



The Council for Children with Behavioral Disorders

A Division of the Council for Exceptional Children

CCBD'S POSITION SUMMARY

ON

The Use of Physical Restraint Procedures in School Settings

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The document provides policy recommendations of the Council for Children with Behavioral Disorders (CCBD) regarding the use of physical restraint procedures in schools. It includes: (a) an Introduction, (b) a Declaration of Principles, and (c) Recommendations Regarding the Use of Physical Restraint in School Settings. Explanation or elaboration of specific recommendations is provided in italics. A similar and parallel document provides policy recommendations related to the use of seclusion procedures in school settings which is often associated with the use of restraint procedures.

Introduction

What is restraint?

To restrain involves “preventing from doing, exhibiting, or expressing something,” and restraining means “limiting, restricting or keeping under control (Restrain, 2009). In the human services, the term restraint is used with three different types of restraint procedures: (a) mechanical restraint, (b) chemical restraint, and (c) physical restraint.

One perspective is that seclusion is not part of the “time-out” continuum but is a form of restraint. This perspective has been more formally clarified in the new Colorado rules which indicate that the use of seclusion is a restraint. Colorado is now providing greater clarification on how the use of seclusion is different from time-out. This is an area of controversy for some of the practitioners.

Mechanical Restraint. Mechanical restraint entails the use of any device or object (e.g., tape, ropes, weights, weighted blankets) to limit an individual's body movement to prevent or manage out-of-control behavior. Mechanical restraints such as handcuffs are universally used in law enforcement, and restraints such as straightjackets and straps have been used in medical and mental health facilities. Mechanical restraints such as tape, straps, tie downs, and a wide variety of other devices have also been used by educators to control student behavior.

Mechanical restraints to limit behavior should be distinguished from medically prescribed devices whose purpose is to compensate for orthopedic weaknesses to protect the student from falling or to permit the student to participate in activities at school. For example, mechanical restraints have been employed in school settings in situations where students with physical disabilities such as cerebral palsy may be placed in standing tables or chairs with restraints which permit them to participate in educational activities where their muscles or bones would not otherwise permit their participation. Recently, weighted blankets and a variety of other devices have been used with students with autism and attention deficit disorders, apparently to calm them and reduce their hyperactivity but these essentially are a form of restraint. The degree of restriction of these devices varies, and they are not themselves teaching strategies although they may increase the opportunity to learn. None of these devices should be employed in schools unless specifically recommended by an occupational or physical therapist, physician, or school nurse with specific recommendations for lengths of time of use and other circumstances for their use. When prescribed in this way, these assistive devices should not be considered mechanical restraints.

Seat belts or other restraints in vehicles to promote student safety in school vehicles should also be distinguished from mechanical restraints and should be employed according to state, provincial, and federal policies. Vehicle restraints should not be considered mechanical restraints as described here. Similarly, law enforcement officers using mechanical restraints in accord with appropriate police procedures in school settings should not be considered mechanical restraints for purposes of this document.

Very little is known about the extent of use of mechanical restraints to control student behavior in school settings. Little is also known about the circumstances when they are used. There are no evaluations of the use of mechanical restraints for students in school. Nevertheless,

anecdotal evidence suggests that mechanical restraints are being used inappropriately in some school settings to control student behavior (National Disability Rights Network, 2009).

Chemical Restraint. The second category of restraint is chemical restraint. This type of restraint uses medication to control behavior or restrict a patient's freedom of movement. One example of this type of restraint can occur in institutional or hospital programs where patients who become agitated are provided with medication specifically to control that agitation or other behaviors. A patient may be injected with medication to manage a crisis which is ongoing. This type of restraint is very unlikely in most school settings other than those schools within institutions or hospitals.

