
# Transforming School Culture

**Pat Amos, MA**

**Anna Moore**

**Peg Kinsell**

**Phyllis Musumeci**

**Janice LeBel, Ph.D.**

**Barbara R. Trader, MS**

"Do not train children to learning by force and harshness, but direct them to it by what amuses their minds, so that you may be better able to discover with accuracy the peculiar bent of the genius of each."

Plato

# Transforming School Culture

Seclusion and restraint (S/R) use has traditionally been associated with residential and inpatient programs but they are increasingly recognized as used in the public and private schools (National Disability Rights Network [NDRN], 2009; Ryan & Peterson, 2004). Only within the last few years has the professional literature in education begun to examine the use of these violent, high risk procedures (Ryan, Peterson, & Rozalski, 2007). As a result, there is limited information and data regarding S/R use in the schools available (NDRN, 2009). What's more, there is no national standard for S/R use in school settings or a dataset from which to compare use by state, district, or school (NDRN, 2009).

In 2009, the National Disability Rights Network (NDRN) issued a report, *"School is not Supposed to Hurt,"* and cited 50 examples from 38 states of incidents of S/R abuses and deaths. Examples included: locking children in make-shift seclusion rooms, breaking arms, forcing them to sit in their urine, and killing several children through physical restraint. The NDRN report, like the Hartford Courant exposé, ignited national attention, a Government Accountability Office investigation, and calls for legislative reform and protective standards to be passed.

The American Civil Liberties Union and Human Rights Watch (ACLU/HRW) released a joint report, *"Impaired Education,"* a short while later documenting children with disabilities "make up 19 percent of those who receive corporal punishment, yet just 14 percent of the nationwide student population" (ACLU/HRW, 2009). The GAO investigation that followed reported "hundreds of cases of alleged abuse and death related to the use of these methods on school children during the past two decades" (USGAO, 2009).

The call for national standards from parents and advocates was heard by Federal legislators, who filed bipartisan bills in 2010 to create a minimum practice standard for reducing and preventing S/R use in schools. With a change in bill sponsorship, the last bill was re-filed by Representative George Miller in 20ll (H.R. 1381) as the *Keeping All Students Safe Act*. In December 2011, Senator Tom Harkin introduced a new Senate version of the Act (S. 2020) with significant changes; most notable is a prohibition on the use of seclusion (NDRN, 2012).

**The Power of Teachers**

"I've come to a frightening conclusion that I am the decisive element in the classroom. It's my personal approach that creates the climate. It's my daily mood that makes the weather. As a teacher, I possess a tremendous power to make a child's life miserable or joyous. I can be a tool of torture or an instrument of inspiration. I can humiliate or heal. In all situations, it is my response that decides whether a crisis will be escalated or de-escalated and a child humanized or dehumanized."

*Haim Ginott, author, teacher & child psychologist*

## Recent developments

Most recently, on March 6, 2012, TASH, a leading disability rights organization, and other advocates attended a conference with the Secretary of Education, Arne Duncan, and Assistant Secretary for Civil Rights, Russlynn Ali. The Department of Education called this meeting to discuss new survey data that highlights inequities in education for minority students. The national survey includes data from more than 72,000 schools serving 85% of U.S. students. This is a first-of-its-kind assessment of national data on equity in educational opportunities. The Department is making it publicly available at http://ocrdata.ed.gov. The Secretary and Assistant Secretary said the data should be viewed as a call to action, and should alarm the public about issues disproportionately impacting students of diverse backgrounds, including those with

disabilities. Secretary Duncan addressed three core areas of emphasis for the administration: teachers, academic rigor and discipline.

The Secretary noted students with disabilities were 2 times more likely to be suspended (13% for IDEA students vs 6% for non-IDEA students). He also reaffirmed a commitment to seeking alternatives to restraint and seclusion. Although 1 in 8 students in the sample has a disability, students with disabilities represent 70% of those physically restrained by adults in their schools. Although 21% of students with disabilities are African American, this group represents 44% of students subjected to mechanical restraint. Of that 21%, African American males represent 18% [emphasis added] (B. Trader, personal communication, March 6, 2012).

While legislative and national changes are slow, some progress is occurring in a few states which have passed more stringent standards (NDRN, 2010) or implemented related efforts such as Massachusetts' collaborative Interagency Initiative to prevent S/R by adopting the Six Core Strategies© across child-serving settings (LeBel, Nunno, Mohr & O'Halloran, 2012). Important resources and tools have also been developed and are being promulgated to support families in becoming their own best advocate in preventing S/R with their child in the school system. TASH, in particular, has also been strongly focused on this issue for years and key to new resource and tool development.

## TASH efforts

Since 1975, TASH has been dedicated to changing the culture of education and human services to one of positive approaches rather than coercive interventions. In 2004, TASH took the lead in founding a national alliance of organizations seeking legislative and regulatory solutions to the problems of S/R in schools. The Alliance for the Prevention of Restraint, Aversive Interventions, and Seclusion (APRAIS) meets monthly under TASH leadership, and TASH dedicates a section of its web site to APRAIS efforts and action alerts. Through TASH, APRAIS issued its first informational guide, *In the Name of Treatment* (2005; 2nd edition 2008), which examines the dimensions of the problem. In 2011 a companion guide, *Shouldn't School Be Safe?,* was issued to counsel parents on the three areas of "prevention, vigilance, and response." TASH has also conducted a nationwide survey on the use of S/R in the schools, which was released to legislators and the public and published in the September 2010 issue of the TASH journal, *Research and Practice for Persons with Severe Disabilities (*Westling, Trader, Smith & Marshal, 2010).

At each of TASH's annual national conferences, a strand and/or a preconference day is devoted to this issue, and, in the Fall of 2011, TASH worked with the National Association of State Mental Health Program Directors (NASMHPD) to present a Train the Trainer event on the subject of keeping children safe in schools. The trainees, five of whom were awarded scholarships to attend, received PowerPoints and handouts to take home and use to educate others. A preliminary survey of

their activities in the four months since this event demonstrates a strong, ongoing impact, and plans are underway to repeat Train the Trainer in 2012. TASH also made information from the conference available as a webinar series starting in April 2012. TASH university-based teacher trainers are now at work on a pre-service and in-service training curriculum on the topic of preventing S/R in the schools; the tentative release date is the end of 2012. A collection of "survivor stories" by self-advocates who have experienced these techniques is also underway.

The TASH Human Rights Committee, one of its standing issues committees, has given the prevention of S/R in the schools its top priority. TASH works diligently to inform members of Congress and their staffs about the dangers of S/R use in our schools, and TASH hosted a well-attended Legislative Briefing in the summer of 2011 as well as various days of visits on the Hill. The TASH publication, *The Cost of Waiting* (now being updated), was issued and distributed so that legislators and others could understand the human impact of the long wait for passage of the federal legislation that was initially introduced in May of 2009 (TASH, 2011).

TASH, both through its Human Rights Committee and through APRAIS, makes it a point to respond thoroughly and promptly to disseminate the latest data on restraint and seclusion, such as the recent OCR findings that restraint and seclusion are used disproportionately on children with disabilities and children of color, and to correct misguided statements and reports. When the latest American Association of School Administrators

issued *Keeping Schools Safe: How Seclusion and Restraint Protects Students and School Personnel* in March 2012, TASH quickly issued a press release with a lengthy rebuttal, correcting the AASA's misinterpretations and clarifying the evidence base. For additional information, please visit TASH's website at http://tash.org/.

## School and School District S/R Reduction Success Stories

A number of schools and school districts in the United States have focused on preventing and reducing their use of S/R. A partial list of those who have successfully decreased their use of these procedures follows:

- Centennial School, PA - 100%
- South Sioux City, NE - 100%
- Greenbay School District, WI - 99%
- Grafton School, VA - 99%
- NW Special Ed. School, PA (w/CPS) - 68%
- Phillips School, MD - 56%
- J.L. Gildner RICA, MD - 50%
- Austin, TX (w/PBIS) - 21%

Additional information about some of these schools can be found on-line, on their web-sites, or in the professional literature.

## Parent experiences with S/R in schools

Phyllis Musumeci is a Parent Advocate and Mom to Christian.

She lives in Viera, Florida.
She wrote this statement about her experience in March, 2012

"My son Christian has Autism and Cornelia de Lange Syndrome. With all this going on in his life he was doing excellent at home and at school. When he wasn't talking at 2 years old I started teaching him sign language so he would be able to communicate some of his needs and wants. I was very surprised at how quickly he picked it up and how well he could communicate using the signs he learned. By the time Christian was 4 1/2 years old he knew over 500 hundred signs and was signing 2-4 words together making small sentences. He also started talking at this time. My husband and I were so proud at how much he had accomplished in his short 4 1/2 years.

Pre-K were good years and he enjoyed going to school and learning. When he got to elementary school things began to change. By second grade I started getting complaints about his behavior. We weren't having any problems at home so I could not identify with what was going on or why. Instead of

addressing the behavior issues with us and developing a plan to help him, they were suspending him. Christian liked going to school but he also liked being suspended because he got to go home and be with mom or dad. He learned quickly how to get out of school and come home.

When Christian got to middle school things really began to change and more behaviors started to come out at school. Middle school seemed to have the attitude that disability or not, behaviors would not be tolerated. We were not having behaviors at home so we did not understand why Christian was having behaviors at school. There were no phone calls or meetings from the school from the school to discuss behaviors so we didn't think we needed to be too concerned. We were sure the school staff were helping Christian get to the root of what was distressing him and causing him to have behaviors. They were the experts and we trusted them to do what was best for our son.

By mid-7th grade Christian was having behavior issues at school that seemed to be escalating almost weekly and we started seeing behaviors at home. On most of the days I picked him up after school he would be standing in the hall by himself with no work and no desk. He used to love to go to school but now he would go into a panic in the morning when it was time to get ready for school. In late 2005 Christian suffered a breakdown and we had to pull him out of the public school system. This child went from a very happy, easy-going child to a very angry child paralyzed with anxiety and phobias.

In 2007, we discovered restraint records with 89 documented restraints over a period of 14 months. The 6th grade restraint log books went missing from the school so we believe there were many more restraints then the 89 we knew about. Isolation was never documented so we do not know how many times he was isolated from the rest of the class. Christian went through some dramatic changes in the way of regression, depression, anxiety attacks and many phobias. In 2008, Christian was diagnosed with Post Traumatic Stress Disorder by two neurological psychiatrists.

