a public high school teacher in Virginia. The Texas Department of Family Protective Services (DFPS) placed the teacher's name on a Texas registry

***School is not supposed to hurt: Investigative Report on Abusive Restraint and Seclusion in Schools*. (2009). Retrieved from http://www.ndrn.org/images/Documents/Resources/Publications/Reports/School_is_Not_Supposed_to_Hurt_3_v7.pdf**
[Whereas Clause 1: pg. 21]
[Whereas Clause 2: pg. 9-16; 21]
[Whereas Clause 5: pg. 9-16; 21]

II. School Children are Continuing to Suffer

NDRN issued reports about the use of restraint and seclusion in 2009[1] and 2010.[2] Since then many others, including the Government Accountability Office, have reported on deaths and injuries resulting from the use of restraint and seclusion in schools. Despite the alarms that have been raised, students are continuing to be hurt in our nation's schools. Below are only a few of the examples that protection and advocacy agencies have collected since NDRN issued its January 2010 report.

ARIZONA – MISUSE OF POSTURAL SUPPORT CHAIRS AS RESTRAINTS

Rifkin, a manufacturer of postural support chairs, has explicitly warned that postural support chairs are not supposed to be used to restrain children and youth to control their behavior. Nevertheless, schools continue to use postural support chairs "off-label." For example, in 2011, a public school teacher strapped a 7-year old child into a postural support chair and moved him into another room because he was disrupting the class. The child tried to twist out of the chair, ending up with his face against the back of the chair and getting scratched by nails in the chair when the teacher tried to untangle him. The school did not take any corrective action. It could have prohibited staff from using postural support chairs to restrain children. Use of postural support chairs for behavioral reasons violates the IDEA because it is not an evidence-based practice and violates the ADA and § 504 because only students with disabilities are being restrained in postural support chairs.

COLORADO – DUCT TAPING CHILD TO WHEELCHAIR

The teacher in a public middle school duct-taped a 12-year old student's only ambulatory arm to his wheelchair, claiming that she was trying to keep him from choking himself, but his grandmother claimed that the reflex in his arm was the only way for him to communicate. The Legal Center for People with Disabilities and Older People (Colorado P&A) did an investigation and recommended that the school do more training on the state law regarding restraint and seclusion because restraints, such as the duct tape, was a mechanical restraint prohibited under state law.

CONNECTICUT – SCREAM ROOMS

According to a complaint filed with the Office of Civil Rights of the U.S. Department of Education, elementary school students with disabilities at Farm Hill School in Middletown, Connecticut, were being held against their will in what administrators called "time out rooms," but which parents called "scream rooms." The complaint stated that these are small, cement-walled rooms and that student in regular education report hearing their classmates screaming and

banging on the door and school staff has reported having to clean up blood and urine from these rooms. Students with disabilities are apparently being secluded, restrained and injured at school repeatedly. The school has acknowledged publicly that it is treating students with disabilities differently from their non-disabled classmates. The school's superintendent stated that "unless you have an IEP, this is not part of your plan." The superintendent later stated that he had directed all staff to cease using the rooms for students who do not have Individualized Education Programs (IEPs) and that the room had been moved to the second floor of the school so general education classes would not be disrupted by the screaming

FLORIDA – RESTRAINING ALREADY TRAUMATIZED STUDENT

A 6-year old, who has autism spectrum disorder and epilepsy, Tourette 's syndrome, and respiratory problems, was traumatized during the fall of 2010 at a charter school as a result of misuse of restraint and seclusion. His parent filed a state complaint against the charter school and settled with the school. His parent subsequently called Disability Rights Florida in the spring of 2011 because of problems with implementing of the settlement agreement. He was attending a different school and despite the Post-Traumatic Stress Disorder (PTSD) diagnosis, the school's plan for him included the use of restraint and seclusion. His mother was concerned because his tantrums and anxiety were increasing. Behavior such as kicking and hiding were increasing and when adults attempted to increase controls, the behaviors worsened. Time out was being frequently used – but without success.

The Florida P&A intervened with the goal of negotiating a new behavior intervention plan that would prevent and preclude the use of any restraint and seclusion. The P&A provided assistance in developing alternative strategies and positive behavior supports, monitoring the efficacy of strategies using Response to Intervention (RTI) principles, and implementing a structured problem solving approach. The P&A continues to monitor implementation and when his behavior becomes challenging, the P&A assists the district in assessing cause, fidelity of interventions and revising the behavior intervention plan as necessary. The child has many other needs and the case(s) remain active due to those other issues. Until all issues are resolved, the P&A will continue to address restraint and seclusion in terms of monitoring, technical assistance and negotiations on behalf of student and be available to the parent thereafter should new problems arise.

IDAHO - REPEATEDLY SECLUDED, RESTRAINED AND SPRAYED

A middle school child with Asperger's Syndrome was repeatedly placed in seclusion for non-compliant behaviors – "shutting down" and being generally non-responsive. The child sustained rug burns on his back from being dragged across the floor to the room by his hands and/or feet; he also indicated he was sometimes sprayed by the teacher with a water bottle containing a chemical cleaning solution for the white board. The child's mother filed complaints with Child Protection Services, the school district and the police, who investigated the allegations. The child was removed from the teacher's classroom; no other disciplinary action was disclosed by the school, citing "personnel matters." An advocate from the DisAbility Rights Idaho intervened. Independent behavior consultants were brought in to conduct assessments and draft an appropriate behavior plan, with positive behavior services provided by trained staff.