However, the use of medications to manage behavioral symptoms has proliferated, including the widespread use in children of medications whose purpose is at least in part to control behavioral symptoms such as hyperactivity and inattention. As a result, one can conclude that the use of chemical restraints among school children in the United States is widespread. Educators have typically not been directly involved in the decision to employ these types of medications since they must be prescribed by a physician and since parents have the right to manage the medical care of their children. Educators, however, have been criticized for urging (or in some cases requiring) parents to seek medications to control the behavior of their children. Some states, provinces, or school districts have policies which regulate the involvement of educators in making any recommendations to parents regarding medications, and the Individuals with Disabilities Education Act of 2004 prevents schools from requiring the use of medication before receiving special education services. Nevertheless, it is generally agreed that if these medications are to be employed with students, special education teachers or other educational personnel should be involved in assisting physicians and parents where possible in the titration and monitoring of these medications to determine whether they are effective.

Physical Restraint. The third type of restraint is sometimes referred to as ambulatory restraint, manual restraint, physical intervention, or therapeutic holding but herein is called physical restraint. A physical restraint is defined as any method of one or more persons restricting another person's freedom of movement, physical activity, or normal access to his/her body (International Society of Psychiatric and Mental Health Nurses, 1999). It is a means for

controlling that person's movement, reconstituting behavioral control, and establishing and maintaining safety for the out-of-control client, other clients, and staff (American Academy of Child and Adolescent Psychiatry, 2000). Physical restraints have been in widespread use across most human service, medical, juvenile justice, and education agency programs for a long period of time. While there have been some who have proposed physical restraint as a therapeutic procedure for some children, this view has no scientific basis and is generally discredited (Day, 2002). Today most schools or programs that employ physical restraint view it as an emergency procedure to prevent injury to the student or others when a student is in crisis, although there is some evidence that it is actually employed for various other purposes including student compliance to adult commands (Ryan & Peterson, 2004). While historically the use of these procedures in education has typically been in special education programs, these procedures are now widely believed to be used more broadly with any student and may be viewed as a part of the overall school program. Although data about the extent or circumstances of the use of physical restraint procedures in schools at the present time is not available, most believe that the use of these procedures in schools has increased as more students with difficult or severe behavioral needs are being served in general education schools and classes.

Focus on Physical Restraints

Although some recommendations will be made in this document regarding mechanical and chemical restraints in schools, the primary focus of these recommendations relates to physical restraint procedures in schools.

What is the purpose of physical restraint?

The purpose of physical restraint is to control the behavior of a student in an emergency situation to prevent immediate danger or possible injuries to that student or others in the environment. While preventing property damage is sometimes included as a purpose for physical restraint, most professionals do not include that as a legitimate purpose of these procedures.

What are the problems with the use of physical restraints?

The *Hartford Courant*, a Connecticut newspaper, reported 142 restraint-related deaths occurred in the United States over a 10-year period in the 1990s, 33% of which were caused by asphyxia (Weiss, 1998). The Government Accounting Office in 1999 stated that an accurate estimate of deaths or injuries due to restraint was impossible since only 15 U.S. states have established reporting procedures for such incidents (U.S. Government Accounting Office, 1999). The Child Welfare League of America estimated that between 8 and 10 children in the U.S. die each year due to restraint procedures while numerous others suffer injuries ranging from bites, damaged joints, broken bones, and friction burns (Child Welfare League of America, 2000). A recent report from the National Disability Rights Network has graphically enumerated a wide variety of abuses of physical restraint procedures in school settings, with many resulting in death or injury (National Disability Rights Network, 2009). There is no precise or scientific way to measure the number or extent of the injuries to children or injuries to staff as a result of the use of physical restraint. These deaths and injuries continue to occur in the present in a variety of child care institutions, including public schools that employ physical restraint procedures.

In addition to physical injury there are strong beliefs that psychological injury may also occur, particularly for those children who have experienced prior abuse by adults. There has also been attention to the psychological effects on those conducting restraints. These effects may range from short-term such as fear and an adrenaline rush of physical confrontation to long-term effects such as Post Traumatic Stress Disorder. While there is little research data to support this hypothesis, it is both plausible and supported by numerous anecdotal reports by those who have been restrained or engaged in restraining. In other contexts, no one questions such effects in connection with circumstances such as medical emergencies, physical assaults, or muggings.

As a result of this situation, the federal government in the U.S. and many states are considering policy development or policy changes related to the use of restraint procedures in schools.

What are the standards for using physical restraint?