Looking back, I know the aversive treatments that were used on this gentle child were so wrong and caused him physical and mental harm that we are still addressing today. Below are just some of the treatments school staff should have available for children with behavior issues brought on by their disabilities. None of these treatments below were used to help Christian.

- I think the most important thing that should have been done was that the school staff should have talked to us and worked with us to identify problem areas and how we all could help Christian.
- All behaviors are a form of communication. The school should have brought in a BCBA to help staff work with Christian to identify the antecedent to his behavior triggers.
- **Applied Behavior Analysis** (**ABA**) is a science that involves using modern behavioral learning theory to modify behaviors.

- **Positive Behavior Support** (PBS) is a set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment.
- **Sensory Integration Therapy**—Children with sensory integration dysfunction frequently experience problems with their sense of touch, smell, hearing, taste and/or sight. Along with this will often be difficulties in movement, coordination and sensing where one's body is in a given space. This is a common disorder for individuals with neurological conditions such as an autism spectrum disorder.
- Exercise Programs or sensory diet at school and at home.
- Coping and relaxation skills.
- Learn to identify body language and when a child is approaching to meltdown mode.
- Develop a workable Functional Behavior Plan and include the parents in the process.
- Create a sensory/comfort room.

- Eliminate aggressive techniques like restraint, seclusion and isolation. I don't understand how anyone can think these kinds of barbaric techniques could help any child with a disability. I can only imagine the fear and panic of the child fighting back to try and protect themselves as staff restrain them longer and harder until this kind of treatment snowballs out of control and then becomes standard practice for "this child."
- Cognitive Behavior Support Therapy (if the child is able to participate).

**For Parents:** Please listen to your child even if they do not have good communication skills. Our children who do not speak or have poor expressive communication use many other forms of communication to tell us something is bothering them. It's up to us as parents to listen to our children and get to the root of the problem that is causing them to be distressed."

If your child is coming home with bruises, is regressing in social/emotional and academics, behaviors are escalating, sleep problems, phobias and not wanting to go to school anymore, please address these problems with your child's doctor and with school staff IEP Team. Always remember that you are your child's strongest advocate and expert and you know your child better than anyone else."

Anna Moore is Isaiah's Mom and a Systemic Advocate.
She has a blog entitled *Families Against Restraint & Seclusion*, and she created a video called *America's Forgotten Children*:
http://familiesagainstrestraintandseclusion.blogspot.com/
http://www.youtube.com/watch?v=QyTfOnPLnSM

"My son's name is Isaiah. He has a diagnosis on the Autism spectrum, able to function at a high level, and mainstreamed. Isaiah has always been a very well behaved child. He exhibited behavior that earned him conduct grades of "Excelling at grade level expectations."

Isaiah was only 7 years old and weighed 52 pounds when the restraints began. I know of 4 restraints that he suffered all within a month and a half towards the end of the school year. Isaiah doesn't have behavior issues—he has sensory issues. We taught Isaiah tools he could use when he felt overwhelmed. He would put his head down or go into the bathroom that was inside the classroom. This was fine until the teacher decided Isaiah was choosing this behavior on purpose, not that it was a manifestation of his disability. The teacher referred to him on several occasions as being "defiant" and "manipulative." Her misinterpretation of his disability and coping strategies put Isaiah in harm's way.

In response to the restraints, I contacted agencies and advocates but no one was helpful; they didn't seem to know

how to deal with restraints. Some assumed my son must have deserved it because schools don't put their hands on children. I felt like I was up against the world, and my head was spinning. I felt so alone and my son was being blamed for what these aggressive adults were doing.

If I go into detail about each of the restraints and the emotional and physical abuse Isaiah had to endure this piece will be too long, so I will share the last and most severe restraint.

Isaiah wasn't restrained because there was imminent danger to himself, others or property. Isaiah was restrained because he was merely an inconvenience. The last restraint was so severe that he suffered a cervical sprain, a busted lip, bruised back & ribs, and bleeding under the skin, face, arms, torso & neck. The force from the restraint was so excessive that his polo shirt was imprinted into his body. Isaiah almost suffocated to death and his neck was almost broken. All of this occurred while I was sitting in the school's front office and was never notified. I was left sitting for over an hour while staff had a meeting with police and my son (I have the video). I filed several police reports and multiple DCF/Department of Children & Families child abuse reports. The police wouldn't do anything because I had to prove that that school staff intended to injure my child. DCF investigated and did find that my child was abused but that's all they can do as they have no authority or jurisdiction over schools. I had ample documentation, police reports, DCF reports, pictures, and videos. We sued the school district and settled as it was my only option for some sort of justice for Isaiah. I kept my son's story in the media, on YouTube, and

was also invited to participate in a documentary "Real Danger: Restraints and Our Children" to raise awareness and let parents know what happens to children with special needs in school.

Isaiah is now in private school. He will be 13 next month and is doing well after therapy. He still wakes up screaming from nightmares sometimes and doesn't like to leave the house too much but we are going forward and the PTSD issues have improved. He loves his new school and has a lot of friends. He still gets "E" in conduct which is excelling at grade level expectations and he receives A's and B's in academics. Isaiah has always been well-behaved, and all he needed was patience and understanding.

If mental health facilities are working toward being 100% restraint-free then why are schools being allowed to use them? Schools are using restraint and seclusion as a first response and for punishment. The system is broken and our children are paying the price. Listen to your children and don't let schools explain away marks and bruises. Show up unannounced often. They may not let you in the classroom, but they can't stop you from having lunch with your child.

"I have given the school system a loving boy. He'll stay loving too if he is nurtured and taught with accommodations. However, if he has to suffer from the systemic abuse of peers, teachers and paraprofessionals, I guess they'll just blame him…."

## Additional Resources

The following resources are included at the end of this chapter:

The TASH Train-the-Trainer PowerPoint entitled, *Shouldn't School Be Safe?*

Massachusetts Department of Public Health Protocol for School Nurses in the Prevention and Reduction in the Use of Restraint and Seclusion in the School Setting, MaryAnne Gapiski et al. December 2013.

# Shouldn't School Be Safe?

What every parent and advocate should know NOW

## What *really* makes a school safe?

The overwhelming majority of teachers, administrators, therapists, and aides want to work in schools that are restraint and seclusion free. Many already do. "It takes a village" to safely educate a child.

# OVERVIEW

The Restraint and Seclusion of School Children

- What is happening in our schools?
- What tools can we use to keep children safe?

## 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

## 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 emergency "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 school staff person who CAN intervene to save a child 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?

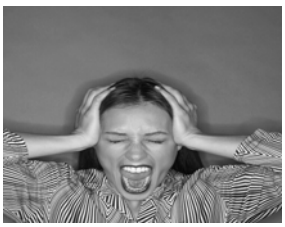
*The evidence base*

# 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.
- Restraint and seclusion do NOT restore calm or emotional stability; they trigger "fight or flight."
- *"Restraints (are) an intervention in search of a research foundation."* -

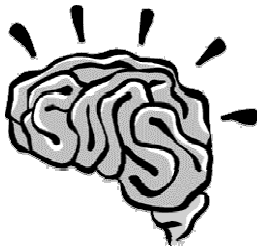
- Kennedy, S. S., & Mohr, W. K. (2001). A prolegomenon on restraint of children: Implicating constitutional rights. *American Journal of Orthopsychiatry,* 77(1), 26-37.

# Cortisol!

- The body's primary stress hormone
- Helps regulate blood sugar and blood pressure in response to danger
- Anti-inflammatory, anti-allergic agent that suppresses the immune system

# This is your brain on cortisol

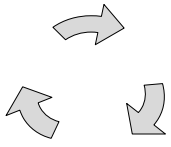
- Hypervigilance
- Difficulty taking in information
- Misinterpreting actions and intent of others
- Language impairment
- Cognitive impairment
- Loss of self-control and executive function
- Rigidity of thought and action
- Distrust and anger



- *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/

# 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.*

## Slogan of MH advocates

- "Restraint is not treatment; restraint is the failure of treatment."

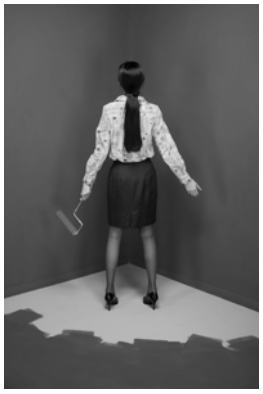

## Do aversives, restraint and seclusion have value as education or training?

## Coercive interventions undermine positive approaches:

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

## 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



## 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, high staff turnover, job dissatisfaction, lack of trust, communication breakdown, and burdensome economic costs that take funds away from the program's mission

## *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

## 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 looked at 10 cases in which there was a criminal conviction, a finding of civil or administrative liability, or a large settlement.

## These "COMMON THEMES" emerged:

- They involved children with disabilities who were restrained and secluded; often
  - they were <u>not</u> physically aggressive, and
  - their parents did <u>not</u> 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:

- 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)

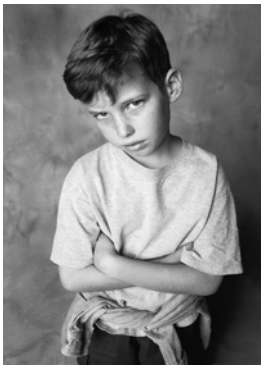
## COPAA Unsafe in the Schoolhouse: May 2009 survey results

- The Council of Parent Attorneys and Advocates (COPAA) creates independent survey
- Initial report on 188 incidents shows the use of restraints, seclusion, and aversives is extensive, and the consequences immense

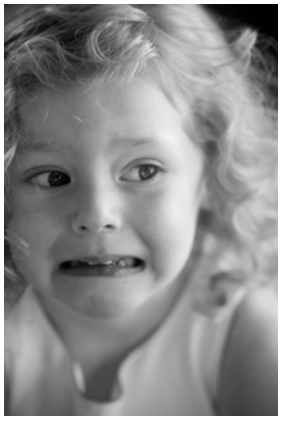
***Unsafe in the Schoolhouse* www.copaa.org**

# COPAA: effects on the child

- The child gets the blame for RS use
- 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, 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 school – parent relationships

- Retaliation
- Lack of trust
  - suspect each other of lying
  - suspect each other of exaggerating
  - students tagged with "severe reputations"
- Relationships irrefutably harmed

# 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.

# ADVOCATING IN THE SCHOOLS: child by child

- Prevention
- Vigilance
- Response

# PREVENTION

Do RS belong in education and behavior plans?