INDIANA - SUICIDE ATTEMPT WHEN SECLUDED

During January 2011, a child who had been repeatedly placed in a seclusion room was not allowed to leave the seclusion room to use the restroom. The child subsequently urinated on the floor. Upon his return to school the following day, the school secluded him again for having relieved himself in the room on the previous day. The final incident occurred on January 20, 2011; reportedly, the child had been in seclusion for approximately four consecutive hours. During which the child had been screaming and cursing for not being allowed out to use the bathroom. It is unclear what prompted staff to check on the child, either the child's sudden silence or the arrival of the child's guardian. However, when the seclusion room was unlocked staff discovered that the child had attempted to hang himself. Since, school personnel do not actively observe children while they are in seclusion, no one knows for how long the child had been hanging prior to the discovery. The guardian immediately took the child to a local hospital.

IOWA – TIED TO A LUNCH TABLE

The Individualized Education Program of a 15-year old student with autism, cerebral palsy, intellectual disabilities and epilepsy stated that he must have two aides with him at all time, but the school failed to consistently provide the aides. When there was only one aide, the school used a gait belt and other means to restrain the child to the lunch table and a recliner "for his own safety." Disability Rights Iowa assisted his parents in filing a complaint with the Iowa Dept. of Education. The complaint alleged that the restraint violated state law, the IEP and behavior plan were inappropriate and the school had failed to provide the student with a free and appropriate public education (FAPE). The state ruled in favor of the child on denial of FAPE, inappropriate restraint and ordered compensatory education for the child and also training for the school district on restraint and seclusion and health programs. The P&A represented the child in the mediation to create a plan for compensatory education.

KANSAS – SECLUDED AS PUNISHMENT

The mother of a 13 year old child with disabilities contacted the Disability Rights Center of Kansas with allegations of extensive improper seclusion. Her son has been diagnosed with intellectual disabilities, speech delays significantly limiting his ability to communicate, and epilepsy. He has no mental health diagnosis, but he has been placed at a school for students with behavior issues. The child has a behavior plan which prohibits him from touching anybody without permission. Impermissible touching includes a hug, high five, or fist bump. If he does not follow the plan, he is sent immediately without warning to the in-school suspension room (ISS) room in the principal's office. The school also has a separate seclusion room in each classroom which is also called an ISS room. All rooms have no windows and only a door. The mother has learned that during the past several weeks her son has spent 8-1/2 days in a seclusion room. The child has been sent to the room for as long as the entire day and sometimes into the following day. The door is always closed. The mother understands that the school does not record the removals on exclusion report forms, and they are noted only on his daily point sheets which she must sign and return to the school. Her son has been suspended over 10 times and has never had a manifestation hearing. The P&A is currently investigating these allegations.

KENTUCKY - RESTRAINED IN DUFFEL BAGS AND POSTURAL CHAIRS

The school district placed a 9-year old child in a duffel bag after he was allegedly misbehaving at an intermediate county school in Kentucky. His mother said that she witnessed him wiggling inside the bag as a teacher's aide stood by. It was apparently punishment for autistic behavior.4 the mother said: They pretty much treated him like trash. Put him inside a bag, tied him up and put him in the hallway…"If you gave me any child that was in a regular classroom that acted up, they don't get thrown in a bag and put in a hallway."5 The case has received a lot of media attention and approximately 170,000 people have signed a petition in support of the mother.6 In another case in Kentucky, a 6-year girl who is diagnosed with autism, fetal alcohol syndrome, shaken baby syndrome, Attention-Deficit/Hyperactivity Disorder, one kidney, and Hoshimoto's Thyroiditis, sustained bruising on her neck and back when she was improperly restrained in a Rifton chair.

MAINE – DANGEROUS SECLUSION ROOMS

The Disability Rights Center of Maine filed a complaint, based on state restraint and seclusion regulations, against a school district regarding the use of a designated time out room that did not meet the physical characteristics requirement specified in the regulations. In fact the room posed significant health and safety risks for children. The P&A staff personally viewed the room which was located within the resource room "bathroom changing area." The wooden door to the room had a rectangular hole cut out on the bottom of the door that was reported to be the required observation window. This is concerning for two reasons; (1) it is impossible to continuously observe the student in the room from the bottom of the door as required, and (2) a student could attempt to climb out of the room through the hole and injure him or herself in the process. In addition, due its original design as a bathroom changing area the room posed other serious risks. The time out area includes an examination table, small metal trash can, and two metal cabinets with locks as well as sink and toilet. A child could be seriously injured by these items and they are not hygienic.