In most medical, psychiatric, and law enforcement applications, strict standards govern the use of physical restraint and seclusion. Hospitals and treatment centers which receive federal funds in the U.S. are governed by federal legislation regulating their use of restraint. Often

accreditation requirements from governing bodies such as the Joint Commission on Accreditation of Healthcare Organizations or other agencies such as the National Association of Psychiatric Treatment Centers for Children (Cribari, 1996) and the American Academy of Pediatrics (American Academy of Pediatrics, 1997) address the use of restraints. These requirements have resulted in widespread training and certification of staff in the medical and psychiatric programs that employ physical restraints, and many of these types of programs have attempted to reduce drastically their use of these procedures as a result of the deaths and injuries related to their use.

Unfortunately, there has been no such accreditation requirement from national professional organizations in education for the use of these procedures in schools. The lack of these commonly accepted written standards in the school's use of physical restraint leaves school settings more susceptible to misunderstanding, improper implementation, and abuse. Recent examinations of state policies or guidelines have found a substantial numbers of states have no regulations or guidelines for the use of these procedures in school settings, and those states which do have some policies or guidelines vary tremendously in their content (Ryan, Robbins, Peterson, & Rozalski, in press). No similar analysis has been conducted in Canada. To make matters worse, school staff may lack training regarding effective behavioral interventions necessary for the prevention of emotional outbursts typically associated with students who have severe behavioral problems (Moses, 2000). Such interventions are critical in preventing student behavior from escalating to potentially dangerous levels where restraint may be needed.

Why has the use of physical restraint in education become an issue?

Injuries and deaths associated with the ongoing use of physical restraint in school settings have come to the attention of the public along with the concern that these procedures violate basic human rights. As a result there is increasing awareness of the abuse of these procedures in school settings and increasing concern by protection and advocacy organizations and by parents.

In addition, a confluence of problems in the educational system may be contributing to the misuse of restraint. Several factors have resulted in physical restraint being thrust into the mainstream of public education. Many students with emotional or behavioral problems, regardless of disability label, are now being "included" in public school environments, frequently in regular schools and classes. These students often have a history of serious psychiatric and

behavioral problems and need varying levels of supports for behavioral and academic difficulties. The use of procedures like physical restraint have moved with these students from therapeutic placements to more typical school and classroom settings and may be used more frequently in school settings than ever before, in part because these students are being served in environments where specialized supports are not well known and are not widely used. Teacher shortages and the movement to “generic” special education training for teachers may have resulted in school staff with limited or no training or experience with severe behavior disorders or the issues involved in employing physical restraint procedures. Additionally, high profile media attention has challenged schools to prevent or contain school violence, and physical restraint may be viewed as one intervention for this purpose (Skiba & Peterson, 2002). Physical restraint is often the first response in the face of actual violence such as fights and may even be a first-line intervention when there is potential for violence such as in incidences of verbal threats, threatening gestures, or intimidating behaviors.

What does research say about the use of physical restraint in schools?

Very little research has been conducted on the prevalence, appropriate applications, or efficacy of physical restraint. Almost no research has been conducted on the use of physical restraint in school settings. We do not know how widely physical restraint is used in the schools or for what purposes. We do not know the extent or nature of student injuries occurring when physical restraint has been used in school settings, although it is becoming widely known that prone restraint where a child is laying on his/her stomach is a dangerous type of restraint (National Disability Rights Network, 2009). We do not know the extent or nature of teacher or staff injuries during restraint. We have no data about the type of physical restraints that are most commonly employed or the nature and extent of training received by educators who apply physical restraint. While most professionals view restraint as an emergency procedure, little is known about its intended purpose or outcomes when it is employed, let alone whether it achieves that purpose or is effective in achieving the desired outcomes. This dearth of information about nature, use, and outcomes of physical restraint is of great concern, particularly given the U.S. mandates of No Child Left Behind and IDEA 2004 and the fact that all educators are to rely on evidence-based practices that are supported by scientific research.