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 assume "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

## 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.*"

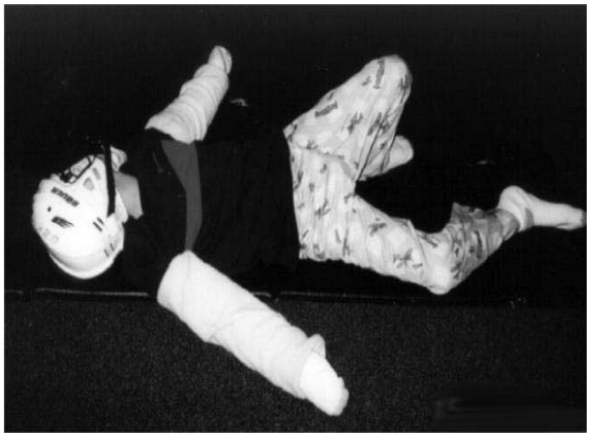
  *(Youngberg v. Romeo, 1982)*

- 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



For "planned" use, informed consent is needed. But 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

# 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
- Scream Room
- ???

## 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

## Due Process

- Required if parents object to SD decision to place RS into an IEP, or wish to rescind permission for RS
- 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 won

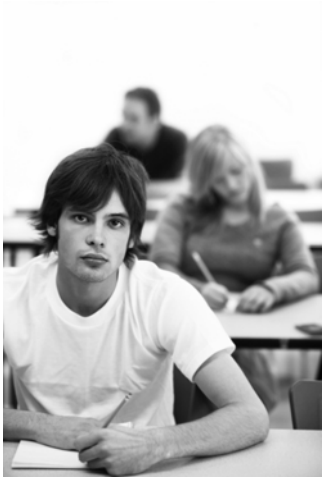
The IEP process remains a child's best protection. Despite obstacles, parents need to remember that each IEP gets only 2 votes:

1. **The school's**

2. **The family's**

## 5 KEY LEGAL ARGUMENTS for keeping ARS out of an IEP, BIP or 504 Plan

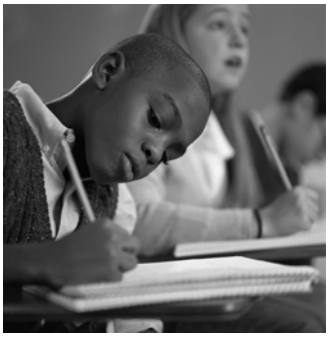
# 1. Presumption in favor of positive interventions



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, not reactive
- Problem-solving: behavior that challenges us seen as symptoms of a problem, not the problem itself

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

## May RS be used as part of a school's disciplinary or "zero tolerance" policies?

- How are restraint and seclusion different from in-school suspension?
- Federal education law prohibits punishing a child for a manifestation of his/her disability
- Manifestation Determination may be needed

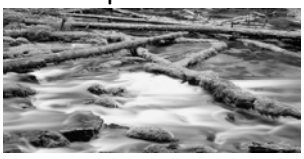
## 2. Requirement for an FBA

When problems arise, a Functional Behavioral Assessment (FBA) is required. The FBA should lead to positive behavioral interventions and supports.

- ✓ FBA: the type of evaluation used to determine a child's behavior support needs
- ✓ Since IDEA of 1997, schools must conduct an FBA and develop a behavioral intervention plan for any student with a disability who exhibits serious behavior problems.
- ✓ FBA also required when a student with a disability is facing serious disciplinary action (e.g., involving a change in placement, suspension of over 10 days, or expulsion).

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

1. include 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, triggers
5. explore the impact of things that 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
9. consider mental and physical health factors
10. consider whether experiences and memories from the past, e.g. of a traumatic event, may impact the present
11. explore quality of life issues
12. explore nonvolitional behaviors



## APBS Standards of Practice

- Defines aims and content of PBS
- Defines aims and content of FBA

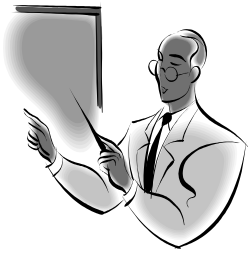
- http://www.apbs.org/standards_of_practice.html

## 3. Requirement for scientifically based & evidence-based practices

- Required under both IDEA and ESEA/NCLB.
- Wishful thinking is not enough!

IDEA (2004) requires that the IEP team's choice of special education, related and supplementary services be guided by scientifically based research, such as peer-reviewed research.

ESEA/NCLB also requires scientifically-based research and evidence of efficacy.



*"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
- ARS have no therapeutic value
- Safe, positive methods of changing and redirecting behavior are scientifically based

# 4. 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*

# 5. State and local protections

- State statutes and regs
- School District policies


# Local level protections

- School-wide safety plan
  - Should be for ALL students
  - Check student handbook
- School district policy
  - Ask for copies!
  - Is there a planning committee you can talk with or join?

## *To review…*

1. IDEA presumption in favor of positive interventions
2. IDEA requirement for FBA
3. IDEA & ESEA requirement for scientifically based practices
4. IDEA requirements for FAPE
5. State and local protections

## Be prepared!
## Be proactive!

- **Get it on paper!**

- **Letters**
- **Parent Report**
- **ABCs**
- **Diary**

# LETTERS!

- No Consent 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

## 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?

## 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
- Classroom observations

# VIGILANCE

- Signs of an endangered child
- Need for "trauma-informed care"

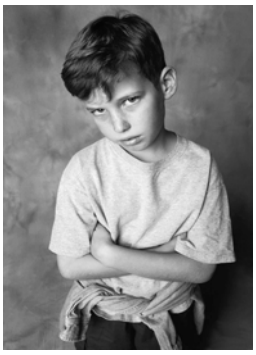
Sudden regressions in behavior or the emergence of new and unexplained behavior problems may indicate psychological distress and offer clues to their origin.

--"In the Name of Treatment," APRAIS

## 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 already know and approve of what is being done to them*

## 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"

## 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

## Emotional/psychological and behavioral signs

- Sleeplessness
- Increased anxiety levels
- Decrease in sociability
- Emergence of a school phobia (especially when the child previously enjoyed school) or 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, closets)
- Appearance or intensification of self-injury
- Sudden change in weight
- Increased aggression or emotional outbursts

In the Mental Health system, these results of ARS are addressed through the teaching and practice of TRAUMA-INFORMED CARE:

programs and services based on an understanding of the vulnerabilities and triggers of people who have been marginalized and mistreated

## 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 ABC 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

## 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)

## 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!

## Should 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.

## Your strategy:

Seek maximum assistance from as many stakeholders as possible.

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

## 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 and Information Centers (PTIs) 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

## *"The rising tide has not yet lifted all boats."*

# Shouldn't School Be Safe?

## A Train the Trainer Event

Presented by TASH and
the National Association of State Mental Health Program Directors (NASMHPD)
TASH 2011 Annual Conference, Atlanta, GA: 11/30 & 12/1

**This CD was created as a handy resource for new trainers. The PowerPoint may be re-used and reduced in length for local presentation. Trainers are welcome to choose among the other suggested handouts listed below.**

### PowerPoint:

- **Shouldn't School Be Safe?** TASH Train the Trainer PowerPoint

### Articles:

- Reducing Restraint and Seclusion in Mental health Settings: Core Strategies for Prevention, by Kevin Ann Huckshorn. *Journal of Psychosocial Nursing,* Vol. 42, No. 9 (2004).

- A Snapshot of *Six Core Strategies for the Reduction of S/R (Revised 11/20/06), by* Kevin Ann Huckshorn.

- *Position Statement on Seclusion and Restraint,* National Association of State Mental Health Program Directors.

- *Six Core Strategies to Reduce the Use Of Seclusion and Restraint Planning Tool* (Draft, March 2008). Kevin Ann Huckshorn, R.N., M.S.N., C.A.P., I.C.A.D.C., Director, OTA, National Association of State Mental Health Program Directors.

- Effectiveness of Six Core Strategies Based on Trauma Informed Care in Reducing Seclusions and Restraints at a Child and Adolescent Psychiatric Hospital, by Muhammad Waqar Azeem, MD, FAACAP, Akashdeep Aujla, MD, Michelle Rammerth, RN, BSN, MAN, Gary Binsfeld, MA, and Robert B. Jones, MD. *Journal of Child and Adolescent Psychiatric Nursing* 24, 11–15 (2011).

- Eliminating Restraint, Seclusion, and Aversives in Our Schools: A parent's thoughts on why we're stuck and how to move forward, by Pat Amos. *Exceptional Parent Magazine* online, Sept. 30, 2007.

## Guides:

- In the Name of Treatment, APRAIS 2008 (2nd edition)
- Shouldn't School Be Safe?, TASH 2010

## Sample Letters:

- No Consent Letter (RespectABILITY Law Center)
- Medical Letter
- Gebser Letter/Notification Letter (Renay Zamloot)
- How to Place Your District on Official Notice that Your Child is Being Harmed by the Use of Restraint and Seclusion (Renay Zamloot)

## How-To's for Parents:

- Creating a Parent Report
- ABCs of Data Collection

**Massachusetts Department of Public Health**

**Protocol for School Nurses in the Prevention and Reduction in the**

**Use of Restraint and Seclusion in the School Setting**

**December 2013**

## Acknowledgments

This document is the work of many who are committed to ending the practice of the use of restraint and seclusion in Massachusetts schools. It was developed with the assistance of Lisa Gurland, RN, PsyD. from the Massachusetts Department of Public Health, Jennifer Honig, Esq., Senior Attorney and Lauren Roy, Esq., Staff Attorney with the Massachusetts Supreme Judicial Court, Mental Health Legal Advisors Committee, Janice LeBel, PhD., from the Massachusetts Department of Mental Health, Child and Adolescent Services and the following school nurses from across the Commonwealth:

Laurie Burnett, M.Ed

Kim Corazzini, RN

Sheri D'Annolfo, BSN, RN, NCSN

Phyllis Ducomb, BSN, RN

Mary Ellen Duggan, BSN, RN

Ann Farrell, MS, M.Ed, RN, NCSN

Mary Ann Gapinski, MSN, RN, NCSN

Jill Gasperini, MN, RN

Tami Harrah, BSN, RN, NCSN

Kathy Hassey, BA, BSN, M.Ed, RN

Cindy Juncker, BSN, M.Ed, RN, NCSN

Nancy Macias-Smith, LSW, MMHS, MA, PSY D

Lucille Nicholson, RN

Karen Palm, BSN, RN, NCSN

Kerry Richardson, MSN, APRN, BC

## Introduction

The purpose of this document is to provide an overview to the prevention and reduction of the use of restraint and seclusion (R&S) in the school setting, the laws and regulations related to the use of R&S in Massachusetts schools and a protocol for interventions by school nurses. School nurses are well-positioned as on-site, and specially trained as healthcare professionals to keep the health and safety of the child a priority in the school setting. The work on the development of this protocol presents opportunities to advocate for trauma-informed care and workforce development, issues that are priorities for school nurses. Every incident of restraint and seclusion is a nonconsensual traumatic incident to the student and is potentially physically and emotionally harmful to the child, other children and staff. (Mohr et al, 2010). The behaviors of some children and youth in schools can be challenging and aggressive, and staff members need training and supervision to learn to prevent escalation, de-escalate early disruption, and recognize the meaning behind the behavior in order to prevent harm to all present. This protocol provides guidelines for school nurses in the prevention and reduction of the use of R&S in schools to prevent traumatizing or re-traumatizing a student. This protocol also presents opportunities to advocate for trauma-informed care and workforce development, issues that are priorities for school nurses.