MASSACHUSETTS – BRUISED AND BATTERED

An 11-year old boy with an emotional/behavioral disability was placed in a 3 ½ hour time-out for behavior issues during a dodge-ball game in gym class. When asked to discuss his behavior, he refused and threw a book and a pencil at the teacher. The teacher immediately slammed the boy to the floor and restrained him. During the restraint, the boy was injured and got a fat lip, abrasions on his shoulder and under his eye, and injuries to his torso. The mother was called by the guidance counselor to report that the boy had assaulted the teacher, but neglected to tell her that he had been injured as a result. When she picked him up, she immediately took him to the E.R. The incident report that the mother received differed greatly from what her son told her. There appears to have been no debriefing of the incident. He never returned to the school.

NEW HAMPSHIRE – SECLUDED WHEN ANXIOUS

A child with a disability had a history of bolting out of the room whenever her anxiety increased. Her classroom teachers came up with an informal plan (permitting her to have some 1:1 time with a preferred staff member when she became anxious) but never conducted a functional behavioral assessment. Unfortunately, the school did not implement this plan consistently and the student continued to refuse to do work and bolt out of the classroom when she became anxious. In response, school personnel repeatedly put her into an 8' X 10' seclusion room for

about 20 – 30 minutes at a time. Rather than helping the student calm down, secluding her made her even more anxious. After the Disabilities Rights Center, the New Hampshire P&A, investigated, the school agreed to stop using the room for this particular student and developed protocols requiring functional behavioral assessment before seclusion is even contemplated, monitoring during seclusion, and documentation of antecedents and consequences of seclusion.

NEW MEXICO - ALMOST STRANGLED ON A SCHOOL BUS

A six-year old child with Down Syndrome was restrained on a school bus by the school bus driver and attendant. A teacher's aide, who was standing outside, told police that she heard yelling from the bus along with the child hitting the window. When the child threw a shoe out of the window, the aide walked to the bus and returned the shoe. The aide saw that the child was strapped to the seat with the seatbelt wrapped around the child's neck. The aide took pictures and contacted the police. The police referred the call to Disability Rights New Mexico. As a result of the P&A's advocacy, the bus company fired the school bus driver and attendant

NORTH CAROLINA - DEAF STUDENT UNABLE TO COMMUNICATE DURING RESTRAINT

At least two staff members placed a student in prone restraint, pinning her hands beneath her chest. The student, age 14 at the time of the incident, is Deaf, has an intellectual disability and a health condition. She uses American Sign Language as her primary method of communication. The use of prone restraint on this student could have exacerbated her health condition. It prevented her from being able to communicate with staff members while in restraint. The force used in restraining the student resulted in her sweater being torn in several places and deep fingertip bruises on her arms. The school did not investigate or otherwise address the incident. Staff delayed in reporting the alleged abuse to the local Department of Social Services. Disability Rights North Carolina conducted a thorough investigation into this incident, including document review and interviews with more than 10 staff members. The P&A substantiated the allegation of abuse, as well as allegations of retaliation against the student, her mother, and staff who advocated on the student's behalf. The P&A released a public report on its findings (available at http://www.disabilityrightsnc.org/intranet/downloadManagerControl.php?mode=getFile&elementID=2295&type=5&atomID=1321) that resulted in the state Department of Health and Human Services (NC HHS), which oversaw the school, conducting its own investigation and ultimately firing the school director. NC HHS put together a panel of professionals to conduct its investigation, including staff from the state Department of Public Instruction. Shortly after the state completed its investigation, the student's mother moved out of this school's catchment area. The student transferred to a different residential school—coincidentally the school where the P&A conducts regular monitoring activities. The student is doing well at her new school. Her communication abilities have improved and she has not been restrained.

OHIO – LOCKED IN A "CLOSET-SIZED" ROOM

An 18-year old student with an intellectual disability was placed in a "locked" closet-sized room with two peep holes on several occasions. One incident occurred after the student was taking too long to leave the bathroom when directed to leave by staff. The student's mother requested that school personnel not use locked time out with the student but instead, use a sensory room to regain control of his behavior. She explained that it traumatized the student to be in this room and, as a result, the student would undress and be incontinent. She further indicated that the

student was exhibiting increased loss of behavioral control at home related to the use of the room, and he repeatedly begged not to be put back into the room. She did not send him back to school. The family doctor subsequently found that the student had a staph infection, which was the result of the student lying unclothed in his urine on the floor of the seclusion room.

OREGON – STRAPPED TO THE WHEELCHAIR

A 15-year old girl with autism who is non-verbal is completely mobile and loves elevators. In the fall of 2010, she was strapped to a wheelchair for up to 80 percent of her school day at her local public school to prevent her from leaving the classroom to get on the elevator. Her parents were given no notice of these restraints and are still unclear on how long this was happening. As a result of Disability Rights Oregon's advocacy, she transferred to a classroom with a higher staff to student ratio and no longer required the restraints. She moved throughout the school even though there was an elevator present and was able to be redirected positively by staff.

UTAH – FECES IN THE SECLUSION BOOTH

A six-year old student in a public non-residential school was placed in a seclusion booth for 45 minutes. The student began defecating in the booth and smearing feces. He was not monitored by an aide or classroom teacher. When his parents arrived, the student was still in the booth and feces were smeared all over the booth and the student. The parent took the child home and cleaned him up. The Utah P&A helped the parent get home instruction for the student until an appropriate Individualized Education Program and Behavior Intervention Plan could be implemented. The P&A and the parents had several discussions with school personnel about using positive interventions and supports prior to moving into crisis intervention. The P&A provided the Utah State Office of Education information about a number of schools, including the school in this incident that create behavior plans but do not follow them.