Declaration of Principles

Given the current situation related to the use of physical restraint procedures in school settings, the Council for Children with Behavioral Disorders wishes to support a set of guiding principles which, if fully implemented, would significantly diminish the need to use restraint procedures in school settings. These principles are adapted in part from the Declaration of Principles by the Council of Parent Attorneys and Advocates (COPAA, 2008). To highlight their importance, the principles provide a preface to the recommendations CCBD is making regarding physical restraint, and CCBD feels that these principles should be reflected in the goals and policies of schools. CCBD supports the principles which follow as part of its recommendations regarding physical restraint.

Declaration of Principles:

- Behavioral interventions for children must promote the right of all children to be treated with dignity.
- All children should receive necessary educational and mental health supports and programming in a safe and least-restrictive environment.
- Positive and appropriate educational interventions, as well as mental health supports, should be provided routinely to all children who need them, and school staff should be trained to employ these techniques.
- Behavioral interventions should emphasize prevention and creating positive behavioral supports.
- Schools should have adequate staffing levels to effectively provide positive supports to students and should be staffed with appropriately trained personnel.
- All staff in schools should have mandatory conflict de-escalation training, and conflict de-escalation techniques should be employed by all school staff to avoid and defuse crisis and conflict situations.
- All staff should have mandatory training in the use of positive behavior supports for student behavior and in preventive techniques for addressing student behavior.
- Schools should have adequate staffing levels to effectively provide positive supports to student and should be staffed with appropriately trained personnel.

- All children whose pattern of behavior impedes their learning or the learning of others should receive appropriate educational assessment, including Functional Behavioral Assessments followed by Behavioral Intervention Plans which incorporate appropriate positive behavioral interventions, including instruction in appropriate behavior and strategies to de-escalate their own behavior.

For physical restraint to be used effectively, it is essential that behavioral interventions which might prevent the need for restraint are in place. Included among these should be a variety of positive behavior supports including establishing and teaching behavioral expectations (acknowledging that for many students, this may require deliberate targeted instruction in what the behavioral expectations mean since being able to repeat the expectations does not necessarily guarantee the student understands them), recognizing and reinforcing positive behavior, providing mental health services and interventions, and relying on functional behavioral assessment and related intervention plans for any student whose behavior indicates a need for intervention. Lack of resources to provide appropriate kinds of services should never be an excuse to employ restraint procedures. Without positive behavior supports, the number of “emergency” situations which might require restraint would be much greater than would otherwise be necessary.

Conflict de-escalation appears to be a crucial intervention needed to prevent the use of restraint as well as useful generally to prevent and defuse behavior problems for students with emotional or behavioral disorders and for all students who may engage in power struggles or escalate emotional crises. As a result this is an area of training which should be provided to all educators and school staff members, not just those in special education, and should be a part of school curriculum for students.

Recommendations regarding “Restraint Procedures” in School Settings

Restraints should be used in school settings only when the physical safety of the student or others is in immediate danger. Restraints should not be viewed exclusively as an issue related to special education. Restraint procedures are employed in school settings with some students who are not in special education. Therefore, regulation and procedures should apply to all students, not just students in special education. The following are CCBD recommendations related to the use of restraints when employed in school settings.

Mechanical Restraints

Mechanical restraints should never be used in school settings when their purpose is to manage or address student behavior.

- Mechanical restraints should only be used in schools for the purpose of providing mechanical support to students’ orthopedic needs in order to permit them to learn and participate in school activities.
- Use of mechanical restraints should only be under the supervision of and with a written order by a physician, occupational therapist, or physical therapist.
- Use of these devices for a student in special education should be included in the student’s IEP and with parent permission.
- There are two other exceptions: (a) Vehicle safety restraints should be used according to state, provincial, and federal regulations, and (b) mechanical restraints employed by law enforcement officers in school settings should be used in accord with their policies and appropriate professional standards.

Chemical Restraints

Medications should never be used as chemical restraints or solely by school personnel to manage or address student behavior.

- Prescription medications delivered to students during the school day should be administered only following a written protocol provided by a physician and with the knowledge and support of the parent.

- Non-prescription medications or over the counter medications and treatments should be delivered to students only with a written order from the parent and a protocol established by the school which includes parent permission and notification after every treatment.
- Educators can and should assist families and physicians by providing data regarding behavioral symptoms and side effects of medications for individual students and changes in symptoms or side effects when medication is being titrated.