## The Dangers of Restraint and Seclusion

While it may seem that a restraint in an emergency situation may be an unavoidable action on the part of a school staff member, restraints and seclusion do not keep students safe. R&S have been associated with a wide range of serious and adverse consequences (Mohr et al, 2010). Restraints and seclusion can escalate student behavior in many instances, and they are no

longer considered therapeutic interventions but are judged to be treatment failures (Mohr et al, 2010; O'Brien & Cole, 2004).

In the school setting, children with mental health issues, developmental delay or other challenges are especially vulnerable to the use of R&S to "control their behavior". (See APPENDIX A: Potential Developmental Conditions and APPENDIX B: Signs and Symptoms of Trauma-Induced Behavioral Concerns).

There is widespread recognition of the dangers of R&S in the school setting. The National Association of School Nurses (NASN) Consensus Statement on The Use of Restraints or Seclusion in the School Setting cites the potential risk of injury or death and states that R&S should only be used as a brief intervention where there is the risk of imminent danger to the child, staff or classmates (NASN, 2013). The U.S. Department of Education (USDOE, 2012) Restraint and Seclusion: Resource Document states that there is a "lack of evidence that use of R&S is effective in reducing the occurrence of problem behaviors". The 15 principles described by the USDOE make it clear that "the use of 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". These principles also state that any behavioral intervention must be consistent with the child's rights to be treated with dignity and be free from abuse (USDOE, 2012).

The Massachusetts Board of Registration in Nursing (BORN) regulations governing Nursing Practice 244 CMR 9.00 (Standards of Conduct) address issues of concern for the school nurse who is involved in the use of R&S in the school setting (BORN, 2013). Under 244 CMR 9.00, 9.02, 9.03(5)(6)(7)(9)(15)(17) and (38), the licensed nurse may be involved in the use of restraints only when there is (a) immediate danger to life or limb or (b) a detailed plan that has

received parent/guardian active consent in writing in the parent/guardian's native language, defining when and how restraints must be implemented has been established. This position is further supported by the American Nurses Association Standards and Scope of Practice, which state the nurse may not be involved in restraints unless certain conditions are met per these nursing practice standards (ANA, 2012). Without such a plan (or if there is no immediate danger to life or limb), restraints would be considered abusive and, as a mandated reporter, *the nurse is required to file a 51A report with the Massachusetts Department of Children and Families on any school staff imposing the restraint (*M.G.L. c,119, §51A).

**Scope of the Problem**

The now well-known 1998 Hartford Courant (Weiss et al, 1998) articles and the 1999 United States General Accountability Office (USGAO) investigation into the use of restraint and seclusion in mental health facilities found alarming results (USGAO, 1999). The professional as well as public outrage over the past 10 years has produced dramatic change in the care and treatment of clients in many of these facilities (Mohr et al, 2010). Reviews and current research recognize the need for a complete culture change including leadership, rigorous debriefings, use of data to inform practice, workforce development, use of R&S prevention tools, and full inclusion of consumers and families (Huckshorn, 2005). These lessons need to be translated into the public school setting to prevent the use of R&S in this environment. School nurses must take leadership of this issue in schools as they are often the sole healthcare provider in the school setting.

In 2009 the USGAO report to the Committee on Education and Labor, House of Representatives included data on the use of R&S on children, including in public schools.

Their review 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. The USGAO found hundreds of cases of alleged abuse and death related to the use of these methods on school children during the past two decades. The USGAO could not find a single internet site, federal agency, or other entity that collects information on the use of these methods or the extent of their alleged abuse (USGAO, 2009).

**Massachusetts Data**

Review of Essential School Health Services (ESHS) data from the Massachusetts Department of Public Health (DPH) School Health Unit demonstrates the need to address the use of R&S in the public school setting. Annual reporting from 2011 indicates that 68,926 of the 638,929 students served by the ESHS grant have behavioral health needs. In 2012 there were 89, 471 mental health encounters reported by the ESHS grant funded districts; these included 2,756 assessments or monitoring for R&S cases (DPH, 2013). A survey of 400 school nurses at a state-wide conference that was conducted in 2012 was consistent with this data with 48.4% reporting use of restraint in their school systems and 13.3% reporting the use of seclusion (NEU, 2012).

A review of the 911 emergency call data from the 2011-2012 school year from 132 school systems revealed 20.5% of the calls were for mental/behavioral health issues. Of that, 36.6% were for out of control behavior for students in grades pre-K to 5, 21.6% for grades 6-8, and 24.6% for grade 9 and higher. Of the behavioral health reports collected that year, approximately 43% were referrals for out of control behavior, with the school nurse being involved in 60% of assessment and 49% of transport decisions (Farrell, 2013).

The school nurse must play an important role in the culture change that is necessary to prevent and reduce the use of R&S. She/he has demonstrated a commitment to working with students who have mental/behavioral health issues by the 212,516 behavioral health interventions reported in 2012. These interventions include:

- Teaching coping enhancement strategies (24,030)
- Providing self-calming activities (42,767)
- Providing reassurance check-ins (44,351)
- Giving emotional support (68,383)
- Coaching in social skills development (4,879), and others (DPH, 2013).

During 2009, the Commonwealth acted to reduce the use of R&S in schools, programs, residential facilities and other child-caring agencies, including those under contract with the state. An executive leadership forum for 225 residential treatment providers was held in May 2009, which served both to galvanize the direction and commitment of five youth serving state agencies: Department of Mental Health (DMH), Department of Children and Families (DCF), Department of Youth Services (DYS), Department of Developmental Services (DDS), Department of Early Education and Care (DEEC), the Department of Elementary and Secondary Education (DESE), and the Massachusetts Office of the Child Advocate (OCA). This forum served to give notice to the residential providers and public school settings that the 'practice as usual' attitude toward the use of R&S was no longer acceptable in Massachusetts. As a result, the state established the Interagency Restraint and Seclusion Prevention Initiative, co-chaired by DMH and DCF. The Massachusetts DPH School Health Unit joined this Initiative in 2010 and the School Nurse Workgroup to Prevent and Reduce the Use of R&S in Schools formed in 2012 as a result of this initiative. The Interagency Restraint and Seclusion Prevention Initiative has

issued a comprehensive charter to guide the work of the committee, which can be found at: http://www.mass.gov/Eeohhs2/docs/dss/irsp_initiative_charter.pdf. The charter establishes a broad goal for the agencies to work "in partnership with providers, advocates, educators, schools, families and youth, to focus on preventing and reducing the use of behavior restrictions that can be re-traumatizing, in particular the use of restraint and seclusion" (EOHHS, 2010). As part of this initiative, steps have been taken to reduce and eliminate use of R&S with children and youth in Massachusetts. These initial efforts have demonstrated that where trauma informed, positive behavioral support practices are implemented the use of R&S was decreased by 80% (Mohr et al, 2010). This initiative has also led to the development of a youth position statement (see Appendix E), the first of its kind in the country and a model other states are beginning to employ (EOHHS, 2010). The statement captures direct quotes and offers suggestions for alternatives to restraints or seclusion and values for programs to embrace to prevent harmful procedures. As OCA staff review institutional 51A and 51B reports concerning abuse and neglect in out-of-home settings, they continue to see injuries from restraints that are not employed as a last resort, but are used as contingent behavior management. Every restraint is a nonconsensual traumatic incident to the child and is potentially physically and emotionally harmful to the child, other children, and staff (OCA, 2009).

**Legal and Regulatory Issues Related to the Use of R&S in Massachusetts Schools**

The Massachusetts Department of Elementary and Secondary (DESE) regulations 603 CMR 46.00 address the use of physical restraint on students in publicly funded elementary and secondary education programs, including all Massachusetts public school districts, charter schools, collaborative education programs and special education schools. The purpose of

603 CMR 46.00 is to ensure that every student participating in a Massachusetts public education program is free from the unreasonable use of physical restraint.

*Physical Restraints*

Massachusetts state regulations state, "*Physical restraint shall be used only in emergency situations, after other less intrusive alternatives have failed or been deemed inappropriate, and with extreme caution."* 603 CMR 46.01(3)

Any use of physical restraint by school personnel must be done with two goals in mind:

(1) To administer a physical restraint only when needed to protect a student and/or a member of the school community from imminent, serious, physical harm; and

(2) To prevent or minimize any harm to the student as a result of the use of physical restraint.

Physical restraint may not be used as a means of punishment; or as a response to property destruction, disruption of school order, a student's refusal to comply with a school rule or staff. 603 CMR 46.01(3).

*Seclusion*

**Under DESE regulations, the use of seclusion restraint is prohibited in all public education programs in Massachusetts. 603 CMR 46.02(5).** Seclusion, as defined by DESE regulation 603 CMR 46.02(5)(b), is physically confining a student alone in a room or limited space without access to school staff. The use of "time out" procedures during which a staff member remains accessible to the student shall not be considered "seclusion restraint" 603 CMR 46.02(5)(b).

*Additional Definitions*

For the purposes of this document, the following definitions will be used as defined by DESE at 603 CMR 46.00.

*Chemical (also known as medication restraint) restraint:* The administration of medication for the purpose of restraint. Note: The use of chemical restraint is prohibited unless explicitly authorized by a physician and approved in writing by the parent or guardian.

*Emergency* shall mean that a reasonable person would perceive one or more of the following:

(a) The present occurrence of serious self-injurious behavior.

(b) The present occurrence of serious physical assault.

(c) The imminent threat of serious self-injurious behavior or behavior which is likely to lead to self injury, where the individual has the present ability to affect such behavior and has engaged in any action which indicates a present intention or inclination to carry out such behavior immediately.

