

Physical Restraints in School

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Abstract

Over the last two centuries the use of physical restraint has typically been associated with psychiatric institutions. Today however, society's emphasis on educating children in the least restrictive environment has resulted in these procedures becoming commonplace across all educational placement settings including public schools. Since their initial use restraints have been and remain controversial procedures. Professionals that utilize physical restraints claim they are necessary to safely manage dangerous behaviors. Child advocates, however, argue that far too many children suffer injury and death from the very staff charged with helping them. This manuscript reviews and provides a brief summary of research literature, legislation and court decisions on topics related to the use of restraints in schools. We also identify position statements and recommended practices from nationally recognized professional organizations and advocacy groups. Lastly, we make recommendations regarding needs for research, policy and procedures for use of physical restraint in schools.

Physical Restraints in School

A headline of the *American Statesman Staff* read that a 14-year old boy died after being restrained in a classroom by his teachers. According to a preliminary autopsy the child succumbed to an intense amount of pressure to his chest (Rodriguez, 2002). Unfortunately newspapers across the nation carry similar stories. The exact number of deaths caused by physical restraints remains in dispute. The *Hartford Courant* a Connecticut newspaper reported 142 restraint-related deaths occurred in the United States over a 10-year period, 33% of which were caused by asphyxia (Weiss, 1998). A more recent investigation by the Government Accounting Office in 1998 stated that an accurate estimate was impossible since only 15 states have established reporting procedures for such incidents. Based on information available, the GAO estimated that there were 24 restraint related deaths in the U.S. among children and adults (USGAO, 1999). More recently the Child Welfare League of America (CWLA) estimated that between 8 and 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). There is no precise way to measure the number or extent of the injuries to children and injuries also to staff as a result of the use of restraint.

Purpose

The purpose of this manuscript is to review available research and court decisions related to physical restraints used in school settings. We review and provide a brief summary of research literature, legislation and court decisions on topics related to the use of restraints in schools. We also identify position statements and recommended practices from nationally recognized professional organizations and advocacy groups. Last, we

make recommendations regarding needs for research, policy, and procedures for use of physical restraint in schools.

What is physical restraint?

As a professional term, “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). The term “restraint” is sometimes used to address three different types of restraint procedures: (1) mechanical, (2) ambulatory, and (3) chemical. Mechanical restraints entail the use of any device or object (e.g., tape, tie downs, calming blanket, body carrier) to limit an individual’s body movement to prevent or manage out-of-control behavior. A second category of physical restraint is sometimes referred to as ambulatory restraint, manual restraint, or “therapeutic holding” (American Academy of Pediatrics Committee on Pediatric Emergency Medicine, 1997). It involves the use of one or more people using their bodies to restrict another individual’s body movement as a means for 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). Chemical restraint is a third type of restraint that uses medication to control behavior or restrict a patient’s freedom of movement. This type of restraint is typically used only in institutional or hospital programs, and has developed only in the past forty years as a result of developments in psychotropic medications.

Today, restraints are used in numerous professional settings including medical and psychiatric facilities, law enforcement and correctional facilities, and in our schools. These different types of restraint are used both with adults and children in the event of

emergency behavior situations for people who exhibit aggressive, violent or dangerous behavior or as a precaution against such behavior.

The primary focus of this manuscript will be on the use of ambulatory or manual restraint as an intervention by educators in schools. There have been numerous instances in which mechanical restraint has also been used in educational settings, but its use will be addressed only in the context of some court decisions and policies that relate to physical restraint. While some might include confinement, such as that which occurs in “time-out rooms” as a form of mechanical restraint, it is beyond our scope to address that controversial issue here. Finally, since chemical restraint is not typically used in schools, it will not be addressed.

