

Physical Restraints in School

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- 142 restraint-related deaths in U.S. over a 10-year period
- 33% caused by asphyxia (Weiss, 1998)

How Many Students are Injured?

- 1998 GAO reported only 15 states have established reporting procedures for such incidents.
- Based on info available, GAO estimated 24 restraint related deaths in the U.S. among children and adults (USGAO, 1999).
- CWLA estimated 8 - 10 children in the U.S. die each year due to restraints, while numerous others suffer injuries ranging from bites, damaged joints, broken bones and friction burns (CWLA, 2002).

Purpose Statement

- Review research literature, legislation and court decisions on topics related to the use of restraints in schools.
- Identify position statements and recommended practices from professional organizations and advocacy groups
- Make recommendations regarding research, policy and procedures for use of physical restraint in schools.

What is physical restraint?

- "Restraint" is defined as any physical method of restricting an individual's freedom of movement, physical activity or normal access to his/her body (International Society of Psychiatric and Mental Health Nurses, 1999).

3 types of restraint procedures:

Mechanical	Entails the use of any device (tape, tie downs) to limit an individual's body movement.	Limited use in schools; with a few exceptions, not permitted.
Ambulatory	Entails the use of one or more people using their bodies to restrict another's movement.	Can be used given certain criteria are met.
Chemical	Entails the use of medication to control behavior or restrict a patient's freedom of movement	Not used in schools; not addressed in this review

History of Restraint

- Originated in France's psychiatric hospitals during the late 18th century.
- Developed by Philippe Pinel & Jean Baptiste Pussin to prevent patients from injuring themselves or others (AACAP, 2000; Fisher, 1994; Weiner, 1992).

History of Restraint *(continued)*

- Restraints have been used for children with ED since the 1950s, and was included in a list of "techniques for the antiseptic manipulation of surface behavior" compiled by Redl & Wineman (1952).
- Authors stated explicitly that physical restraint should not be used as, nor be associated with physical punishment.

Standards and Guidelines for Using Restraint

- Most medical, psychiatric and law enforcement applications, strict guidelines govern the use of physical restraint
 - Joint Commission on Accreditation of Healthcare Organizations
 - National Association of Psychiatric Treatment Centers for Children
 - American Academy of Pediatrics
- Unfortunately, no such accreditation requirement for schools, or child caring agencies

Use of Restraints in Education

- Growing concern due to IDEA concept of serving children with special needs in LRE.
- "Regular Education Initiative" and "inclusion" movements of the 1990s have accelerated this process

Professional training programs

Representative Examples- No endorsement is implied

- Handle With Care Behavior Management System, Inc.
 - <http://www.handlewithcare.com>
- JKM Training, Inc.
 - <http://www.jkmtraining.com>
- The Mandt System®
 - <http://www.mandtsystem.com>
- Crisis Prevention Institute, Inc. (CPI)
 - <http://www.crisisprevention.com>
- Professional Assault Response Training (PART)
 - Phone: 916-723-3802
- Therapeutic Crisis Intervention (TCI)
 - <http://www.therops.com>

Results of Professional Training

- National training prevention programs advertise that intensive staff training in schools reduced assaultive incidences by 80%, and resulted in a 77% reduction in disruptive incidents (Crisis Prevention Institute, 2002).

Research on Restraint

- 3 articles reviewed legal aspects of restraints (Coffin, 1999; Kennedy & Mohr, 2001; and Lohrmann-O'Rourke & Zirkel, 1998)
- 5 articles reviewed the use of physical restraints (Day, 2002; Fisher, 1994; Soloff, Gutheil & Wexler, 1985; and Wright, 1999)

Research on Restraint (Cont)

- 8 position articles offer guidelines for the proper use of restraints with children (Cribari, 1996; Luiselli, et. al., 1994; Milliken, 1998; Mohr & Anderson, 2001; Ross, 2001; Schloss & Smith, 1987; Selekman & Snyder, 1997; and Stirling & McHugh, 1998)

Research on Restraint (Cont)

- 14 experimental research studies investigated restraints with children.
- Only 3 were conducted school settings (Grace, et. al., 1994; Ruhl & Hughes, 1985; and Magee & Ellis, 2001).
- Majority of studies (6) were conducted in psychiatric facility or hospital (Barlow, 1989; Hunter, 1989; Miller, Walker & Friedman, 1989; Persi & Pasquali, 1999; Petti, et. al., 2001; and Swett, Michaels & Cole, 1989)

Researcher's Findings of Interest

- Restraints more common among younger children. (possibly due to possessing fewer coping mechanisms for frustration.)
- Male staff members more likely to initiate restraints than females (Miller, Walker & Friedman, 1989).