Physical Restraints

Physical restraint procedures should rarely be used in school settings and if used should meet the following requirements:

- Restraints should be conducted by persons who are trained in the use of physical restraint procedures.
 - Training should result in some form of certification or credential for each individual staff member and overall certification or credential for the school district, agency, or school.
 - Training should be recurrent with annual updates at a minimum and should be appropriate to the type of school setting and to the age and developmental level of students.
 - Training should include content and skills on the use of positive, instructional, preventive methods for addressing student behavior.
 - Training should include content and skill development on conflict prevention, de-escalation, conflict management, and evaluation of risks of challenging behavior.
 - Training should include information about the effects of medications students may be receiving and how restraint procedures might affect the physical well-being of the student during restraint procedures.
 - Training should include multiple methods for monitoring a student's well-being during a restraint.
 - Training should minimally also include certification in First Aid and cardiopulmonary resuscitation (CPR) in the event of an emergency related to restraint.

- A pulse oximeter and a portable automatic electronic defibrillator, and related training for staff on their use, should be available and readily accessible in any school where the use of physical restraint is permitted by policy with the oximeter employed during any restraint.

If physical restraint is to be used with students, it is critical that anyone using these procedures is carefully trained in all aspects of their use. Many entities offer appropriate training which often entails credentialing, recurrent training, and conflict de-escalation as components. However, it is important that the training is relevant to the particular setting. Training that was designed for mental health agencies may not translate well into school settings. Likewise, procedures designed for self-defense may be inappropriate in school settings.

It is less common for these entities to include training on the interactive effects of medications or other health issues with restraint, let alone require First Aid or CPR training for those who receive instruction in the use of physical restraint. We believe that, given the deaths or injuries associated with these procedures, training in first aid, cardiopulmonary resuscitation (CPR), inexpensive pulse oximeters, and automatic electronic defibrillators should also be required for those trained to use restraint procedures. Recent advances in technology make the availability of portable defibrillators feasible and could prevent deaths in sports, when restraints occur, or in other emergencies.

It is also less common for these types of training to include information regarding the potential psychological harm that the use of these procedures may have on children who have experienced trauma related to previous abuse.

- Restraints to control behavior should be used only under the following emergency circumstances and only if all four of these elements exist:
 - The student's actions pose a clear, present, and imminent physical danger to him/her or to others;
 - Less restrictive measures have not effectively de-escalated the risk of injury;
 - The restraint should last only as long as necessary to resolve the actual risk of danger or harm; and
 - The degree of force applied may not exceed what is necessary to protect the student or other persons from imminent bodily injury.

These four components define the circumstances and limits of the use of restraint. They do entail professional judgment on the part of individuals within the school who have specific training related to these procedures.

- Physical restraint should be conducted by a team of trained personnel. Restraints should not be conducted without at least one additional staff member present and in line of sight. This is a safety issue for the student restrained, the staff conducting the restraint, and other students.
- Prone restraints (with the student face down on his/her stomach) or supine restraints (with the student face up on the back) or any maneuver that places pressure or weight on the chest, lungs, sternum, diaphragm, back, neck, or throat should never be used. No restraint should be administered in such a manner that prevents a student from breathing or speaking.

The risks associated with both of these procedures clearly outweigh any possible benefit, and the use of these types of restraints should be banned. Any training programs should specifically train how and why they must be avoided.

- Restraint procedures are not teaching procedures and should never be used as a punishment, to force compliance, or as a substitute for appropriate educational support.
The only legitimate rationale for the use of restraint is to prevent injury or harm. Use of restraint as a punishment is inappropriate and should never be condoned, although students often perceive the use of restraint as a form of punishment. Restraints have a history of being used as punishment. Correcting this perception in the minds of students and staff will require deliberate targeted instruction. This should be part of the training provided to staff.
- Physical (ambulatory) restraints or mechanical restraints should never be used for the purpose of managing student behavior, addressing non-compliance, or responding to students running away unless there is imminent risk of injury related to that flight.
- Each of the four elements described above, along with the names of those staff members involved and any other circumstances surrounding use of restraint, must be documented immediately after any use of restraint with a copy placed in the student's record and provided to the parent.
 - Parents or guardians should be informed as soon as possible after each and every instance of the use of restraint and should be provided a copy of all documentation as soon as it is created.