History

The use of physical restraint originated in the psychiatric hospitals of France during the late 18th century. Restraint procedures were developed by Philippe Pinel and his assistant Jean Baptiste Pussin for the same intent it is used today, as a means of preventing patients from injuring themselves or others (American Academy of Child and Adolescent Psychiatry, 2000; Fisher, 1994; Weiner, 1992). From their initial usage, mechanical and manual restraint have been and remain controversial procedures. Almost immediately after the procedures became popular, a “non-restraint” movement was started in England in an attempt to prevent physical and often brutally aversive mechanical restraints from being used on psychiatric patients in hospitals (Jones, 1972; Masters, et al., 2002; Scull 1979). In response, a Lunacy Commission was established in 1854 to monitor and regulate the use of seclusion and restraint in asylums. In contrast to England’s decreased use of restraints during this time frame, the United States viewed

physical restraint as a form of therapeutic treatment and adopted it as an accepted practice for dealing with violent patients (Masters, et al., 2002; Tomes, 1988).

Physical restraint has a long history in hospitals and psychiatry, particularly in the clinical treatment of violent persons (Romoff, 1985). The use of physical restraint has also been applied to children with emotional disturbance, at least since the 1950s, and was included in a list of “techniques for the antiseptic manipulation of surface behavior” compiled by Redl & Wineman (1952). Redl & Wineman stated explicitly that physical restraint should not be used as, nor be associated with physical punishment. They advocated that a child’s loss of control should be viewed as an emergency situation where the educator or clinician should either remove the child from the scene, or prevent the individual from doing physical damage to themselves or others. The person performing the restraint should remain calm, friendly, and affectionate, attempting to maintain a positive relationship with the child, thereby providing the opportunity for therapeutic progress once the child’s crisis subsides.

Over the past many years, law enforcement and correctional agencies have employed physical restraint and related conflict de-escalation procedures as tools in apprehending and managing the behavior of people they are concerned about. Primarily driven by the needs of law enforcement, and the needs of medical or psychiatric hospitals and their accreditation, over the past 25 years several programs to train and certify staff members in the use of physical restraint procedures have been developed, and are now employed by a variety of child caring agencies and programs as well.

Standards and Guidelines for Using Restraint

In most medical, psychiatric and law enforcement applications, strict guidelines govern the use of physical restraint. Often these standards include 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). These requirements have resulted in widespread training and certification for staff in these programs.

Unfortunately, there has been no such accreditation requirement for schools, or many other child caring agencies. The fact that there are not commonly accepted guidelines or accreditation standards for the use of physical restraint in schools makes their use more susceptible to misunderstanding and abuse, let alone improper implementation. To make matters worse, school staff that work with this population are often poorly trained regarding effective behavioral interventions necessary for the prevention of emotional outbursts, typically associated with children 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.

Restraint in Education

Once thought of as an exclusive tool of psychiatric institutions, physical restraint has been thrust into the mainstream of public education. This is, in part, due to the Individuals with Disabilities Education Act's (IDEA) concept of serving children with special needs in the least restrictive environment. In the quarter century since the original passage of the law back in 1975, many students with emotional or behavioral problems, regardless of disability label, are now being managed in public school environments, frequently in regular schools and classes. The "Regular Education Initiative" and "inclusion" movements of the 1990s have accelerated this process. Schools are now challenged with educating an increasing number of children who frequently exhibit

challenging and sometimes violent behaviors. As a result, the use of physical restraint has moved from only occurring in hospitals and treatment programs, to now being common in public schools as well. Physical restraint has moved along with the students to the new less restrictive environments.

Recent concern for school violence, may have served as a further impetus for using physical restraint in schools. Schools have been encouraged to take all kinds of actions that might both prevent and deter violence in schools. Implementing procedures that include physical restraint might be one element of an overall plan for managing violence and disruption when they do occur in school (Skiba and Peterson, 2002).

Professional training programs

Today, most training in physical restraint for schools is done by a handful of agencies that specialize in this type of training, usually in conjunction with other strategies for conflict de-escalation and problem solving. (See Table 1 for a list of representative organizations and contact information. No endorsement of programs listed should be implied). Most of these training systems evolved from training programs for staff at residential treatment and psychiatric facilities or from psychiatric hospitals, but these training organizations now offer their training to various agencies including schools.