Causal Factors for Restraints

- Debrief of staff and clients following 81 incidents of restraint in a psychiatric hospital setting resulted.
 - Staff reported 65% of restraints initiated due to perceived safety threat, while 19% were for patient noncompliance.
 - Patients reported that a staff member threatening time-outs were a causal factor for escalated levels of aggressive behavior (Petti, et. al., 2001).

Efficacy of Restraint

- Proponents of therapeutic holding justify restraint procedures through the attachment theory developed during the early to mid 1970's (Bowby, 1973; Cline, 1979; and Zaslow & Menta, 1975).
- Day (2002) reviewed these theories and found there was very little empirical support that posit benefits to children receiving restraint.
- There was also no scientific evidence of psychological damage or harm beyond the clear physical danger of injury or death.

Efficacy of Restraints Cont.

- Massachusetts' law addressing restraints effectively reduced the number of chemical restraints and seclusionary procedures within a juvenile psychiatric facility, but increased the number of physical restraints (Swett, Michael and Jonathan, 1989).
- Study in psychiatric inpatient unit (children 5 - 12 yrs) found using therapeutic holds (e.g., ambulatory restraints) slightly reduced duration of behavioral episodes, and was effective in reducing the number of restraints by 15.9% (Berrios and Jacobowitz, 1998).

Prevalence of Restraints

- Persi and Pasquali (1999) tracked restraints among 281 children (4 - 17 yrs) for psychiatric inpatient unit, residential group home, day treatment program, and day treatment program in community schools.
- Reported 107 restraints overall with males slightly more likely to be restrained than females
- No linear relationship with age, but noted the onset of adolescence brought about an abrupt increased level of restraints administered.
- In direct contrast of earlier findings, study found female staff initiated larger numbers of restraints than male counterparts.

Prevalence of Restraints (continued)

- A study of EBD teachers in public schools found that many used restraints as part of a planned behavioral intervention, or as a spontaneous reaction to aggressive behavior.
- Prevalence Rate among Public School EBD Teachers
 - 71% of EBD teachers used restraint with their students if they displayed aggression toward others,
 - 40% to prevent self-abuse, and
 - 34% to prevent destruction of property (Ruhl & Hughes, 1985).

Prevalence of the Use of Physical Restraint

- Survey of childcare workers from psychiatric facilities found restraints were frequently used, with 34% of staff reporting to have used these procedures more than twice per week (Hunter, 1989).
- Study conducted at adolescent psychiatric unit found 23% of population experienced at least one restraint during an 18 month period.
- Higher occurrences of restraints on Monday and Friday due to what the authors called weekend anxiety.

Policy Related to Restraint

- *Legislation*
- *Court and Hearing Officer Decisions*

Legislation

- Children's Health Act of 2000, P.L. 106-310 established national standards regarding the use of physical restraints with children in psychiatric facilities.
 - Unfortunately this legislation did not affect schools.
 - Nevertheless, Massachusetts, Colorado, Illinois, Connecticut and Texas passed legislation affording protection to children in the school environment.
 - Maryland, has proposed legislation on this topic.

State Legislation Typically Contains:

- Definitions of terms common to physical restraint;
- Required procedures and training for staff;
- Conditions when physical restraint can and cannot be used;
- Guidelines for the proper administration of physical restraint;
- Reporting requirements when restraint is employed.

Does Physical Restraint Violate a Student's Individual's Rights?

- Plaintiffs typically argue restraints violate an individual's rights under:
 - Eighth Amendment, which prohibits administering cruel or unusual punishment, and
 - Fourteenth Amendment, which provides for an individual's liberty interests in freedom of movement and personal security

Parental Options for Filing a Complaint

- The Office for Civil Rights (OCR) in the U.S. Department of Education serves as the primary administrative enforcement mechanism for Section 504 and the Americans with Disabilities Act (ADA) in relation to schools.
- Additionally, educational cases are frequently handled by the State Education Agency (SEA), which resolves disputes regarding the IDEA using impartial due process hearings, and at the state's option, a second-tier impartial administrative review.
- All OCR and SEA Hearing Officer Reports may also be appealed to federal court.