WEST VIRGINIA – STRAPPED TO A POSTURAL SUPPORT CHAIR

A 7-year-old child with autism was being restrained in a Rifton chair. While he may have had the chair prescribed for his physical condition, it was clearly being used as a restraint device for behaviors that weren't being adequately addressed by the school. The West Virginia P&A got involved, intervened with the school, and the situation was resolved.

WISCONSIN - CHILD ABUSE, INCLUDING RESTRAINTS

Disability Rights Wisconsin represents five of the six victims in a case in which a teacher abused children, in Appleton, Wisconsin for at least 6 years. The abuse included the use of restraints. The teacher was subsequently arrested and terminated. The principal of the school is still under investigation for failing to report child abuse. The parents have received a partial settlement which resolved the due process cases by obtaining compensatory education, training, and policy changes at the district level. The parents reserved rights to file a civil lawsuit, and intend to do so if they do not receive monetary compensation and have the school district accept administrative responsibility, possibly through termination of the principal.

U.S. Department of Education, Restraint and seclusion: Resource Document, Rep., at 1-45 (2012). http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.doc

[Whereas Clause 1: pg. iii]
[Whereas Clause 2: pg. 2; pg.12-13]
[Whereas Clause 3: pg. 12-13]

In 2009, after legislation was introduced in the House of Representatives to severely curtail the use of restraint and seclusion in schools, on December 8, 2009, Secretary Arne Duncan issued letters to Representatives George Miller and Cathy McMorris Rodgers supporting their proposed legislation. In his letter, the Secretary noted several "principles" that Congress should consider as it developed legislation:

- Any behavioral intervention must be consistent with the child's right to be treated with dignity and to be free from abuse regardless of the child's educational needs or behavioral challenges;

- Physical restraint and seclusion should never be used as punishment or discipline;

- Physical restraint and seclusion should never be used that restricts a child's breathing;

- Limit the use of physical restraint and seclusion in schools...except when it is necessary to protect a child or others from imminent danger;

- Every instance of physical restraint and seclusion should be appropriately monitored to ensure the safety of the child, other children, teachers, and other personnel;

- Parents should be notified promptly following the use of restraint or seclusion on their child, and any such use should be documented in writing;

- Teachers and other personnel should be trained regularly on the appropriate use of restraint and seclusion and the use of effective alternatives, such as positive behavioral intervention and supports.

May 15, 2012

As education leaders, our first responsibility must be to ensure that schools foster learning in a safe and healthy environment for all our children, teachers, and staff. To support schools in fulfilling that responsibility, the U.S. Department of Education has developed this document that describes 15 principles for States, school districts, schools, parents, and other stakeholders to consider when developing or revising policies and procedures on the use of restraint and seclusion. These principles stress that every effort should be made to prevent the need for the use of restraint and seclusion and that any behavioral intervention must be consistent with the child's rights to be treated with dignity and to be free from abuse. The principles make clear that restraint or seclusion should never be used except in situations where a child's behavior poses imminent danger of serious physical harm to self or others, and restraint and seclusion should be avoided to the greatest extent possible without endangering the safety of students and staff. The goal in presenting these principles is to help ensure that all schools and learning environments are safe for all children and adults.

As many reports have documented, the use of restraint and seclusion can have very serious consequences, including, most tragically, death. Furthermore, there continues to be no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques. Schools must do everything possible to ensure all children can learn, develop, and participate in instructional programs that promote high levels of academic achievement. To accomplish this, schools must make every effort to structure safe environments and provide a behavioral framework, such as the use of positive behavior interventions and supports that apply to all children all staff and all places in the school so that restraint and seclusion techniques are unnecessary.

I hope you find this document helpful in your efforts to provide a world-class education to America's children. Thank you for all you do to support our schools, families, and communities and for your work on behalf of our nation's children.

Arne Duncan

{Whereas Clauses 2 & 4, page 2}
The foundation of any discussion about the use of restraint and seclusion is that every effort should be made to structure environments and provide supports so that restraint and seclusion are unnecessary. As many reports have documented, the use of restraint and seclusion can, in some cases, have very serious consequences, including, most tragically, death. There is no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques.
Physical restraint or seclusion should not be used except in situations where the child's behavior poses imminent danger of serious physical harm to self or others and restraint and seclusion should be avoided to the greatest extent possible without endangering the safety of students and staff. Schools should never use mechanical restraints to restrict a child's freedom of movement.[21] In addition, schools should never use a drug or medication to control behavior or restrict freedom

of movement unless it is (1) prescribed by a licensed physician, or other qualified health professional acting under the scope of the professional's authority under State law; and (2) administered as prescribed by the licensed physician or other qualified health professional acting under the scope of the professional's authority under State law.

{Definition note, page 3}
Restraint or seclusion should not be used as routine school safety measures; that is, they should not be implemented except in situations where a child's behavior poses imminent danger of serious physical harm to self or others and not as a routine strategy implemented to address instructional problems or inappropriate behavior (e.g., disrespect, noncompliance, insubordination, out of seat), as a means of coercion or retaliation, or as a convenience.