<Insert Table 1 About Here>

Currently these systems of physical restraint and related conflict de-escalation procedures are used in various professions that deal with the management of violent behavior, including juvenile correctional facilities, group homes and schools.

Research on Restraint

An extensive search was conducted to identify articles related to physical restraint. Computer databases of Education Resource Information Center (ERIC), LEGALTRAC, psychINFO and FindArticles were searched for relevant articles. Keywords used in the computer search included: restraint, physical restraint, therapeutic holding, ambulatory restraint, and mechanical restraint. Second, a hand search of studies published between 1970 - 2002 from the following journals was conducted: *The Journal of Psychosocial Nursing*, *Journal of Special Education*, *Journal of Emotional and Behavioral Disorders*, *Behavioral Disorders*, and *Exceptional Children*. Lastly, an ancestral search was performed by checking the citations from relevant studies to determine if any of the articles cited would qualify for inclusion in this review. Literature related to restraint in the field of geriatrics was not reviewed.

After conducting an extensive search 25 articles were identified. There were three articles that reviewed the legal aspects of restraints (Coffin, 1999; Kennedy & Mohr, 2001; and Lohrmann-O'Rourke & Zirkel, 1998), and five articles reviewing the use of physical restraints (Day, 2002; Fisher, 1994; Soloff, Gutheil & Wexler, 1985; and Wright, 1999). While there were 14 experimental research studies investigating the use of restraints with children, only three were conducted in school settings (Grace, et. al., 1994; Ruhl & Hughes, 1985; and Magee & Ellis, 2001). The majority of studies (six) were conducted in either a psychiatric facility or hospital (Barlow, 1989; Hunter, 1989; Miller, Walker & Friedman, 1989; Persi & Pasquali, 1999; Petti, et. al., 2001; and Swett, Michaels & Cole, 1989). The last five studies were conducted with children and adolescents suffering from severe autism or mental retardation attempting to reduce mechanical restraints used for the prevention of self-injurious behaviors (SIB) (Favell,

McGimsey & Jones, 1978; Fisher, et. al., 1997; Luiselli & Waldstein, 1994; Milliken, 1998; and Wallace & Iwata, 1999). Last, there were eight position papers offering 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).

Prevalence of the Use of Physical Restraint

After an extensive search, no research could be identified indicating how widespread the use of restraint in schools has become. Anecdotal information based on court cases, and legislation would seem to indicate that it has become common at least for larger school systems to have some staff performing physical restraints in public school settings. While studies regarding the prevalence of physical restraint procedures in more restrictive settings was also limited, Day (2002) recently asserted that the use of these procedures in residential settings has become commonplace. A survey of frontline 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). Currently the accreditation of psychiatric hospital programs requires written procedures and training on these topics, presumably meaning that these procedures are commonplace in these settings as well. An early study conducted within an adolescent psychiatric unit found that 23% of the population experienced at least one restraint during an 18-month period. Additional findings of interest included higher occurrences of restraints on Monday and Friday due to what the authors called weekend anxiety. Researchers also reported restraints were more common among younger children potentially due to possessing fewer mechanisms for coping with frustration. Last, the

study found male staff members were more likely to initiate restraints than females (Miller, Walker, & Friedman, 1989).

For the most part this type of physical restraint has not been researched as an educational intervention (Selekman, 1997). A review of literature found several journals had published articles regarding restraint, but most articles focused on addressing the controversial nature of the procedure. One of the first research articles on reducing restraints was performed by Swett, Michael and Jonathan (1989), who investigated whether the passage of a Massachusetts' state law addressing restraints effectively reduced the number of chemical restraints and seclusionary procedures used in a juvenile psychiatric facility. The researchers found that while the number of chemical restraints had decreased significantly, the number of physical restraints had actually increased. More recently, Berrios and Jacobowitz (1998) conducted a study in a psychiatric inpatient unit with children ranging in age from 5 to 12 years using therapeutic holds (e.g., ambulatory restraints). The study claimed therapeutic holding only slightly reduced the duration of a child's behavioral episode, but was effective in reducing the number of restraints performed by 15.9%.