Rulings can be grouped into four general categories:

- **Decisions affecting the use of mechanical restraints;**
- **Decisions affecting the use of ambulatory restraints;**
- **Professional training pertaining to staff who perform restraints; and**
- **Individual rights related to the Eighth and Fourteenth Amendments, Section 504, and the American with Disabilities Act (ADA).**

Mechanical Restraints

- The preponderance of rulings by the Courts, SEA and OCR found the use of any type of mechanical restraint other than a time out or tray chair to be unacceptable, and in clear violation of a student's individual rights.

Federal Court	Rulings
<i>Jefferson v. Yselta Independent School District</i> (1987)	Teacher and principal did not have qualified immunity from liability for tying a second grade student to a chair.
<i>Ronnie Lee S. v. Mingo County Board of Education</i> (1997)	Elementary school did not have qualified immunity from liability when restraining a child with autism to chair by means of a vest.
SEA	Rulings
<i>Portland (ME) School District</i> (1987)	Teacher's strapping down of a student with profound retardation violated his Sec. 504 rights.
OCR	Rulings
<i>Oakland (CA) Unified School District</i> (1993)	Student's Sec. 504 and ADA rights had been violated when his mouth was taped shut
<i>Aiken County (SC) School District</i> (1995)	Student's Sec. 504 and ADA rights had been violated when his mouth was taped shut

Ambulatory Restraints

- Courts, SEA, and OCR have consistently found ambulatory restraints may be used without violating an individual's rights or threatening their safety.

Federal Court	Rulings
<i>Garland Independent School District v. Wilks</i> (1987)	Restraining a child with autism engaged in aggressive and self-injurious behavior was not considered to be excessive or violate the child's constitutional protection from cruel and unusual punishment
SEA	Rulings
<i>Florence (SC) County No.1 School District</i> (1987)	School personnel had not violated student's Sec. 504 rights restraining him to prevent harm, despite language in the IEP forbidding corporal punishment.
OCR	Rulings
<i>Ohio County Public Schools</i> (1989)	Did not find evidence to support parent's claim that a teacher used excessive force in restraining a student.
<i>Wells-Orgunquit (ME) County Schools</i> (1990)	School district did not violate a student's Sec. 504 rights when using a physical restraint to control violent behavior
<i>Gateway (CA) v. Unified School District</i> (1995)	Determined a student's behavior modification plan permitted the use of physical restraint

Professional Training

- *Wyatt v. King* (793 F. Supp 1058, 1992), U.S. Circuit Court determined staff working with mentally ill required specific training regarding interventions germane to their unique care.
- Training should include psychopharmacology, psychopathology, psychotherapeutic interventions, as well as interviewing and assessment procedures for determining a patient's mental status.

Individual Rights

- Decisions pertaining to an individual's rights regarding the Eighth and Fourteenth Amendments, Section 504 and ADA.
- Courts ruled institutions must take into account a patient's rights at all times, and that any restrictions to individual liberties must be in their best interest.

Federal Court	Rulings
<i>Jackson v. Bishop</i> (1968)	Interventions not professionally indicated and unnecessarily restrictive may violate a patient's 14 th Amendment liberty interest.
<i>Bell v. Wolfish</i> (1979)	Supreme Court stressed that innocent persons have a right to be free from punishment
<i>Youngberg v. Romeo</i> (1982)	Supreme Court ruled persons involuntarily committed to state institutions have a constitutionally protected liberty interest under the due process clause of the 14 th Amendment to reasonably safe conditions of confinement, and freedom from unreasonable bodily restraints. These were fundamental liberties that can be limited only by an overriding, non-punitive state interest.
<i>Converse v. Nelson</i> (1995)	Mass Superior Court ruled inappropriate behavioral programs that constitute punishment disguised as treatment should be subject to analysis under Eighth Amendment standards.
Office of Civil Rights	Rulings
Chicago (IL) Public Schools District decision (1993)	Determined a district's failure to monitor and respond to conditions at a private school for students with severe cognitive disabilities violated the student's Section 504 and their ADA rights

Advocacy Statements

- *Professional Organizations*
- *Advocacy Groups*

AACAP, APA, AAP, & AMA Guidelines for Restraint

- Establish procedures and policies addressing the circumstances in which restraints are permissible.
- Call for documentation procedures
- In-service training requirements for all staff
- Recommend restraints be used only as an emergency intervention to maintain safety
- Be implemented in a manner sensitive to the child's particular developmental level, specific vulnerabilities, and overall treatment goals (AACAP, 2000).