- The program supervisor or building administrator should be informed as soon as possible after each use of restraint.
- Due to the risk of shock, potential delayed effects, or possible injury, the physical well-being of the student should be monitored for the remainder of the school day. Similarly, the physical well-being of the person(s) who conducted the restraints should be monitored.

Given the potential for the possibility of injury or death as well as the possibility of these procedures being abused, appropriate documentation of the use of these procedures is essential. Parents must be informed immediately for each and every use of physical restraint with their child.

- A staff de-briefing should occur as soon as possible after every incident of the use of restraint but no later than 48 hours after the incident.
 - This de-briefing should include all of the participants in a restraint situation, an administrator, and at least one other staff member who has expertise in the use of behavioral techniques and who was not involved in the restraint procedure.
 - Parents or guardians should be invited to participate in this de-briefing.
 - The student should also be invited to participate. If not, a special debriefing with the student should occur separately.
 - The debriefing should focus on antecedent conditions that preceded the behavior of concern, alternate interventions that were used and why they were unsuccessful in de-escalating the behavior, how this situation could have been handled in such a way to prevent the need for the use of restraint, and how a similar event could be avoided in the future.
 - A report of the finding of this de-briefing should be included in the student's file with a copy provided to all of the student's teachers and sent to the parents or guardians.

The components in these sections are needed to insure that information to permit evaluation of the use of these procedures is available and is communicated to appropriate administrators, parents, and others capable of providing oversight on their use.

- Repeated use of physical restraints for any one student or multiple physical restraints across different students should be viewed as the failure of educational programming and

the likelihood that supports, educational methodologies, and other interventions for the students are inadequate and should be modified.

Since this is an emergency procedure and is used only if there is a threat of imminent physical danger to the student or others, a large number of “emergencies” is a clear sign that the normal educational or behavioral programming is failing and should be revised. For students in special education, this should trigger an IEP team review of the individual student’s programs and placement as well as overall school evaluation of its behavior support plans and programs serving students with behavioral needs.

- School wide safety planning.
 - School wide or general safety plans or policies should clearly identify if physical restraint might be employed in emergency situations within a school setting. These should be disseminated to parents of all students in that school.
- Individualized safety or emergency plans.
 - For students with disabilities: The use of restraint is an emergency procedure and should not normally be incorporated into the student’s Individual Educational Program (IEP) or Behavior Intervention Plan (BIP) and should not be used as a behavior change strategy.
 - However, if a separate document identified as a “safety” or “emergency plan” is deemed necessary, that document should be created by the IEP team and may be appended as an attachment to the student’s IEP. This plan may include restraint procedures along with other procedures for use in an emergency with that student.
 - For students who are not in special education but for whom an individualized safety plan would be needed, a plan should be created according to procedures established within that setting with parent or guardian participation.

Individualized Education Plans (IEPs), Personal Program Plans (PPPs), and Behavior Intervention Plans (BIPs) reflect plans for educational programming. Physical restraint is regarded as an emergency procedure that should be a part of an emergency or safety plan, not a part of routine programming. As a result, a persuasive argument can be made that physical restraint should not be included as normal intervention in students’ IEPs, PPPs, or BIPs. Such inclusion might legitimize physical restraint as part of normal educational programming. Moreover, inclusion of restraint procedures in a student’s IEP, PPP, or BIP may imply that it could be used routinely by educators and may often be interpreted by staff members (though wrongfully) that the parent or

guardian has provided consent or support for its use by signing the IEP. Neither of these should be the case.