A more recent study performed by Persi and Pasquali (1999) tracked the frequency of physical restraints used among 281 children aged 4 to 17 placed in four different types of segregated settings: psychiatric inpatient unit, residential group home, day treatment program, and day treatment program located in community schools. The study found that 107 restraints were performed throughout the year. The incidence of restraints varied among settings, with the group home and day treatment programs in segregated schools utilizing the procedure more frequently than either the community day treatment or inpatient unit. The study also found males were slightly more likely to be

restrained than females, and there was a mild significant relationship between age and restraints. Researchers did not find a linear relationship with age, but noted the onset of adolescence brought about an abrupt increased level of restraints administered.

Surprisingly, and in direct contrast to earlier findings, the study found that female staff initiated larger numbers of restraints than their male counterparts. When comparing the use of restraints among placement settings, the study concluded the pattern of physical restraint in actual settings is highly variable and difficult to explain, requiring additional studies.

Situations or Behaviors That Prompt Use of Restraint

Only one study (Petti et. al., 2001) was identified that examined the circumstances of when physical restraints were employed. Researchers debriefed both staff and clients following 81 incidents of restraint in a psychiatric hospital setting. Findings of interest included staff reporting that 65% of restraints were initiated due to a perceived safety threat, while 19% were the direct result of patient noncompliance. An interesting finding from patient interviews was that a staff member threatening time-outs was a causal factor for escalated levels of aggressive behavior. This may suggest that time-outs are perceived by patients as a coercive intervention.

Unfortunately, no similar studies were performed in a school environment. What is known and recognized by the professional community is that physical restraints are widely used protective procedures, often implemented for a variety of reasons including violence prevention, prevention of self-injurious behavior, noncompliance, and injury or property damage due to temper tantrums. However, physical restraint has long been considered to be a behavior management technique appropriate for teachers when crisis behavior occurs (Rizzo & Zabel, 1988; Fagen, 1996), and may be used for a much wider

set of student behaviors such as preventing children from leaving a classroom or school grounds, or from destroying private or school property. One study conducted with teachers of students with emotional or behavioral disorders (EBD) in public schools found that many had used restraints as either part of a planned behavioral intervention, or as a spontaneous reaction to aggressive behavior. The study reported 71% of these teachers used physical 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).

Efficacy of Restraint Procedures

Despite the belief that physical restraint is a commonly used procedure in schools serving children with emotional or behavioral disorders, very little is known about its efficacy, due to a lack of research (Persi & Pasquali, 1999). Few of the proponents of physical restraint have claimed the procedure has any therapeutic value in and of itself. However, proponents of therapeutic holding justify restraint procedures through the attachment theory developed during the early to mid 1970s (Bowlby, 1973; Cline, 1979; and Zaslow & Menta, 1975). Day (2002) reviewed these theories, and for the most part concluded that there was very little empirical support for therapeutic benefits to children receiving restraint. Most of the studies located were of poor quality and relied upon “unverifiable, and hence questionable, anecdotal evidence and case reports” (Day, 2002, p. 272). There was also no evidence for any potential side effects of restraint. While some might believe that children diagnosed with emotional and behavioral disorders who are exposed to restraints on a daily basis could be humiliated by such highly aversive procedures, there is no scientific evidence of psychological damage or harm beyond the clear physical danger of injury or death. Instead restraint is usually

viewed as a physical safety mechanism that may permit continuation of other therapeutic interventions once the restraint is completed. Most educational textbooks dealing with aggressive or violent behavior, or students with EBD suggest that physical restraint might be warranted for purposes of safety despite a lack of empirical research supporting such claims.

Summary of Research. 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 restraint in school settings. We do not know how widely physical restraint is used in the schools, the extent or nature of injuries occurring when it has been used in the schools, or its effectiveness in achieving the desired outcomes.