(d) The imminent threat of serious physical assault, where the individual has the present ability to affect such assault and has engaged in any act which indicates a present intention or inclination to carry out such assault immediately.

***Note: The occurrence or imminent threat of property damage is not an emergency unless such damage is also likely to lead to the serious self injury of the individual or to the serious harm of those present.***

*Extended restraint*: A physical restraint the duration of which is more than twenty (20) minutes. Extended restraints increase the risk of injury and, therefore, require additional written documentation as described in 603 CMR 46.06.

*Mechanical Restraint:* The use of a physical device to restrict the movement of a student or the movement or normal function of a portion of his or her body. A protective or stabilizing device ordered by a physician shall not be considered mechanical restraint

*Physical escort*: Touching or holding a student without the use of force for the purpose of directing the student to a particular destination. If physical force is used to overcome the active resistance of the individual held or to interrupt then-occurring movement by the individual toward a particular destination, then the procedure is not an escort or a guide but instead constitutes physical restraint.

*Physical restraint*: The use of bodily force to limit a student's freedom of movement.

*Protective hold: C*omforting or gentle holding of an individual by a staff person for no more than five minutes. If physical force is used to overcome the active resistance of the individual held or to interrupt then-occurring movement by the individual toward a particular destination, or if more than two staff persons are holding the individual, then the procedure is not a comforting or gentle holding but instead constitutes physical restraint, regardless of the length of time the individual is being held.

*Seclusion Restraint*: Physically confining a student alone in a room or limited space without access to school staff. The use of "time out" procedures during which a staff member remains accessible to the student shall not be considered "seclusion restraint."

Procedures and training for the use of restraints in Massachusetts schools are defined under the DESE regulations 603 CMR 46.00**.** Trainings must be comprehensive and must include the information related to policies, interventions and the development of behavioral intervention plans in order to prevent the need for the use of necessary restraints.

***Every incident of restraint and seclusion is a nonconsensual traumatic incident to the student and is potentially physically and emotionally harmful to the child, other children and staff. (Mohr et al, 2010). DESE regulations support the requirement of school staff individual responsibilities as a mandated reporter pursuant to Massachusetts General Law Chapter 119, Section 51A. M.G.L. c 119, s 51A(a). These regulations cannot prevent any school staff from reporting neglect or abuse to the appropriate state agency. 603. 46.04(4)(c).***

**Barriers and Constraints to the Prevention and Reduction of the Use of R&S**

According to the Substance Abuse and Mental Health Service Agency (SAMHSA) R&S are violent, expensive, largely preventable, adverse events and the rationale for their use is inconsistently understood (SAMHSA, 2011). However, many factors including staffing ratios, school culture, staff training and leadership have all been seen as barriers to the prevention and reduction of the use of R&S in schools (Mohr, 2010).

One major barrier is the fragmented approach to understanding a child's behavior. Instead of a holistic approach, academics and a healthy social and emotional development are often viewed separately, i.e., teachers teach, school nurses care for the physical needs, psychologist and behavioral specialists manage emotional concerns and administrators tend to the operational functioning of the school district. Often times a holistic approach may be used

when a significant need of a student is first identified, however, after a meeting or a series of meetings occur, each "team member" will go back to her/his area of expertise, neglecting the comprehensive, multi-disciplinary approach previously discussed (Macias-Smith, 2012).

In order to address this issue on a practical level, schools need to use a blended learning approach. However, professional development, focused on student R&S, is often limited by role delineations and does not use a multi-disciplinary approach. This approach obstructs the ability to teach prevention to a broad audience, and to recognize that one method alone may not be the best way to prevent and reduce the use of R&S. The lack of a formal process that perpetuates the use of restraints, seclusion, and aversive techniques is both a barrier and a constraint. The need is for a collaborative multi-disciplinary team approach (including school nurses, school teachers, occupational therapists, mental health providers, support personnel, administrators, parents and education leaders and others) to preventive efforts to reduce R&S across the whole school district. (Macias-Smith, 2012).

Some educational leaders believe that R&S are a useful and a necessary strategy for use in schools. This is problematic. Recent reports suggest that restraints reinforce aggressive behaviors (Kahng et al, 2008). "The evidence that restraints are therapeutic is unconvincing" (Mohr, 2010). Nonetheless, perception of R&S as a helpful tool misinforms the general public and perpetuates the use of R&S in school systems. For example, the American Association of School Administrators stated "If school districts were unable to occasionally use these techniques with students with severe behavioral or emotional disorders, then these students would have to be institutionalized or sent to private facilities where they may not have the same rights and services available to them" (Pudelski, 2012). This statement has a number of

limitations. There is no evidence that the inability to use restraint would result in students being institutionalized or sent to private facilities. Further there is no evidence to support that R&S will help students with severe behavioral or emotional disorders, and it is speculative to suggest that students with these needs will end up in facilities that may or may not be able to meet their mental health needs.

The lack of uniform or sufficient rules regarding restraint and alternatives to restraint at the local, state and federal levels impedes the proper training to support quality standards of practice. Such policies, regulations and laws would include reference to functional data systems, ongoing trainings, and culturally competent materials would put processes in place that would foster collaborative efforts towards the reduction and prevention of R&S in schools across the United States. In addition, policies and laws would support the inclusion of trauma-informed and developmentally appropriate classroom management skills.

There is an essential need to put systems, protocols, processes, policies and regulations in place that protect and support the development of peaceful and non-aversive pro-social or social emotional learning techniques that support the holistic development of **all children in all schools** in order to reduce and prevent the use of R&S (Macias-Smith, 2012).

**Implications for School Nursing Practice**

The presence of professional registered nurses who engage in patient-focused interventions has been shown to reduce the adverse outcomes of R&S (Canatsey & Roper, 1997). School nurses have been called upon to take a leadership role in preventing and reducing R&S in schools (Mohr et al, 2010).

School nursing interventions for the prevention and reduction of the use of restraint and seclusion in the school setting are two-fold: at the school and district-wide level and as well as at the individual student intervention level. "School nurses advocate for the health and well-being of all children; with or without disabilities." (NASN, 2013). The American Nurses Association (ANA) strongly supports nurse participation in reducing restraint and seclusion. "Restraining or secluding [individuals] either directly or indirectly is viewed as contrary to the fundamental goals and ethical traditions of the nursing profession, which upholds the autonomy and inherent dignity of each [individual] (ANA, 2012).

**Nursing Role at the School-wide Level**

The Office of Technical Assistance of the National Association of State Mental Health Program Directors has developed Six Core Strategies To Reduce the Use of Seclusion and Restraint Planning Tool © (Huckshorn, 2005). This approach has been approved as an evidence-based tool for facilitating change, including prevention and was adopted by youth serving state agencies – Department of Mental Health (DMH), Department of Children and Families (DCF), Department of Youth Services (DYS), Department of Developmental Services (DDS), Department of Early Education and Care (DEEC), and the Department of Elementary and Secondary Education (DESE) and the Massachusetts Office of the Child Advocate (OCA). The tool includes the following strategies toward implementation of change:

1. Leadership Toward Organizational Change
2. Use of Data to Inform Practices
3. Workforce Development

4. Use of R&S Reduction Tools

5. Consumer Roles in Intervention Settings

6. Debriefing Techniques

The school nurse can utilize these same strategies to create a school-wide environment for the prevention and reduction of the use of R&S in the school setting:

1. Provide leadership among a multi-disciplinary team to define a vision and values that incorporate an understanding of trauma-informed practices that are sensitive to the needs of all children. The team will create school-wide plans to prevent and reduce the use of R&S while maintaining that school staff be held accountable to this mission.

2. Utilize data collected from nursing observations and interventions to assess environmental, psycho-social, neurobiological and other causes and risk factors related to student behaviors. Indicate the appropriate staff response to those behaviors in the school setting.

3. Educate staff on trauma-sensitive care strategies that are less likely to be coercive or act as triggers for conflict as a primary prevention intervention. School nurses must include information related to the prevalence of "out-of-control behaviors" among the students served, the effects of traumatic life experiences on developmental learning and subsequent emotional development of students during professional development programs for all staff.

4. Implement appropriate assessment, planning and intervention tools that are integrated into all school and classroom policies and procedures. This includes the need to identify risk for violence and provide for de-escalation plans. Support environmental changes such as comfort and sensory rooms (a therapeutic calming space) that provide for emotional self-management for students.

5. Include students, staff, family and other providers in implementation of programs to assist in the prevention and reduction of R&S in the school setting. All individuals take responsibility for supporting, protecting and advocating for a R&S free school environment. Teachers must learn how to assist students with self-regulation skills (high academic standards, known safety priorities, expected behaviors, setting limits, etc.) in the classroom.

6. Debrief and follow-up on any incident in which R&S is used. The reduction of R&S comes from (a) understanding the causes of behavioral issues; (b) implementing policies, procedures and practices created to avoid use of R&S and (c) address potentially dangerous behaviors in the school setting. Debriefing also serves to reduce the adverse and traumatizing effects of R&S on students, staff and others who have witnessed any R&S. These debriefings must include an assessment of the situation in which R&S was used as well as the identification of educational needs of school staff to prevent and reduce future incidents of R&S.

**Nursing Role at the Individual Student Level**

While the above describes the school nurse's role at a school/district-wide level, the school nurse also has a responsibility for the prevention and reduction of the use of R&S at the individual student level. Using the same Six Core Strategies©, the school nurse must:

1. Work with the multi-disciplinary team along with the student and his/her family toward behavioral change at the student level:

    a. Completing a history and assessment PRIOR TO ENTRY to school for students at risk for behavioral issues (See Appendices A and B for related conditions for behavioral concerns).

    b. Understand the student's trauma history and response (emotional, behavioral, or trauma history; psychosocial, and/or cultural concerns, developmental delay, autism assessment; hearing and speech problems; learning issues; substance abuse, etc.)

    c. Plan appropriate responses to the student's behavior which must begin prior to admission to the school.

2. Assist with a Functional Behavioral Assessment (FBA) of the student when concerns are identified. The student's FBA should lead to positive behavioral interventions and supports (Amos, et al, 2012). By identifying antecedent to and reinforcers of aggressive behaviors, individual student plan for interventions can be developed for use in the classroom and other school settings (Mohr, 2010). The school nurse should assist the process of functional analysis and make it part of the ongoing nursing

assessment and intervention process for the student. See APPENDIX C: School Safety Tool for assistance with planning for appropriate interventions.