- *According to IDEA-04 an IEP must identify services which are designed to confer “meaningful education benefit.” The statute states also that the IEP should include “a statement of special education services and supplementary aids and services based on peer reviewed research.” Physical restraint does not meet the standard of providing “meaningful educational benefit” nor is it based on “peer reviewed research.” It is only an emergency procedure.*
- *While attempting to prevent and anticipate safety issues is important and valuable, a school which uses physical restraint will use these procedures only in an emergency situation whether or not they were anticipated for a student or whether or not an individualized safety plan was in place.*
- *Therefore, all parents should be informed regarding the possible use of physical restraint as well as other emergency procedures which are in a school safety plan addressing procedures for dealing with life threatening emergencies. This might exist in a separate document, the school’s code of conduct, handbook, or other sources of policy. These are routinely distributed to all parents and would reflect a more complete way of informing all parents about their use.*
- *Parent should be involved and informed regarding any individualized safety plans.*
 - *We would expect that these safety plans might be created in specialized school treatment settings (such as special schools and programs serving students with emotional or behavioral disorders) and that such plans should be created only in situations where a student presents a heightened or predictable risk for serious injury to self or to others.*
 - *For students with disabilities, a safety or emergency plan may be appended as an attachment to an IEP or PPP when the team including the parent believes it is needed.*
 - *These individualized safety plans should never be limited only to physical restraint and should include procedures and actions which might be needed in various emergency situations.*
- *There is great value in talking to parents about the potential for the use of restraints for those students who present high risks, such as those with behavioral challenges. Many of these students have physical conditions that preclude the use of specific restraint techniques.*
- All U.S. states and Canadian provinces should have specific regulations for the use of physical restraints within school settings.
 - States or provinces which do not have specific regulations should create them.

- Regulations:
 - Should apply to all students, not just students eligible for special education.
 - Should apply to all schools, not just public schools.
 - Should specifically identify how standards provided will be monitored at the state or provincial level (for example, inclusion in school accreditation procedures and monitoring) to include:
 - Reporting of accurate incident by incident data to an outside agency on a regular basis.
 - Identifying responsibility for assessing the accuracy of data provided by schools, analysis of data, and oversight and intervention if necessary when data indicates overuse or potential abuse of restraints.

Given the potential for death or injury as a result of these procedures and given the nature of the abuses of these procedures across the U.S. which have been identified in the media, it seems reasonable that any state, province, and school system which chooses to use these procedures should have specific laws and strict regulations in place. Such laws and regulations will be likely to ensure that both educators and policy makers are informed about and receive training on the use of these procedures and their potential for misuse and the liability which might result.

According to recent U.S. court decisions, when there is a potential issue of child abuse in schools, state Advocacy and Protection agencies can request access to all school records of restraint (and seclusion) in that school district to investigate the possibility that abuse is occurring. Not having accurate records could itself be a partial basis for a finding against the school. It makes sense to have the state or provincial department of education provide oversight of this data much in the way that it now does for school discipline data.

- In any school where physical restraint is used a written set of policies should be in place, and the possibility of emergency use of physical restraint procedures should clear.

Regarding these policies:

- Any school district which employs physical restraint procedures should have a written school-wide positive behavior support plan which includes the use of positive behavior interventions and de-escalation techniques, training of all school

personnel on how to implement positive behavior supports, and documentation procedures.

- District and school policies should be made known to all staff.
 - Compliance with district and school policies should be mandatory for all school staff with clear lines of responsibility and oversight identified.
 - District and school policies should be available to parents and the public.
 - The fact that physical restraint might be used in a school should be made known to all parents and students in the school via the school handbook, emergency plan, or other mechanisms for informing parents and the public about school policies.
 - These policies and related training should be a part of school-wide accreditation standards.
 - Senior administrators (i.e., the school principal or designee) must ensure the implementation of these policies.
 - If physical restraint is used in school settings, all of the requirements which were described above should be incorporated into these written policies.
 - This plan should be on file with the state or provincial education agency and be available for review by parents and advocacy or parent organizations.
- A special education program within a school which employs physical restraint procedures should have a written positive behavior support plan specific to that program, pre-established emergency procedures, and data to support the implementation of the principles of positive behavior supports in that environment.
 - Federal, state, and provincial legislation or regulations which would require the implementation of the recommendations above is necessary, and CCBD will support such legislation or regulation.
 - CCBD does not believe that “guidelines” or “technical assistance documents” are generally adequate to regulate the use of these procedures since abuses continue to occur in states or provinces where guidelines are in place and these guidelines have few mechanisms for providing oversight or correction of abuses.
 - Legislation or regulation is necessary in order to insure adequate oversight.