Policy Related to Restraint

An extensive search was conducted to identify court or hearing officer decisions, as well as legislation related to physical restraint. In order to identify cases which have dealt with restraint, a search of legal data bases was conducted (*Federal Supplement* which lists all Federal Trial Court decisions; *Federal Reporter 3rd Series* listing all Middle Appellate Court decisions; *United States Reports*, the official publication for all U.S. Supreme Court rulings; LEGALTRAC, a database that indexes law reviews and other legal periodicals; and finally, *Individuals with Disabilities Education Law Report* (IDELR), a specialty law reporter that publishes case law specific to special education, including some hearing officer reports). The results of this search are described below.

Legislation

The passage of the 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. Five states

Massachusetts, Colorado, Illinois, Connecticut and Texas have passed legislation over the past several years addressing the use of physical restraint with children in the school environment. Texas is the most recent state to do so (Amendments to 19 TAC Chapter 89, 2002), while one additional state, Maryland, has proposed legislation on this topic. Although state guidelines differ, the legislation typically contains many similar elements including; 1) definitions of terms common to physical restraint; 2) required procedures and training for staff; 3) conditions when physical restraint can and cannot be used; 4) guidelines for the proper administration of physical restraint; and 5) reporting requirements when restraint is employed.

Court and Hearing Officer Decisions

Over the years, parents and advocacy groups have filed numerous litigation and/or grievances against school districts and psychiatric units regarding the use of restraints on children. Plaintiffs have typically argued that restraints violate an individual's rights under the Eighth Amendment, which prohibits administering cruel or unusual punishment, and the Fourteenth Amendment, which provides for an individual's liberty interests in freedom of movement and personal security (Kennedy & Mohr, 2001). Cases resulting from these complaints have been lodged through state education agency hearings (e.g., under the Individuals with Disabilities Education Act, or state school disciplinary laws), with the U.S. Office for Civil Rights, and through state and federal court cases.

While the Constitutional issues mentioned earlier can be brought directly in federal court, other options exist as well. 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

(Lohrmann-O'Rourke & Zirkel, 1998). Additionally, educational cases are frequently handled by the State Education Agency (SEA), which resolves disputes regarding the Individuals with Disabilities Education Act (IDEA) using a system of 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.

A potentially powerful but underutilized tool for protecting the civil rights of confined or detained youth is the Civil Rights of Institutionalized Persons Act (CRIPA). Established by Congress in 1980, CRIPA provides the Civil Rights Division of the Department of Justice (DOJ) the authority to bring legal action against state and local governments for violating the civil rights of persons institutionalized in publicly operated facilities. Under CRIPA the Civil Rights Division of DOJ protects detained or incarcerated juveniles in prisons, jails, psychiatric hospitals, and other publicly operated facilities from dangerous conditions and unsafe practices of confinement (Puritz & Scali, 1998). The Office for Civil Rights has verified that CRIPA would apply to students in school settings (Complaints can be directed to: Special Litigation Section, Civil Rights Division, U.S. Department of Justice, P.O. Box 66400, Washington, DC 20035-6400. 202-514-6255). However, no records of CRIPA's use related to the use of restraints in schools were located.

Findings. Court rulings can be grouped into four general categories pertaining to the use of physical restraints: 1) decisions affecting the use of mechanical restraints; 2) decisions affecting the use of ambulatory or manual restraints; 3) professional training pertaining to staff who perform restraints; and 4) individual rights related to the Eighth and Fourteenth Amendments, Section 504, and the American with Disabilities Act (ADA).

Mechanical & Ambulatory Restraints. The preponderance of rulings by the Courts, State Education Agencies (SEAs) and the Office for Civil Rights (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. Specific rulings by each agency are shown below in table 1. In contrast, the Courts, SEAs, and OCR have consistently found ambulatory restraints may be used without violating an individual's rights or threatening their safety. Specific rulings by each agency are shown below in table 2.