{Whereas Clauses 1,2,3,4 &5 page 12-13}

Fifteen Principles

1. Every effort should be made to prevent the need for the use of restraint and for the use of seclusion.
2. Schools should never use mechanical restraints to restrict a child's freedom of movement, and schools should never use a drug or medication to control behavior or restrict freedom of movement (except as authorized by a licensed physician or other qualified health professional
3. Physical restraint or seclusion should not be used except in situations where the child's behavior poses imminent danger of serious physical harm to self or others and other interventions are ineffective and should be discontinued as soon as imminent danger of serious physical harm to self or others has dissipated.
4. Policies restricting the use of restraint and seclusion should apply to all children, not just children with disabilities.
5. Any behavioral intervention must be consistent with the child's rights to be treated with dignity and to be free from abuse.
6. Restraint or seclusion should never be used as punishment or discipline (e.g., placing in seclusion for out-of-seat behavior), as a means of coercion or retaliation, or as a convenience.
7. Restraint or seclusion should never be used in a manner that restricts a child's breathing or harms the child.
8. The use of restraint or seclusion, particularly when there is repeated use for an individual child, multiple uses within the same classroom, or multiple uses by the same individual, should trigger a review and, if appropriate, revision of strategies currently in place to address dangerous behavior;[2] if positive behavioral strategies are not in place, staff should consider developing them.
9. Behavioral strategies to address dangerous behavior that results in the use of restraint or seclusion should address the underlying cause or purpose of the dangerous behavior.

10. Teachers and other personnel should be trained regularly on the appropriate use of effective alternatives to physical restraint and seclusion, such as positive behavioral interventions and supports and, only for cases involving imminent danger of serious physical harm, on the safe use of physical restraint and seclusion.
11. Every instance in which restraint or seclusion is used should be carefully and continuously and visually monitored to ensure the appropriateness of its use and safety of the child, other children, teachers, and other personnel.
12. Parents should be informed of the policies on restraint and seclusion at their child's school or other educational setting, as well as applicable Federal, State, or local laws.
13. Parents should be notified as soon as possible following each instance in which restraint or seclusion is used with their child.
14. Policies regarding the use of restraint and seclusion should be reviewed regularly and updated as appropriate.
15. Policies regarding the use of restraint and seclusion should provide that each incident involving the use of restraint or seclusion should be documented in writing and provide for the collection of specific data that would enable teachers, staff, and other personnel to understand and implement the preceding principles.

Developmental Disabilities Assistance and Bill of Rights Act of 2000, H.R. 4920, 106th Cong. § a, 5 (2000).
http://www.gpo.gov/fdsys/pkg/PLAW-106publ402/html/PLAW-106publ402.htm
[Whereas Clause 3: Section 101 a, 5]

Individuals with developmental disabilities are at greater risk than the general population of abuse, neglect.

Ryan, J. B., Robbins, K., Peterson, R., & Rozalski, M. (2009). Review of state policies concerning the use of physical restraint procedures in schools. *Education and Treatment of Children*, *32*(3), 487-504. http://www.ode.state.or.us/initiatives/elearning/nasdse/statepolicyphysicalrestraint.pdf [Whereas Clause 1: pg. 288]

Although there is currently no reliable data on the number of deaths and injuries resulting from physical restraints, the Child Welfare League of America (2002) estimates that between 8 to 10 deaths occur each year as a result of improperly performed restraint procedures. An investigative report by the Hartford Courant identified 142 restraint-related deaths across 30 states within schools and mental health facilities over a decade long period. Of these deaths, it is believed that over one-third were due to the improper implementation of these procedures, resulting in death by asphyxia or suffocation exertion of a restraint (Mohr et al., 2003). (Weiss, 1998). More recently, Mohr, Peti and Mohr (2003) reviewed medical research investigating the leading causes of death associated with physical restraint. Their findings showed fatalities were most commonly attributed to either: (a) positional asphyxia, in which a person's respiratory process is inhibited by being placed in a prone (face down) position on the floor, or when staff members place their body weight on a student's back or chest area to help maintain control of the student when s/he resists; (b) aspiration, resulting from being restrained in the supine (face up) position; and (c) blunt trauma to the chest, experienced during the "take down" or initiation of restraint procedure, resulting in cardiac arrhythmia leading to sudden death. The authors also mentioned other risk factors including pre-existing medical conditions (e.g., heart conditions), obesity, and side effects of psychotropic medications. The laser is especially important given that drug therapy has become a common medical intervention for treating children and adolescents with emotional and behavioral disorders (Connor, Boone, Steingard, Lopez & Melloni, 2003), with medication prevalence rates reaching as high as 76% (Connor, Ozbayrak, Harrison, & Melloni, 1998; Ryan, Reid & Ellis, in press). Specifically, neuroleptic (antipsychotic) medications increase the risk of sudden death by 2.39 times, while antidepressants can increase the heart's QT (electrical cycle) interval which is frequently associated with sudden death. In addition, many medications inhibit the body's cooling mechanisms which can lead to heat exhaustion or stroke during the prolonged This potential risk of injury and death has long been associated with restraint procedures ever since its inception within the psychiatric institutions of France over two centuries ago (Sturmey, Lou, Laud & Matson, 2005). The use of restraint procedures has since migrated from institutional settings, to less restrictive environments such as residential facilities and special day schools. Over the past few decades with the increased practice of including students with emotional and behavioral challenges in the general education environment, the use of restraint has now emerged in public schools. Additionally, schools have become very sensitive to student behavior problems, and on how they will respond to potential aggression as a result of widely publicized incidents of school violence. Physical restraint has become a tool for potential use by schools as a mechanism for controlling violence.