- Without legislation or regulation, individual school districts or school programs should proceed on their own to implement policies in accord with the recommendations contained in this document.
- CCBD calls for additional research regarding the use of physical restraint with students across all settings. Areas for future research include but are not limited to:
 - The extent to which schools currently employ physical restraint and, if so, which of the restraint systems are used;
 - The nature of the antecedents or behavior that precipitates restraint;
 - The Diagnostic and Statistical Manual diagnoses (American Psychiatric Association, 2002), special education category (if applicable), or other characteristics of students who receive restraint;
 - The intended purposes or goals of restraint;
 - The efficacy of restraint procedures in achieving these goals;
 - The potential outcomes or side effects including injuries and fatalities as a result of the use of restraint in schools as well as other long term effects on students or staff;
 - The training level of each staff members involved with the incident where restraint is employed;
 - The degree to which procedures for de-escalation of student behavior and positive behavior supports are used before, during, and after restraint; and
 - The existence or lack thereof of policies and procedures related to restraint.

At the present time there is virtually no data about the use of these procedures in public school settings. Research about these procedures is needed and would permit better understanding of both negative and positive outcomes of the use of restraint procedures.

References

- American Academy of Child and Adolescent Psychiatry. (2000). *Policy statement on the prevention and management of aggressive behavior in psychiatric institutions with special reference to seclusion and restraint*. Washington, DC: Author.
- American Academy of Pediatrics Committee on Pediatric Emergency Medicine. (1997). The use of physical restraint interventions for children and adolescents in the acute care setting. *Pediatrics*, 99(3).
- American Psychiatric Association. (2002). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington, DC: Author.
- Child Welfare League of America. (2000). *Advocacy: Seclusion and restraints: Fact sheet*, 1-2. Retrieved March 23, 2002 from <http://cwla.org/advocacy/seclusionrestraints.htm>
- Council of Parent Attorneys and Advocates (COPAA). (June 2008). *Declaration of principles opposing the use of restraints, seclusion, and other aversive interventions upon children with disabilities*. Retrieved November 11, 2008 from <http://www.copaa.net/news/Declaration.html>
- Cribari, L. (1996). Facilities rethink policies on use of physical restraint. *Brown University Child & Adolescent Behavior Letter*, 12(8), 1-3.
- Day, D. M. (2002). Examining the therapeutic utility of physical restraint and seclusion with students and youth: The role of theory and research in practice. *American Journal of Orthopsychiatry*, 72, 266-278.
- International Society of Psychiatric and Mental Health Nurses, (1999). ISPN position statement on the use of restraint and seclusion. *Journal of Child and Adolescent Psychiatric Nursing*, 14(3), 100-102.

Moses, T. (2000). Why people choose to be residential child care workers. *Child and Youth Care Forum*, 29(2).

National Disability Rights Network. (2009). *School is not supposed to hurt: Investigative report on abusive restraint and seclusion in schools*. Washington, DC: Author.

Restrain. (2009). In Merriam-Webster Online Dictionary. Retrieved March 9, 2009 from <http://www.merriam-webster.com/dictionary/restrain>.

Ryan, J. B. & Peterson, R. L. (2004). Physical restraint in school. *Behavioral Disorders*, 29(2), 154-168.

Ryan, J., Robbins, K., Peterson, R., & Rozalski, M. (In press). Review of state policies concerning the use of physical restraint procedures in schools. Manuscript submitted for publication. *Education and Treatment of Children*.

Skiba, R. & Peterson, R.L. (2002). *The Safe and Responsive Schools Guide (Draft)*. Lincoln, NE: Safe and Responsive Schools Project, University of Nebraska-Lincoln and Indiana University. Retrieved from <http://www.unl.edu/srs/>.

United States Government Accounting Office, T-HEHS-00-26 (OCT 1999).

Weiss, E.M. (1998). A nationwide pattern of death, *The Hartford Courant*, (OCT 11, 1998). Accessed at <http://courant.ctnow.com/projects/restraint/data.stm>.

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