<Insert Table 2 and Table 3 About Here>

Professional Training. In *Wyatt v. King* (1992), the U.S. Circuit Court determined that staff working with the mentally ill required specific training regarding interventions germane to their unique care. The Court stated that training should include psychopharmacology, psychopathology, psychotherapeutic interventions, as well as interviewing and assessment procedures for determining a patient's mental status. These findings have since been supported by national training prevention programs which 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). Similarly, the states of Pennsylvania and Delaware experienced a 90% reduction in the

use of physical restraints in their state's mental health facilities after instituting intensive staff training programs. Training included crisis management and crisis prevention procedures for staff, as well as extensive training on methods for determining when and how to conduct physical restraints. Texas legislation now requires school personnel who use restraint to be trained and its supporting technical assistance materials have identified critical components for training programs (Amendments to 19 TAC Chapter 89, 2002). Courts, hearing officers and legislation strongly support adequate training before these procedures are employed.

Individual Rights. Numerous court cases have addressed patient rights. This section provides a synopsis of all decisions pertaining to an individual's rights regarding the Eighth and Fourteenth Amendments, Section 504 and ADA. In essence, the Courts have ruled that 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. Specific rulings by each agency are shown below in table 2. Perhaps the most influential decision regarding the use of restraint came from the Supreme Court decision *Youngberg v. Romeo* (1982). The court emphasized its concern that the judicial system should not invade the province of those whose job it is to make medical and custodial decisions. This case was critical in establishing a precedent for the establishment of procedures used to determine if the use of physical restraint was considered reasonable, and hinged on whether staff exercised professional judgment. Professional judgment, the court ruled was to be considered presumptively valid. This presumption effectively shifted the burden of proof from the caretaker to the individual alleging that the imposition of restraint was unreasonable. However, to ensure the use of restraints were not being improperly used, the Courts determined in *Converse v. Nelson* (1995) that inappropriate behavioral programs that

constitute punishment disguised as treatment should be subject to analysis under Eighth Amendment standards. Last, as described earlier, CRIPA may also provide a vehicle for advocacy and protection related to the use of restraints.

<Insert Table 4 About Here>

Summary. A review of state and federal policies regarding the use of physical restraint in schools has resulted in several findings: 1) limited forms of mechanical restraints are permitted, 2) ambulatory restraints performed with trained personnel are authorized, and 3) any agency, including schools, that uses restraints needs to provide professional training for staff that perform these procedures.

Advocacy Statements

While professional organizations and advocacy groups frequently hold differing opinions regarding specific issues, it is important to recognize areas of agreement to promote standardization and policy. Position statements regarding the use of physical restraint from nationally recognized advocacy groups and professional organizations were reviewed and summarized.

Professional Organizations

In 1998 the American Medical Association (AMA) reviewed existing restraint guidelines and attempted to coordinate the development of updated national guidelines for the safe and clinically appropriate use of restraint techniques for children and adolescents. In a 1999 report, the AMA supported the development and use of guidelines currently issued by the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics (AACAP), and the American Psychiatric Association (APA) regarding restraint, while encouraging future empirical studies on physical

restraint with children and adolescents across all settings (American Medical Association, 2001).

AACAP's policy statement suggests institutions that use physical restraints establish procedures and policies addressing the circumstances in which restraints are permissible. AACAP also calls for documentation procedures, and in-service training requirements for all staff. Last, they recommend physical restraints be used only as an emergency intervention to maintain safety, and be implemented in a manner sensitive to the child's particular developmental level, specific vulnerabilities, and overall treatment goals (American Association of Child and Adolescent Psychiatry, 2000). The American Psychiatric Association (APA) policy statement is similar to AACAP's, but expressed concerns regarding P.L. 310-106 terminology. The APA believes this legislation defined physical restraint so broadly it essentially encompassed any unwanted touching that might reduce an individual's ability to move freely (American Psychiatric Association, 2002). This definition would classify commonly used escort procedures as a type of physical restraint.