Butler, J. (2009, May). *Unsafe in the schoolhouse: Abuse of children with disabilities*. Retrieved from http://c.ymcdn.com/sites/www.copaa.org/resource/collection/662B1866-952D-41FA-B7F3-D3CF68639918/UnsafeCOPAAMay_27_2009.pdf
[Whereas Clause 2: pg. 7-9; pg. 10-12]
[Whereas Clause 3: pg. 9-10]
[Whereas Clause 4: pg. 10-12]
[Whereas Clause 5: pg. 10-12]

Stories of Abuse

Of the respondents to COPAA's survey who reported information, 64.4% described a situation in which a child was abused through restraints, and 58.3%, through seclusion; and 30% through aversive. The full 185 reports are summarized in Appendix A. These are a sampling of them:

• A young girl with autism and mild mental retardation moved from an inclusive environment to a largely-segregated one in Iowa in second and third grades. She was forcibly restrained by teachers. As many as four staff members held the girl in her desk while forcing her to color a sheet of paper for 1-2 hours. The young girl was placed in locked seclusion room as many as five hours a day, during which she experienced severe duress and wet herself. She was told that she could not change her clothes until she finished her timeout and then finished the work she Had refused. Even when time-out for noncompliance was over, the child was kept in seclusion room because it was designated as her classroom. Both a hearing office and court held that the school had violated her rights. ***(Case C01 in the Appendix).***

• A 9 year old boy with autism in Tennessee was restrained face-down in his school's isolation room for four hours. One adult was across his torso and another across his legs, even though he weighed only 52 pounds. His mother was denied access to him, as she heard him scream And cry. He received bruises and marks all over his body from the restraints. He was released to his mother only after she presented a due process hearing notice under the IDEA. The events occurred in a school for children with severe conduct disorders in which the school district placed the child over the mother's objection. It had no autism program, no staff trained in autism, and no other children with autism. A civil action for violation of civil rights and the IDEA is pending in federal court in Eastern District of Tennessee ***(Case C02).***

• The teacher of a 15 year old Californian with Down Syndrome reported to his parents that he had been confined inside a closet with an aide as in school suspension. The teacher was concerned about the confinement and believed it to be wrong. Although the child had a behavioral intervention plan, the school district did not follow it. He was in the closet all day. He was only allowed out to go to the bathroom, causing extreme humiliation as he walked in front of his classmates. He declined to go back into the closet and began talking to himself. Staff ignored the child's behavior support plan and threatened the child, who became upset and kicked a desk and walls. The parents report that the police were called and informed that the child would not go to his desk, but not that his desk was in the closet. They also believe that, due to his cognitive impairments, school administrators knew that the child would not be able to communicate that he had been put into a closet. ***(Case C137).***

• An 11 year old South Carolinian girl was being restrained with beanbags on the floor, and the school attempted to use a straightjacket restraint on her. As a result of advocacy by her attorneys, the restraints were terminated. Her behavior improved as a result of paying appropriate attention to medical needs, an upgrade in curriculum and a modification of the staff response to behavior. Her curriculum, in particular, was changed to be more age appropriate because her behaviors likely resulted from being bored with curriculum. A new crisis plan was put into place to avoid restraint: if the student became aggressive toward staff, the staff would break away from the student and briefly leave the classroom. Using this plan, the child quickly calmed down and went to her desk area. Previously, school district had requested that the parent take the child home early on regular basis; parents report this has not happened for the last 2 months. With the new behavioral plan, the child has made substantial progress in school.
• An elementary school child in Maine was placed in a prone restraint while in a school district's self-contained classroom. The district was on notice from the child's doctor that the child should not be restrained for medical and psychological reasons. The child regressed as a result of the Incident. The restraint aspect of the due process hearing was dismissed by the hearing officer as being outside the jurisdiction of an IDEA due process hearing. ***(Case C07).***
• A Palm Beach 14 year old with a severe emotional disturbance was handcuffed in an isolation room, defenseless. He spit at a school officer, even though he was handcuffed and unable to hurt anyone, the officer pepper-sprayed him, injuring him. A civil rights case was filed in Southern District of Florida and the school district entered a consent decree enjoining further such action and ordering damages for the child ***(Case C03).***
• A 6 year old child in Georgia with a brain injury, autism, and a language disorder could be self-injurious and aggressive. He was restrained repeatedly by staff, and has come home with head and facial injuries, as well as indications that he is biting his own clothing. The school has not used any comprehensive positive behavioral approaches. Private experts have determined that restraints are harmful to the child and also encourage continued acting out. The private experts asked to observe in the classroom and the request was denied. The mother has been allowed to observe, but only 15 minutes a day through a small window in the door. It took her 3 weeks to observe an entire day, and she was forced to quit her job to be able to do so. Parents have filed for due process. The school district is represented by a national law firm that often represents school districts aggressively. School district counsel has repeatedly filed motions claiming that the parent's complaint is insufficient even though it lays out the factual allegations at length. The effect is to improperly deny the parents access to the legal system, preventing them from redressing the restraint of their child.
• Staff repeatedly locked a child with severe autism and epilepsy in a bathroom as a behavior management technique, rather than provide a research-based positive behavioral intervention plan. He came home bruised from banging into the toilet and a steel table in the bathroom. He was capable of overturning the table and injuring himself, and would also have been injured if he'd had a seizure while locked in the bathroom. The school psychologist recommended that police be used to handle the 7 year old, 42 pound child. The parents asked to have an independent psychologist observe the child, but their requests were denied. The child was often kept locked in this room for more than 30 minutes and on numerous occasions was isolated for several hours. The parent reported, "I could always tell when he had been isolated even if his teacher forgot to tell me because he would alternate between aggressive behavior and extreme sadness and crying at home." The child has since changed schools but has been severely traumatized. ***(Case C67)***