International Society of Psychiatric-Mental Health Nurses (ISPN) Guidelines

- Restraints should be used as a last resort and only when less restrictive alternatives have failed.
- Family members be informed immediately after the use of a restraint
- Child receive a debriefing from their caregivers in clear words that they can understand.
- All staff should be trained on the cycle of aggression, verbal intervention skills, and critical thinking strategies designed to select the least restrictive intervention that is best suited to the presenting needs of the child (International Society, 1999).

Advocacy Groups

- Some parents and advocacy groups have argued for the outright banishment of physical restraints, claiming its usage unfit for man, woman, or beast.
(Williams & Finch, 1997)

Child Welfare League of America

- Called for a minimum national standard of training in behavior management techniques (i.e., de-escalation).
- Emphasized need for future research to develop a better understanding of what crisis prevention models work best for specific situations (Child Welfare League, 2002).

Autism National Committee

- Calling for Congress and state legislatures to limit the use of restraints on children with disabilities to brief, emergency situations involving serious threat of injury to the person with disabilities or to others.
- Recommend standardized reporting procedures following a restraint, with an investigation of circumstances leading to the incident to develop supports and accommodations for the prevention of future restraints (Autism National Committee, 2000).

Recommendations for Use of Physical Restraint in School Settings

- Restraint Procedures*
- Professional Training*
- Reporting and parent notification*
- Advocacy*
- Research*

Restraint Procedures

- Restraints should never be performed as a means of punishment or to force compliance from a student.
- Restraints should never be performed with untrained personnel.
- Mechanical restraints are not permissible with students in a school setting, and that physical or ambulatory restraints should be administered only when the safety of the student, peers, or staff members are at-risk.
- When restraints are administered, staff must perform the safest method available using the minimal amount of force necessary to protect the student and others from physical injury or harm.
- Once a restraint is performed, its use should be discontinued as soon as possible.
- No restraint should be administered in such a manner that prevents a student from breathing or speaking.
- The student's physical status including respiration and skin color should be continuously monitored throughout the restraint procedure.

Professional Training

- All staff that work with students with EBD should be trained in conflict de-escalation, crisis prevention and behavior management techniques.
- A core team of staff should receive training on restraints before the procedure is used.
- Initial training period should be followed by yearly refresher sessions.
- Staff should receive certification in First Aid and CPR.

Reporting and Parent Notification

- School procedures for reporting and notification should be in place.
- Following a restraint, the staff member who administered the restraint should verbally notify an administrator ASAP.
- A written report should be provided to the administrator responsible for maintaining an on-going record of all physical restraints conducted by the school within a 24-hour period.
- The administrator should verbally inform the student's parents or guardians of the restraint verbally ASAP.
- Written reports to the parents including a description of the event and staff involved should be postmarked no later than 3 working days following an incident.

Advocacy

- Guidelines for schools regarding the use of restraints on children are the result of decades of professional practice, state and federal legislation, case law, and grass roots efforts by advocacy groups concerned with the safety of children.
- Advocacy organizations need to act as watchdog agencies monitoring the compliance of schools across the nation to ensure children are kept out of harms way.

Recommendations for Research

- Extent to which schools currently employ physical restraint, and if so, which of the restraint systems are used.
- Nature of the antecedents or behavior that precipitated the restraint.
- DSM diagnoses, special education category or other characteristics of students who receive restraint.
- Intended purposes or goals of restraint.
- Efficacy of restraint procedures in achieving these goals.
- Potential outcomes or side effects including injuries and fatalities as a result of the use of restraint in schools.
- Training level of the staff who actually perform restraints.
- Degree to which procedures for de-escalation of student behavior are used before, during and after restraint.

Conclusion

- Current level of student injuries and mortality rates requires immediate action.
- Need for clear standards regarding the use of restraint procedures in schools
- Professional Training
- Standardized record keeping, and notification of administrators and parents of incidents.
- Future Research to define situations where restraint is appropriate in schools, as well as its effectiveness in containing or preventing violent or destructive behavior.

For Additional Information

Final paper will be available in the Journal *Behavioral Disorders* in 2004:

Ryan, J.B. & Peterson, R.L. (In press). Physical Restraints in School. Accepted for publication in *Behavioral Disorders*.

Temporary access to a draft of the complete paper; and the fact sheets:

Draft paper via website at: <http://www.unl.edu/srs/publications.html>

Fact sheet on Physical Restraint at: <http://www.unl.edu/srs/facts.html>

Or Contact:

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