Finally, the position statement by the International Society of Psychiatric-Mental Health Nurses (ISPN) claims restraints should be used as a last resort and only when less restrictive alternatives have failed. ISPN recommends family members be informed immediately after the use of a restraint, and that the child receive a debriefing from their caregivers in clear words that they can understand. The organization claimed the debriefing process is necessary to minimize negative effects related to patients' experiences of being restrained. ISPN also advocates training all staff members 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

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). Many nationally recognized advocacy groups have posted position statements regarding the use of physical restraint on their World Wide Web sites. The National Alliance for the Mentally Ill recently posted a position statement supporting P.L. 310-106 regarding the use of physical restraints, and proposed similar standards be established for schools (National Alliance, 2001). Another professional and advocacy group, the Child Welfare League of America, called for a minimum national standard of training in behavior management techniques, especially in the area of de-escalation. In addition, it called for future research to develop a better understanding of what crisis prevention models work best for specific situations (Child Welfare League, 2002). More recently, the Autism National Committee has called upon 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. They are also asking for 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

After reviewing the compilation of research, legislation, case law and position statements regarding the use of physical restraint, it would appear that extreme caution should be used by schools when the use of physical restraint procedures is being

contemplated. The following recommendations regarding restraint procedures, staff training, notification and monitoring seem to combine the best practices emerging from our review, and would be advisable for any school that would employ these procedures.

Restraint Procedures

Restraints should never be performed as a means of punishment or to force compliance from a student. In addition, physical restraint procedures should never be performed with untrained personnel. The courts have established through numerous rulings that very limited forms of mechanical restraints are 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 physical restraints are administered, staff must use 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. In addition, 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 members who work with students with emotional and behavioral disorders should be required to receive specialized training in conflict de-escalation, crisis prevention and behavior management techniques. At least a core team of these staff members should receive specialized training in the use of physical restraint before any such procedures are used. Physical restraint should never be used unless the person doing it is trained specifically in the particular technique to be used. Training should

include recognition of the various phases of the cycle of aggression, verbal de-escalation strategies, as well as restraint and counseling procedures. An initial training period should be required, followed by yearly refresher sessions. Staff should also receive certification in First Aid and cardio pulmonary resuscitation in the event of an emergency related to restraint.

Reporting and parent notification

Procedures for reporting and notification should be in place. Following the administration of a physical restraint, a staff member who administered the restraint should verbally notify an administrator as soon as possible. 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. In addition, the administrator should verbally inform the student's parents or guardians of the restraint as soon as possible. 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

It is important to remember that policies, procedures, and legislation, even if noble in intent, are all but meaningless if not enforced. The guidelines for schools regarding the use of physical restraint on children are the result of decades of professional practice, state and federal legislation, case law, and grass roots efforts by advocacy groups all concerned with the safety of children. To ensure empirically based best practices are developed and become common practice among schools, it is incumbent upon these same bodies to monitor and hold school districts across the nation accountable. Organizations such as the National Alliance for the Mentally Ill, American Psychological Association, Academy of Child and Adolescent Psychiatry, Council for

Children with Behavioral Disorders, Child Welfare League of America, Autism National Committee, and many others need to act as watchdog agencies monitoring the compliance of schools across the nation to ensure children are kept out of harm's way.

Recommendations for Research

It is evident that there is a strong need for additional research regarding the use of physical restraint with students across all settings. Areas for future research include:

1. The extent to which schools currently employ physical restraint, and if so, which of the restraint systems are used;
2. The nature of the antecedents or behavior that precipitated the restraint;
3. The Diagnostic and Statistical Manual diagnoses (American Psychiatric Association, 2002), special education category (if applicable) or other characteristics of students who receive restraint;
4. The intended purposes or goals of restraint;
5. The efficacy of restraint procedures in achieving these goals;
6. The potential outcomes or side effects including injuries and fatalities as a result of the use of restraint in schools;
7. The training level of the staff who actually perform restraints;
8. The degree to which procedures for de-escalation of student behavior are used before, during, and after restraint.

Using the data compiled where states require reporting will be very useful in beginning to address some of these issues, and make it more likely that restraint will be used safely.