• A teen-aged boy with Asperger's Syndrome was singled out by principal for punishment on daily basis in Pennsylvania. He was forced to sit in a school office cubicle up against a window looking into the hallway without moving. He was ridiculed in front of various classes on a regular basis by staff pointing out Asperger's Syndrome behaviors and mannerisms (especially lack of eye contact and aversion to having others in personal space) This lasted for 7 months until an advocate was retained. ***(Case C83)***

• A nonverbal child with autism moved to a new school in South Carolina. His previous school had provided an augmentative communications device, but the new one did not. With no way to communicate, he resorted to pinching, biting, and running away. A school aide then bit him to "teach him a lesson." The school district never gave the child a research-based Positive Behavior Intervention Plan. ***(Case C102)***

• A teacher withheld food as punishment from a student with multiple disabilities in Mississippi who failed to complete his work. Then, when the child sought food, he was physically prevented from retrieving his lunch bag, causing him to go hungry. When the child protested, he was restrained. ***(Case C64)***

• A child with Central Auditory Processing Disorder spent 17 days in one year in a windowless 5'x6' seclusion room. He was sent there for failing to follow instructions. His teacher gave him directions too quickly, and then repeated them and repeated them, each time more quickly than the time this child needed to process the original instruction because of his disability. ***(Case C132)***

• A gifted child with Asperger's syndrome in Florida had been performing on grade level. Her placement was changed to a behavioral day school. After spending 79 days on average per year in a 6'x'8' seclusion room without a teacher, she will be receiving only a special diploma. ***(Case C82)***

• An untrained aide denied lunch to a child with autism and Tourette Syndrome because he had been speaking in funny voices. The aide used physical restraint to keep the child in cafeteria. After this event, the child's placement was changed to a storage closet that locked from the outside. Parents report that the school district failed to educate the child. He had no interaction with other children and made no academic progress. The school even required permission from other parents before the child was allowed to eat with other children. T school district was cited by State Department of Education for its actions; compensatory education was ordered. The district did not provide it. The district is now paying for the child to receive education at private school where he is on honor roll and with peers for first time in four years.

• A medically fragile child in Colorado with developmental disabilities and mental illness had a history of getting locked in closets as a small child prior to his adoption. Nonetheless, the school district placed him in a seclusion room that was a small 2x4 foot cubicle closed on 3 1/2 sides with no light. (It was ironically called the "take space place.") He had to sit in a chair facing the back wall with his hands folded. A teacher sat outside the opening "supervising" him until they felt that he had "calmed down" for up to 1/2 hour at a time. He was secluded because after being in a psychiatric hospital for a suicide attempt, he threatened to kill himself at school. Advocate reports that the district did not tell his parents. The full compilation of 185 incidents is provided in Appendix A. It is only the tip of the iceberg with regard to restraints, seclusion, and aversives in school. There is no national repository or tracking system for the use of aversive interventions, and therefore, incidents are reported anecdotally.

{Whereas Clause #3, pages 9-10}
Children with disabilities are a vulnerable population, at special risk of being subject to aversive interventions. Their disabilities may manifest in what appears to be misbehavior, or they may have great difficulty following instructions. Rather than provide positive behavioral interventions, schools may react with aversive interventions. In addition, children may have communication, emotional, cognitive, or developmental impairments that may impede understanding or the ability to effectively report what happened to them. Moreover, they may be unable to comply with instructions that are made a condition for ending the abusive intervention and unable to communicate pain or danger while in the intervention. Children with these kinds of impairments are frequently segregated in self-contained classrooms with other children with disabilities, and few witnesses who can describe the occurrence.

{Whereas Clauses #2, 4 & 5, page10-12}
Accordingly, Congress should enact legislation to protect children with disabilities nationwide from abusive interventions, including restraints, seclusion (confinement) rooms, and aversives. Legislation should prohibit the following in schools under all conditions:

- prong restraints;
- any restraints that interfere with breathing;
- mechanical and chemical restraints;
- any other form of restraint except in situations in which the student
- poses a clear and imminent physical danger to himself or others;
- locked seclusion rooms or other rooms from which a child cannot exit,
- unless there is an imminent threat of immediate bodily harm, in which
- case a child can be placed in a locked room while awaiting the arrival of
- law enforcement or crisis intervention team;
- use of restraint or seclusion when they are medically or
- psychologically contraindicated for a child and;
- any behavior management or discipline technique that is intended to
- inflict injury, cause pain, demean, or deprive the student of basic human
- necessities or rights.