3. Develop a treatment plan (Individual Health Care Plan) that involves a multi-disciplinary team and includes the student and his/her family in the planning process. The plan must incorporate interventions that prevent and reduce risk factors and triggers, and include use of sensory techniques and comfort measures to alleviate out-of-control behaviors.
4. Document all triggers, signs, symptoms and responses to interventions in the student's health record. This documentation must be used to monitor and evaluate responses to interventions and determine appropriate outcomes.
5. Assist classroom teachers with understanding and planning for appropriate interventions. This includes trauma informed responses (responses that are respectful and sensitive to a child's past adverse experiences) to a student's behavior in the classroom as well as prevention of triggers and means to de-escalate out-of-control behaviors. The school nurse must assist with teaching the student self-regulation of emotions and behavioral responses as identified for the student.
6. Encourage school administration and teachers to develop trauma-sensitive classrooms; support teachers with creating trauma-sensitive classrooms as well as environmental response, techniques that include individual sensory and comfort interventions to assist the student with emotional self-regulation in the classroom and other school environments.

7. Debrief, review, report and revise student treatment plans as necessary. School nurses, in conjunction with other school staff, must notify parents/guardians each time restraint or seclusion is used in response to their child's behavior. The school nurse should assist the classroom teacher and other school staff with debriefing and revising behavioral response plans as needed. School nurses must provide opportunities for other witnesses of any restraint or seclusion to verbalize feelings and emotions resulting from such events.

**Nursing Protocol for Response to Restraint and/or Seclusion**

School nurses must work toward the prevention and reduction in the use of restraints and the prevention of seclusion in the school setting. "School nurses should be active members of the crisis intervention teams and be involved in the development and planning of prevention and intervention programs within the school." (NASN, 2013). If, however, interventions fail and an incident involving restraint and seclusion occurs due to imminent danger to life or limb of the student or others, the following protocol must be observed:

1. The school nurse will be notified by a staff member at the start of any physical restraint or incident of seclusion. As soon as possible, the school nurse will be available and participate only as an observer during the restraint.

2. The nurse is to take immediate action to end the hold/restraint as soon as possible; the restraint must be stopped immediately if the student shows any sign of distress.

3. The restraint must be released immediately upon determining that the student is no longer at risk of causing imminent physical harm to him/herself or others. No child

should be placed in seclusion at any time. This is illegal in Massachusetts schools and should be reported to school authorities.

4. The student in restraint must be assessed for skin color, respiratory effort, level of consciousness, level of agitation, and range of motion and/or swelling of the extremities.

5. A restraint must be stopped immediately if the student shows any signs of medical distress.

6. After the hold/restraint the nurse will assess the student as well as staff for any injury.

7. The school nurse must report the results of any nursing assessment following the use of *any* known use of physical restraint or seclusion of a student to the parents/ guardians of the student on the same day of the occurrence. (If the school provides a parent or guardian of a student with report cards and other school-related information in a language other than English, the written restraint report and assessment must also be provided to the parent or guardian in that language). The report to the parent must include:

    a. The names and job titles of the staff who administered the restraint, and observers, if any; the date of the restraint; the time the restraint began and ended;
    b. A description of the activity, as reported to the school nurse, in which the restrained student and other students and staff in the same room or vicinity were engaged immediately preceding the use of physical restraint. This includes the behavior that prompted the restraint; efforts made to de-escalate the situation;

alternatives to restraint that were attempted; and the justification for initiating physical restraint.

c. A description of the administration of the restraint including the type of restraint used. This report must include the student's behavior and reactions during the restraint, how the restraint ended, documentation of injury or distress to the student and/or staff, if any, during the restraint, and any medical care provided (CAPS, 2013).

8. The school nurse, with administrative support, will ensure that a debriefing of the situation occurs with all staff and students involved to determine the cause for the restraint or seclusion. The debriefing will occur within a reasonable amount of time (no more than 48 hours following any incident).

9. If a restraint has been administered to a student pursuant to an Individualized Education Plan ("IEP") or other written behavioral plan which has been developed in accordance with state and federal laws, and the student's parent or guardian have provided active, written consent, the school nurse must report and document the restraint in the same manner as above.

10. Any restraint that does not meet the requirements of 603 CMR 46.00 must be reported to the Department of Children and Family in accordance with all other mandated reports of abuse.

11. If there is a certain frequency of the use of “emergency restraints” that is, more than two in a week or three in a month (Anzer, 2009), the school nurse must assess the situation and identify teaching or other strategies or interventions that will reduce the

need for emergency restraints in the future. The school nurse has the responsibility to review with the student, his/her family, the school staff and other team members the circumstances that created a need for restraint and to develop an intervention to reduce that need.

12. The nurse, as part of the multi-disciplinary school team, must ensure that a debriefing of any use of restraint or seclusion in the school occurs within 48 hours (see Debriefing and Evaluation below). This debriefing must also include a plan to review the situation with all the students and other staff who may have witnessed the event.

13. Documentation of the incident in the student's health record, including precipitating factors, any resulting injuries and when parents/ guardians were notified, must be completed immediately following the incident.

**Debriefing and Evaluation**

All school staff and other individuals who were involved in any incident of restraint or seclusion must participate in a debriefing after each episode (See APPENDIX D: Restraint Debriefing Evaluation Form). This must occur as soon as possible, preferably by the end of the next school day. The debriefing is used to:

1. Identify antecedents that led to the incident and identify what actions were taken;
2. Assess what might have been done to prevent the need for restraints;
3. Determine if the individual behavioral plan was used (if in place);
4. Evaluate whether the student's wellbeing, comfort and right to privacy were addressed;
5. Process the episode with the student who was restrained and, with the student's input (if appropriate) modify the behavior plan accordingly;

6. Determine the need for counseling/ medical evaluation/ treatment for the student, classmates or staff involved;
7. Determine any known trauma history;
8. Interview student, parent/guardians, and school staff re: restraint to assist in determining causative behaviors or triggers, if known (Belchertown Public Schools, 2013);
9. In addition to completing of the Debriefing Evaluation Form, document the incident in the student school health record as determined by school nurse protocols and procedures;
10. Send a report of the incident, without student identifying information, to the DPH School Health Unit for surveillance purposes.

Literature related to the adverse and sometimes, fatal, consequences of the use of restraint and seclusion in schools, compels school nurses to take a leadership role in preventing and reducing the use of sometimes abusive and neglectful interventions. School nurses must intervene to prevent and reduce the use of R&S by educating colleagues and other adults, establishing safe environments for all children, and leading efforts to build positive behavioral supports for the entire school community.

**APPENDIX A: Potential Developmental Conditions** (including genetic, neurodevelopmental or physical disorders that have a significant overlap with intellectual disability, and result in behavioral support needs) (DDS, 2013):

(a) Williams Syndrome;

(b) Prader-Willi Syndrome;

(c) Lesch-Nyhan Syndrome;

(d) Angelman Syndrome;

(e) Cri du Chat Syndrome;

(f) Down Syndrome;

(g) Fragile X Syndrome;

(h) Cerebral Palsy;

(i) Autism Spectrum Disorders: Autistic Disorder, Rett's Syndrome, Childhood Disintergrative Disorder, Pervasive Developmental Disorders and Pervasive Developmental Disorder-not Otherwise Specified (NOS);

(j) Spina Bifida (Myelomeningocele type MMC);

(k) Tuberous Sclerosis;

(l) Fetal Alcohol Syndrome

**APPENDIX B: Signs and Symptoms of Trauma-Induced Behavioral Concerns**

According to the National Child Traumatic Stress Network (NCTSN) *"How children experience traumatic events and how they express their lingering distress depends, in large part, on the children's age and level of development."* (NCTSN, 2008). The school nurse is in a unique position to identify signs and symptoms of trauma in children and adolescents. Some behaviors will be seen by the nurse and some behavioral information can be elicited from discussions with parents. Behavior is children's way of communicating. School nurses may see children and adolescents for physical symptoms that, upon further assessment, may reveal a trauma history. Each child responds to trauma in their own individual way. Some overall signs may include:

- Trouble sleeping or falling asleep
- Nightmares or unwanted memories of the event
- Problems concentrating or paying attention
- Difficulty getting along with family or friends or becoming less social
- Regressive behavior such as bedwetting, clinging to caregivers, or thumb-sucking
- Anger and other emotional outbursts
- Avoidance of people, places and things that are reminders of the event
- Nervousness or startling easily
- Depression
- Increased problems with school or grades
- Increase or decrease in appetite
- Frequent complaints of stomach aches or headaches without physical cause

## APPENDIX C: School Safety Tool

**We are committed to providing a safe and comfortable environment for your child. It is very helpful to us to understand the types of things that make your child upset and what helps him/her calm down or de-escalate when he/she is agitated or upset. Please answer the following questions so that we can keep this in your child's school health record and use it to help problem solve when your child feels upset.**

Child's name _____ Grade _____ Date of Birth _____

What particular "triggers" will cause your child to escalate/have a hard time? Number the top triggers **1-4** below.

| | | | |
|---|---|---|---|
| Being touched | | Being isolated | |
| Particular time of day (when?) | | People in uniform | |
| Loud environment | | Time of year (when?) | |
| Not having control/input. Explain | | Yelling or angry/agitated people | |
| Arguments with friends or family | | Having to wait for things | |
| Other (please explain): | | Other (please explain) | |

What types of warning signs might we see that can help us understand that your child is getting upset? Number the top warning signs **1-4** that apply to your child below.

| | | | | | |
|---|---|---|---|---|---|
| Sweating | | Breathing hard | | Racing heart | |
| Clenching teeth | | Clenching fists | | Red faced | |
| Wringing hands | | Loud voice | | Sleeping in class | |
| Bouncing legs | | Rocking | | Pacing | |
| Squatting | | Can't sit still | | Swearing | |
| Crying | | Isolating/ avoiding people | | Hyperactive | |
| Not taking care of self | | Hurting myself | | Hurting others or things | |
| Singing inappropriately | | Sleeping less | | Eating less | |
| Eating more | | Being rude | | Laughing loudly/ giddy | |
| Other: | | | | | |

We may not be able to do all of these, but think about the top **4** specific things that might help your child feel better.