Conclusion

Due to the current risk of student injuries and the mortality rates associated with the use of physical restraint, immediate action is required to ensure that schools

employing restraint do not jeopardize student safety. Based on the review of case law, legislation, and recommended procedures from both professional organizations and advocacy groups, there is a need for clear standards regarding the use of restraint procedures in schools, as well as mandatory training of staff before they use restraints. Improved and standardized record keeping, and notification of administrators and parents of incidents where restraint occurs are also important. Additional research is needed to define situations where restraint is appropriate in schools, as well as its effectiveness in containing or preventing violent or destructive behavior. Unless these recommendations are heeded and action is taken, headlines will continue to appear across our nation describing these preventable fatalities.

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Table 1.

Representative Training Programs on Ambulatory Restraint*

Program	Contact Information
Handle With Care Behavior Management System, Inc.	184 McKinstry Road, Gardiner, NY 12525; 845-255-4031; fax 845-256-0094; http://www.handlewithcare.com
JKM Training, Inc.	36 South Pitt Street; Carlisle, PA 17013; 717-960-0457; fax 717-960-0458; http://www.jkmtraining.com
The Mandt System®	David Mandt & Associates, PO Box 831790, Richardson, TX 75083-1790; 972-495-0755; Fax 972-530-2292; http://www.mandtsystem.com/ or e-mail comment@mandtsystem.com
Nonviolent Crisis Intervention	Crisis Prevention Institute, Inc. (CPI) 3315-K North 1245h Street, Brookfield, WI 53005; 800-558-8976; http://www.crisisprevention.com
Professional Assault Response Training (PART)	6105 Glenhurse Way, Citrus Heights, CA 95621-1720; Phone: 916-723-3802
Therapeutic Crisis Intervention (TCI)	Residential Child Care Project, Family Life Development Center, College of Human Ecology, Cornell University; Ithaca, NY 14853; 607-254-5210; fax 607-255-4837
Therapeutic Options®	Therapeutic Options, Inc., 100 Delaplane Avenue, Newark, Delaware 19711; 302- 753-7115;

<http://www.therops.com/>; info@therops.com

* These programs are listed as examples. No endorsement of these programs should be implied by their listing here.

Table 2.

Summary of Court, State Education Agency and OCR Rulings on Mechanical Restraint

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>Heidemann v. Rother</i> (1996).	Blanket wrapping techniques were not a substantial departure from accepted professional judgments, practice, or standards
<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.
State Education Agency	Rulings
<i>Portland (ME) School District</i> (1987)	Teacher's strapping down of a student with profound retardation violated his Sec. 504 rights.
<i>White Settlement Independent School District</i> (1996)	School district acted in accordance with IEP provisions allowing a tray chair for redirection and maintaining attention to task
Office for Civil Rights	Rulings
<i>Oakland (CA) Unified School District</i> (1993)	Student's Sec. 504 and Americans with Disabilities Act (ADA) rights had been violated when his mouth was taped shut
<i>Aiken County (SC) School District</i> (1995)	Student's Sec. 504 and Americans with Disabilities Act (ADA) rights had been violated when his mouth was taped shut

Table 3.

Summary of Court, State Education Agency & OCR Rulings on Ambulatory Restraint

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
State Education Agency	Rulings
<i>Florence (SC) County No.1 School District</i> (1987)	Determined school personnel had not violated a student's Section 504 rights while restraining him to prevent harm, despite language in the IEP forbidding corporal punishment.
Office of Civil Rights	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

Table 4.

Summary of Federal Court and OCR Rulings on Individual Rights

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>Parham v. J.R.</i> (1979)	Supreme Court determined children did not enjoy the same degree of constitutional protection as adults.
<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>Farmer v. Brennan</i> decision (1994)	Supreme Court ruled restraints violated the prohibition against cruel and unusual punishment when used in a correctional facilities, and that prison official have a duty to provide humane conditions of confinement and can be held liable for acting with deliberate indifference to the health or safety of an inmate.
<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

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