2. Make clear the other physical restraints can be used in school settings only to control acute or episodic aggressive behaviors that pose a clear and imminent physical danger to the student or others. Restraints must (a) be applied only by trained personnel, (b) may last only as long as necessary to resolve the actual risk of danger or harm, and (c) be limited to only the degree of force needed to protect from imminent injury and no more. They may not be used when less intrusive methods would resolve the threat of harm, or to coerce compliance, as punishment, or for staff convenience.

3. Prohibit the use of locked seclusion rooms and spaces from which children cannot exit, as noted above. If, in order to allow a child to de-escalate, timeout or cooling-off spaces are used, children must be able to exit them, they must be supervised at all times. The rooms must not be

used for other purposes (*e.g.*, punishment) or in place of providing appropriate related services and behavioral supports in the classroom. A child's legal right to learn with her peers in the least-restrictive environment must be respected and enforced.

4. Adhere to IDEA requirements that parents and school staff should work together collaboratively–as equals–to ensure that children receive appropriate interventions. School districts must ensure that parents are equal, participating members of the IEP team with regard to all decisions. Any proposed bill should not allow school personnel to avoid its restrictions on aversive interventions by putting them in the child's IEP.

5. Parents must receive full information about any proposed interventions and their possible harms and dangers, as well as their children's rights and the legal requirements imposed on school districts. Because of the dangers that restraints and seclusion pose, staff must immediately notify parents and senior administrators in writing of any use of seclusion or restraint, and document the incident in the child's file.

6. Require extensive training of all personnel in educational settings who have contact with children. Training must include the proper use of research validated positive behavioral supports, crisis reduction and de-escalation techniques, along with other best practices. Training must also ensure that staff fully understands their legal obligations under the legislation and other statutes. Including prohibitions and restrictions on the use of aversive interventions, and requirements for documentation and reporting. If the use of a particular restraint or form of seclusion is approved for use with any student in an emergency or dangerous.

***National Fire Protection Association: NFPA 101 Life Safety Code*. (2006). Retrieved from https://law.resource.org/pub/us/code/ibr/nfpa.101.2006.pdf**
[Whereas clause 5: pg. 41 Section 101-35]

2-1. Every building or structure, new or old, designed for human occupancy shall be provided with means of egress and other safeguards to permit prompt escape of occupants, or shall furnish other means to provide a reasonable degree of safety for occupants. The design of means of egress or other safeguard shall be such that reliance for safety to life will not depend solely on any single safeguard: additional safeguards shall be provided for life safety in case any single safeguard is ineffective due to human or mechanical failure
2-4. In every building or structure, means of egress shall be arranged and maintained to provide free and unobstructed egress from all parts of the building or structure at all times when it is occupied. No lock or fastening shall be installed to prevent free escape from the inside of any building. Means of egress shall be accessible to the extent necessary to ensure reasonable safety for occupants having impaired mobility.

Exception: Locks shall be permitted in mental health, detention or correctional facilities where supervisory personnel are continually on duty and effective provisions are made to remove occupants in case of fire or other emergency.

Notes: As outlined in the OCR CRDC definitions referenced in the US DOE Resource Document (page 10), the term "restraint" encompass the terms "physical restraint" and "mechanical restraint". References to "seclusion" encompass "seclusion" as defined in the CRDC. According to the GAO report, each of these types of restraint is currently being used in schools.

The CRDC defines *physical restraint* as:

- A personal restriction that immobilizes or reduces the ability of a student to move his or her torso, arms, legs, or head freely. The term physical restraint does not include a physical escort. Physical escort means a temporary touching or holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a student who is acting out to walk to a safe location.

The CRDC defines *mechanical restraint* as:

- The use of any device or equipment to restrict a student's freedom of movement. This term does not include devices implemented by trained school personnel, or utilized by a student that have been prescribed by an appropriate medical or related services professional and are used for the specific and approved purposes for which such devices were designed, such as:
  - Adaptive devices or mechanical supports used to achieve proper body position, balance, or alignment to allow greater freedom of mobility than would be possible without the use of such devices or mechanical supports;
  - Vehicle safety restraints when used as intended during the transport of a student in a moving vehicle;
  - Restraints for medical immobilization; or

- Orthopedically prescribed devices that permit a student to participate in activities without risk of harm.

The CRDC defines *seclusion* as:

The involuntary confinement of a student alone in a room or area from which the student is physically prevented from leaving. It does not include a timeout, which is a behavior management technique that is part of an approved program, involves the monitored separation of the student in a non-locked setting, and is implemented for the purpose of calming.

An Analysis of State Seclusion and Restraint Laws and Policies

http://www.autcom.org/pdf/HowSafeSchoolhouse.pdf

Link to personal r & S story videos http://vimeo.com/681020370