Number the top **4** of the ones that apply to your child below **or** add your own for a total of **4** items.

| | | | |
|---|---|---|---|
| Quiet time in room away from others | | Drinking warm milk | |
| Seek help with school nurse | | Exercise | |
| Talking with teacher or aide | | Using ice as a grounding technique | |
| Talking with parent | | Lying down with cold face cloth | |
| Writing in a diary/journal | | Using a scent box (perfume in a small container) as grounding technique | |
| Deep breathing exercises | | Working on a puzzle | |
| Wrapping up in a blanket | | Meditation or using pleasant images | |
| Listening to music | | Drawing | |
| Reading (specify what you like to read) | | Other (please list) | |
| Time in activity room | | | |
| Pacing the halls | | | |

Do you have any cultural, religious or spiritual practices that help (_____) when he/she is upset?

Do you use any Sensory Techniques to help your child calm down?

Does your child have any medical issues that we should be aware of?

Do you have any other comments?

_____

_____

_____

Thank you for taking the time to complete this form. We are committed to assist your child to have a wonderful and successful year at school.

_____ _____ _____

Parent/Caregiver Signature Parent/Caregiver Printed Name Date

_____ _____ _____

School Nurse Signature / title School Nurse Printed Name Date

**Acknowledgements:**

This safety tool was developed by the Massachusetts Department of Mental Health in 1997 and used extensively locally, nationally and internationally. Credit for the adaptation of this tool is given to: Tamika Wallen, MSN, RN and Sharon DiVItto RN, MA, MS, CS (June 2013), Emergency Mental Health Service, UMASS Memorial Medical Center, Worcester, MA.

## APPENDIX D: Restraint Debriefing Evaluation Form

**Please meet as a group to discuss and review the event. Answer all of the questions and offer any suggestions you feel may assist the staff to better handle restraint/de-escalation events.**

Date of Incident:_____ Location:_____

Description of what led up to incident_____

Were any antecedent behaviors or triggers noted? Yes____ No_____

If so what_____

Did the staff utilize any de-escalation techniques or sensory intervention? Yes____ No____

If no, explain_____

If yes, explain_____

Did the staff utilize the students behavioral care plan (if applicable) Yes____ No____

If yes, note response to plan_____

If no explain_____

Did staff or student recognize any prevention strategies that may prevent further episodes? Yes___No__

Description of student's behaviors during and reaction to restraint_____

How restraint ended_____

Did student's treatment plan get updated? Yes____No____ If no, explain_____

Description of any physical/emotional injury to student:_____

Description of any physical/emotional injury to staff:_____

External crisis team called Yes___No___ Student /Staff sent for medical treatment_____

Was there anything that could have been done differently?_____

Staff members involved_____

Any issues requiring follow-up?_____

Was nurse and administrator notified at time of restraint?_____

Was the nurse present during the restraint? Yes____If no, explain_____

Physical assessment by nurse? Yes____If no, explain_____

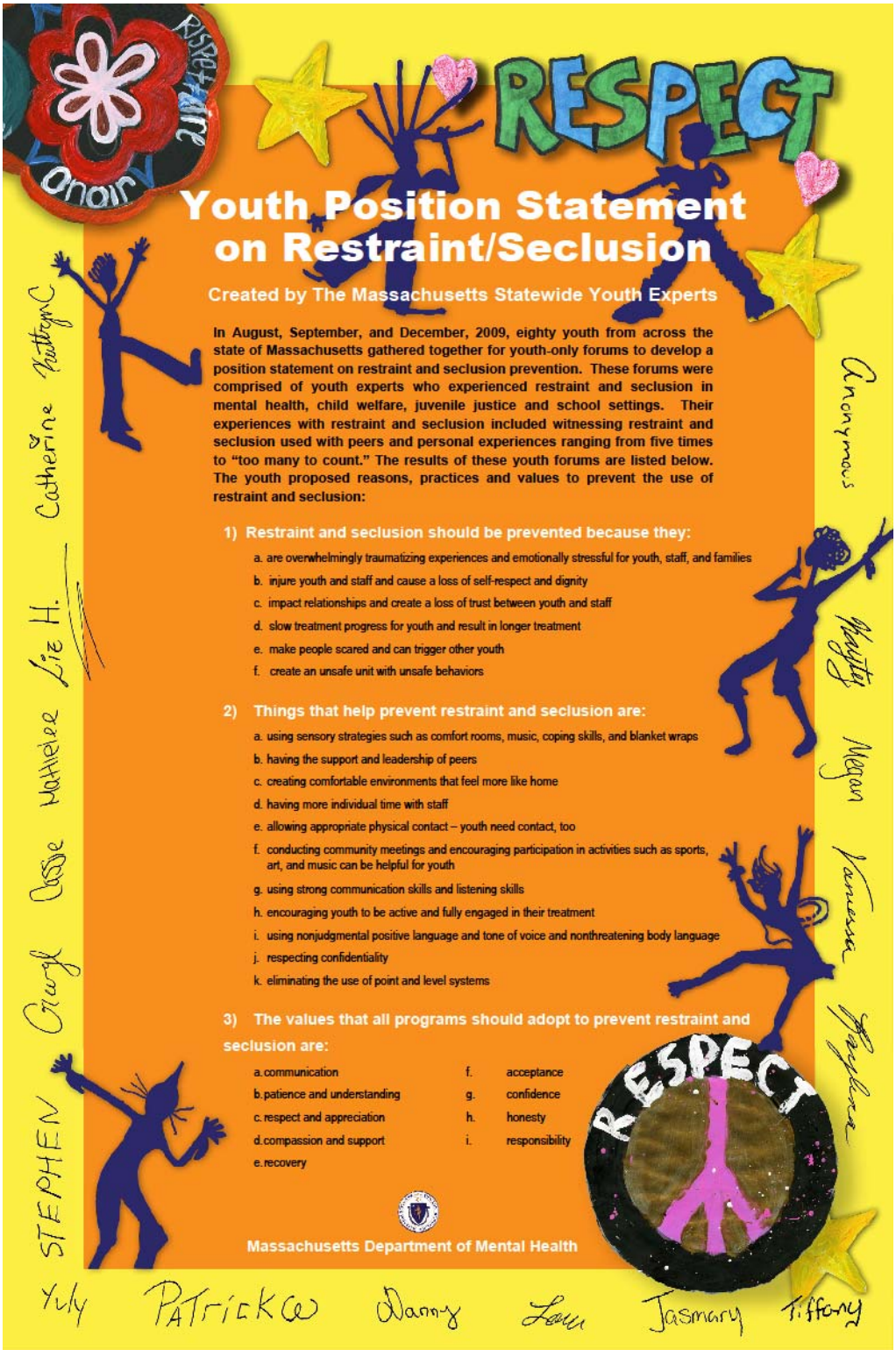
Parent/guardian informed of restraint Yes____ No____ Date_____By whom_____

Debriefing with staff, student? _____ Date_____

DESE sent copy of written report? _____ Date_____

**Acknowledgements to the Belchertown Public Schools and Wing Memorial Hospital, Palmer, Massachusetts, for use of this tool.**

## APPENDIX E: DMH Youth Position Statement on Restraints and Seclusions



## APPENDIX F: Domains of Trauma Impact

| Domain | Impacts of Trauma | Strategies |
|---|---|---|
| **R**elationships | • Interference with trust: children/ youth do not instinctually see adults as in their court. A lack of safety to even form relationships is created.<br>• Interferes with relationship formation with peers.<br>• Interferes with accurate processing of social cues and therefore relationships.<br>• Sense of future is diminished<br>• Fear of losing friends.<br>• May not have appropriate boundaries: student may get too close, touch or share more personal information than is comfortable for other students or adults.<br>• Student may sabotage relationships as a way of feeling safe. | • Provide models and opportunities for student to form and maintain trusting relationship(s) with peer(s) and adult(s).<br>• Consistency and predictability: create a sense of fairness, provide routine, critical steps to development of trust.<br>• Teach the interpretation of social cues. Break down social cues into small components. Explain.<br>• Differentiate between unconditional respect and care for student as a person and behaviors of student. |
| **A**cademic and Non-Academic Competence | • Impairs child's ability to use and receive language. (Expressive and Receptive language difficulties)<br>• Auditory processing difficulties<br>• Consequences for ability to understand and respond to instruction/instructions. ? Not sure what this means?<br>• Interferes with a child's executive functions: organizing, planning, filtering, prioritizing, multi-step follow through.<br>• Compromised verbal memory.<br>• Compromises child's self-worth, confidence, sense of competence, motivation.<br>• Difficulty generalizing information learned to new areas.<br>• Highly emotional environments not conducive to learning: mental energy focused on emotional cues rather than verbal language and | • Break down expectations into small, step by step components.<br>• Identify what you assume the student already knows or can do.<br>• Find areas of competency and make them stronger.<br>• Identify potential emotional distractions and determine if possible to remove them.<br>• Teach executive skills.<br>• Make expectations challenging, but also something you know they will be able to accomplish with effort. Often this can be breaking down larger or long term goals into smaller components.<br>• Utilize known expressive and receptive language |

| | | |
|---|---|---|
| | cognitive tasks.<br>• Difficulty completing long term projects due to lack of future *orientation*. | intervention and/ or auditory processing interventions. |
| **S**elf-Regulation | • Chronic arousal: "High speed" or "Off." Interferes with concentration and attention for school work. Over-attention to threat.<br>• Interferes with a child's understanding of the relationship between behavior and consequences.<br>• Survival instinct erases any planning or "mental" time for making choices when a triggering situation occurs.<br>• Interferes with a child's belief that s/he has control over consequences.<br>• Distortion of social emotional cues interferes with appropriate emotional and behavioral responses.<br>• Cannot distinguish feelings; numb, bored, diffuse agitation, anger.<br>• Help children "calm down" to learn. (or children do not have the skills needed to calm down in order to learn. | • Help students to identify feelings.<br>• Help students to predict triggers.<br>• Create an environment as free from triggers as possible.<br>• Provide examples, model appropriate responses, to social emotional cues.<br>• Identify what makes a student feel unsafe & threatened and develop a means for limiting these threats.<br>• Process a difficult situation with the student when they are no longer in fight, flight or freeze mode and when they feel safe.<br>• Provide student with safe place to go, cue to give teacher, for when student recognizes trigger for fight, flight or freeze. |
| **P**hysical & Mental Health Impacts | • Child's presence at school is compromised:<br>o Physical presence – due to injuries, home instability, highly stressed family, neglect, fear of what might happen when not with caregiver, impact of trauma on caregiver.<br>o Emotional presence – Dissociation (shut down in response to over-arousal)<br>• Somatic complaints, health & hygiene problems<br>• Compromised body image, body concept: body disconnection, poor physical skills<br>• Self-harming, risk taking behaviors, self-injury<br>• Children need movement to increase ability to self-regulate. | • Identify reasons for attendance issues.<br>• Consider impact of trauma as factor in caregivers responses to the student and the school.<br>• Teach health and hygiene skills.<br>• Provide/ do not remove as consequences physical outlets to express, let out tensions, emotions.<br>• Provide opportunities for the student to develop healthy body image and to gain control over body image.<br>• Work with nurse, Doctor, mental health professionals to help address needs. |

| | | |
|---|---|---|
| | • Unsafe in his/her own skin<br>• Mental health symptoms<br>• Lack of belief that own actions can impact future. | • Verbalize examples of how a student positively impacted future opportunities and successes. |

**(*Helping Traumatized Children Learn*, 2005, Massachusetts Advocates for Children © Jessica P. Greenwald O'Brien, Ph.D., 2009)**

**References:**

American Nurses Association Board of Directors (2012). Position Statement: Reduction of Patient Restraints and Seclusion in Health Care Settings.

Amos, P., Kinsell, P., LeBel, J., Moore, A., Musumeci, P., Trader, B. (2012). Transforming school culture, Creating Positive Cultures of Care Resource Guide. Department of Mental Health, Boston, MA.

Anzer, T. (2009). Emergency restraint vs hold as behavioral intervention redux. Rights Review, Vol. 5 (1). Boston, MA.

Belchertown MA Public Schools (2013). Restraint debriefing evaluation form, Belchertown, MA.

Canatsey, K. and Roper, J.M. (1997). Removal of stimuli for crisis intervention: Using least restrictive methods to improve the quality of patient care. Issues in Mental Health Nursing. 18(1), 35-44.

CAPS Education Collaborative (2013). CAPS school health services protective hold/restraint protocol, Gardner, MA.

Farrell, A. (2013). 911 Calls and implications for school nursing. National Association of School Nurses Annual Conference. Orlando, FL**.**

Greenwald O'Brien, J. (2005). Helping Traumatized Children Learn. Massachusetts Advocates for Children © Jessica P. Greenwald O'Brien, Ph.D., Boston, MA.

Huckshorn, K.A. (2005), Six Core Strategies for the Reduction of Seclusion and Restraint©, National Association of State Mental Health Program, Office of Technical Assistance, Washington, DC.

Kahng, S., Leak, J., Vu., C. Mishler, B. (2008). Mechanical restraints as positive reinforcers for aggression. Behavioral Interventions. 23(2), 137-142.

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., Harper, G., LaFlair, L., Sudders, M., (2004). Child and adolescent inpatient restraint reduction: a state initiative to promote strength-based care. Journal of the American Academy of Child Adolescent Psychiatry, 43:1 (37-45).

Macias-Smith, N. (2012). Doctoral Project. Prevention and reduction of restraint and seclusion in public schools: a comprehensive approach. Brookline, MA.

Massachusetts Board of Registration in Nursing (BORN) (2013). Standards of Conduct. 244 CMR 9.00.

Massachusetts Department of Developmental Services (DDS). (2013). Definitions: 115 CMR 2.00.

Massachusetts Department of Elementary and Secondary Education (ESE). (2013). Physical Restraint. 603 CMR 46.00.

Massachusetts Department of Mental Health (DMH). (2009). Youth Position Statement on Restraint/Seclusion. Retrieved from: http://www.mass.gov/eohhs/docs/dmh/rsri/kids-position.pdf

Massachusetts Department of Public Health (DPH) School Health Unit (2013). 2012 Program update: Essential School Health Services. Retrieved from: http://www.mass.gov/eohhs/docs/dph/com-health/school/eshs-report-11-12.pdf

Massachusetts Executive Office of Health and Human Services (2010) Charter: Massachusetts Interagency Restraint and Seclusion Prevention Initiative. Retrieved from: http://www.mass.gov/eohhs/docs/dmh/rsri/restraint-charter.pdf

Massachusetts General Law Chapter 119, Section 51A.

Massachusetts Office of the Child Advocate (OCA) (2009). Annual Report 2009. Retrieved from: http://www.mass.gov/childadvocate/docs/annual-report2009.pdf

Mohr, W.K. (2010). Restraints and the code of ethics: an uneasy fit. Archives of Psychiatric Nursing, (24)(1):3-14.

Mohr, W.K., LeBel, J., O'Halloran, R., & Preustch, C. (2010). Tied up and isolated at the school house. The Journal of School Nursing, 26(2): 91-101.

National Association for School Nurses (NASN) (2013). Consensus Statement, The use of restraints or seclusion in the school setting. Retrieved from: http://www.nasn.org/Portals/0/statements/consensus_restraints_seclusion_13.pdf

National Child Traumatic Stress Network (NCTSN) (2008). Child welfare training tool kit: trauma referral tool. Retrieved from: http://nctsnet.org

Northeastern University School Health Institute (NEU) (2012). Restraint and seclusion survey results. Marlborough, MA.

O'Brien, L. & Cole, R. (2004). The concept of physical restraint as a nurse sensitive adverse outcome in acute care psychiatric treatment. Archives of Psychiatric Nursing, 20: 648-652.

Pudelski, S. (2012). Keeping schools safe: ensuring federal policy supports school safety. American Association of School Administrators.

Substance Abuse and Mental Health Service Agency (SAMHSA) (2011). The business case for preventing and reducing restraint and seclusion use. (Note: White paper created for SAMHSA by LeBel Janice et al). Retrieved from http://store.samhsa.gov/shin/content/SMA11-4632/SMA11-4632.pdf

Sullivan, K. (2011). The right to be safe in school: Advocacy and litigation strategies to combat the use of restraint and seclusion. The Council of Parent Attorneys and Advocates, Inc. Towson, MD.

United States Department of Education (USDOE) (2012). Restraint and seclusion: resource document. Washington, DC. Retrieved from http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf

United States General Accounting Office (USGAO) (2009). Seclusions and restraints: selected cases of death and abuse at public and private schools and treatment centers. (Report No. USGAO-09-719T). Washington, DC.

Wallen, T. & DiVitto, S. (2013) School safety tool, University of Massachusetts Memorial Medical Center, Emergency Mental Health Services, Worcester, MA.

Weiss, E.M., Altimari, D., Blint, D.F., & Megan, K. (October 1998). Deadly restraints: A nationwide pattern of death. *The Harford Courant*.

Wing Memorial Hospital (2013). Restraint debriefing evaluation form. Belchertown, MA.

## References

# Transforming School Culture


American Civil Liberties Union / Human Rights Watch (2009). *Impairing education: Corporal punishment of students with disabilities in us public schools.* Retrieved March 30, 2012 from http://www.hrw.org/en/reports/2009/08/11/impairing-education-0.

Alliance to Prevent Restraint, Aversive Interventions, and Seclusion (APRAIS). (2005). *In the name of treatment: A parent's guide to protecting your child from the use of restraint, aversive interventions, and seclusion.* http://stophurtingkids.com/wp-content/uploads/2013/05/In-the-Name-of-Treatment_Second-Edition.pdf

Fogt, J.B., George, M.P., Kern, L, White, G.P., & George, N.L. (2008). Physical restraint of students with behavior disorders in day treatment and residential settings. *Behavioral Disorders, 34(*1), 4-13.

Gapinski, M. A. (2013) Protocol for school Nurses in the Prevention and Reduction in the Use of Restraint and Seclusion in the School Setting. Massachusetts Department of Public Health, Massachusetts, USA.

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. *The Journal of the Association for Persons with Severe Handicaps, 19*(4), 263-276

LeBel, J. (2011, March). *Issue Paper: The business case for Preventing and reducing restraint and seclusion use.* Published as: Promoting Alternatives to the use of Seclusion and Restraint: Issue Paper: Making the Business Case. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

## References


LeBel, J., Nunno, M., Mohr, W.K., & O'Halloran, R. (2012). Restraint and seclusion use in U.S. school settings: Recommendations from allied treatment disciplines. *American Journal of Orthopsychiatry, 82*(1), 75-86

Miller, D. N., George, M. P., & Fogt, J. B. (2005). Establishing and sustaining research-based practices at Centennial School: A descriptive case study of systemic change. *Psychology in the Schools, 42*, 553-567.

Mohr, W.K., LeBel, J., O'Halloran, R., Preustch, C. (2010). Tied up and isolated in the schoolhouse. *Journal of School Nursing, 26*(2), 91-101.

National Disability Rights Network (NDRN). (2012). *School is not supposed to hurt v.* 3. Retrieved April 6, 2012 from http://ndrn.org/images/Documents/Resources/Publications/Reports/School_is_Not_Supposed_to_Hurt_3_v7.pdf

National Disability Rights Network. (2010). *School is not supposed to hurt: Update on progress in 2009 to prevent and reduce restraint and seclusion in schools.* Retrieved April 9, 2012 from http://www.ndrn.org/images/Documents/Resources/Publications/Reports/School-is-Not-Supposed-to-Hurt-NDRN.pdf

National Disability Rights Network (NDRN). (2009). *School is not supposed to hurt: Investigative report on abusive restraint and seclusion in schools.* Retrieved April 6, 2012 from http://www.ndrn.org/images/Documents/Resources/Publications/Reports/SR-Report2009.pdf

Ryan, J. B., & Peterson, R. L. (2004). Physical restraints in schools. *Behavioral Disorders, 29*, 154-168.

Ryan, J. B., Peterson, R. L., & Rozalski, M. (2007). State policies concerning the use of seclusion timeout in schools. *Education and Treatment of Children, 30*(3), 215-239.

## References


TASH. (2011). *The cost of waiting: Use of restraint, seclusion, and aversive procedures with students with disabilities*. http://www.tilrc.org/assests/news/publications/TASH_The-Cost-of-Waiting_April-2011.pdf

TASH. (2010). *Shouldn't school be safe: Working together to keep every child safe from restraint and seclusion in school*. http://stophurtingkids.com/wp-content/uploads/2013/05/TASH_Shouldnt-School-Be-Safe.pdf

United States Government Accountability Office (GAO). (2009). *Seclusion and restraints: Selected cases of death and abuse at public and private schools and treatment centers* (No. GAO-09-719T). Washington, DC: Author. Retrieved March 29, 2012 from http://www.gao.gov/products/GAO-09-719T

Westling, D., Trader, B., Smith, C., Marshal, D. (2010). Use of restraints, seclusion and aversive procedures on students with disabilities. *Research and Practice for Persons with Severe Disabilities, 35*(3-4):116-127. https://pdfs.semanticscholar.org/bcb7/3c1065db466824dff548e5ea9fe6a020675c.pdf