Restraint and Seclusion Use in U.S. School Settings: Recommendations From Allied Treatment Disciplines

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Restraint and seclusion (R&S) are high risk, emergency procedures that are used in response to perceived violent, dangerous situations. They have been employed for years in a variety of settings that serve children, such as psychiatric hospitals and residential treatment facilities, but are now being recognized as used in the public schools. The field of education has begun to examine these practices in response to national scrutiny and a Congressional investigation. The fields of mental health and child welfare were similarly scrutinized 10 years ago following national media attention and have advanced R&S practice through the adoption of a prevention framework and core strategies to prevent and reduce use. A review of the evolution of the national R&S movement, the adverse effects of these procedures, and a comprehensive approach to prevent their use with specific core strategies such as leadership, workforce development, and youth and family involvement in order to facilitate organizational culture and practice change are discussed. Proposed guidelines for R&S use in schools and systemic recommendations to promote R&S practice alignment between the child-serving service sectors are also offered.

R estraint and seclusion (R&S) are used in a variety of settings that serve children with special needs such as psychiatric hospitals, juvenile justice programs, and residential treatment facilities. They are high-risk procedures that are employed in response to behavior that is violent, out of control, or dangerous to the self or others (Day, 2008). Each occurrence of R&S is high risk and nonconsensual, limits freedom of movement, and creates the possibility of severe physical injury and emotional trauma to the child, staff, and other children in the setting (Kennedy & Mohr, 2001). Moreover, R&S use can trigger strong emotions such as humiliation, fear, loss of control, and anger and negatively impact the quality of any relationship (National Association of State Mental Health Program Directors [NASMHPD], 2011; Steckley, 2010; Steckley & Kendrick, 2007).

By definition, restraint is any manual method or device used to restrict freedom of movement (Mohr, LeBel, O'Halloran, & Preustch, 2010). But restraint does not include devices that provide physical support or compensate for a lack of orthopedic control (Shaughnessy, 2008). Seclusion is considered involuntary confinement of a person to a room or area from which

a person is physically prevented from leaving (Mohr et al., 2010). Functionally, R&S use is intended to serve two purposes: (a) to interrupt and contain harmful behavior and (b) to decrease the likelihood of future occurrence (Jones & Timbers, 2002; Luiselli, 2009). The latter objective is referred to in psychological learning theory (operant conditioning) as punishment, where an action following behavior reduces its frequency (Domjan, 2010).

Legal advocates and legal standards do not view R&S within the learning theory paradigm of *punishment*. Rather, R&S are considered *corporal punishment*, which is defined as "any punishment in which physical force is used and intended to cause some degree of pain or discomfort" (American Civil Liberties/Human Rights Watch [ACLU/HRW], 2009, p. 3; UN Committee on the Rights of the Child, General Comment No. 8, 2006, para. 11). Corporal punishment is allowed in 20 states, but increasingly acknowledged nationally and internationally as unethical, abusive, and a violation of children's human rights (ACLU/HRW, 2009; Gershoff & Bitensky, 2007; Shaughnessy, 2008; UN Committee on the Rights of the Child, General Comment No. 8, 2006). Corporal punishment has been found not only to be harmful but also possibly leading to an erosion of mental health (Gershoff & Bitensky, 2007). Its use can increase rates of aggression and violence, problematic behavior, and R&S use (Daffern, Howells, & Ogloff, 2007; Gershoff & Bitensky, 2007; Magee & Ellis, 2001) and result in what some

researchers describe as "a lose-lose outcome for everyone" involved (Jones & Timbers, 2002, p. 40).

Restraint and seclusion are now recognized as being used in school settings, and the field of education is being scrutinized at the national level by federal authorities for R&S deaths, abuses, and injuries to students, in addition to a lack of national standards to govern their use (ACLU/HRW, 2009; NDRN, 2009, 2010; Ryan & Peterson, 2004; Shaughnessy, 2008). For more than 10 years, allied treatment disciplines of physical health, mental and behavioral health, and child welfare experienced similar scrutiny and public outrage, which resulted in the national movement to reform R&S practice and reduce their use in treatment settings.

This article will review the evolution of the national R&S initiative to the current focus on their use in schools. The adverse effects of R&S, "lessons learned" from allied treatment disciplines, and core strategies to reduce and prevent R&S use will also be discussed. Finally, proposed minimum standards and recommendations to promote alignment between the service sectors that use R&S are offered.

The National R&S Initiative

In 1998, a Connecticut newspaper, *The Hartford Courant*, published a groundbreaking investigative report over five consecutive days titled, "Deadly Restraint" (Weiss, Altimari, Blint, & Megan, 1998). The investigation was prompted by the restraint deaths of two children: one in a specialized school and one in a psychiatric hospital. The *Courant*'s investigation highlighted the fragmented and incomplete reporting of R&S use, injuries, and death, in addition to the deleterious physical and psychological effects on child, adolescent, and adult consumers (Busch & Shore, 2000; Huckshorn & LeBel, 2009).

The *Courant* noted that R&S-related deaths occurred in a variety of settings, often for seemingly innocuous reasons, i.e., refusing to obey staff orders, moving to another seat, relinquishing a family photograph, or disputing a missing teddy bear (Weiss et al., 1998). The journalists' findings also revealed the lack of (a) formalized R&S reporting, (b) standardized, federal regulations, (c) a national database recording deaths and serious injuries, and (d) accountability for R&S use, injuries, or deaths in health care provider organizations (Lieberman, Dodd, & DeLauro, 1999, March). As a result of the *Courant*'s investigation, the United States General Accounting Office (now called the Government Accountability Office [USGAO]) conducted its own investigation (News & Notes, 1999) and confirmed and expanded upon the *Harford Courant*'s findings (USGAO, 1999a,b).

Collectively, these activities compelled mental health leaders and advocates in the United States to action (Huckshorn & LeBel, 2009; National Association of State Mental Health Program Directors [NASMHPD], 1999a,b, 2001). In 1999, NAS-MHPD unanimously approved a policy statement committing to the reduction and eventual elimination of R&S, and its Medical Directors' Council authored a series of technical reports on R&S use with recommendations for practice change (NASMHPD, 1999a,b, 2001). In 2003, the Substance Abuse Mental Health Services Administration (SAMHSA) launched a "National Call to Action to Eliminate R&S" and appropriated millions of dollars to develop alternatives to R&S and training curricula to teach staff Six Core Strategies© on how to prevent, reduce, and replace R&S use (LeBel, Huckshorn, & Caldwell, 2010; NASMHPD, 2011). Many other national organizations issued practice parameters, policies, position statements, and/or guidelines as well, including, but not limited to, the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Hospital Association and National Association of Psychiatric Health Systems, American Psychiatric Nurses Association, Child Welfare League of America, American Association of Community Psychiatrists, National Alliance for the Mentally Ill, National Mental Health Association, and The Bazelon Center for Mental Health Law (Haimowitz, Urff, & Huckshorn, 2006).

Regulatory and accrediting bodies, specifically the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission, also mobilized to advance R&S practice following the US-GAO report (LeBel, 2008). Both health care standard-setting organizations rapidly issued new, more stringent R&S requirements. Among the new standards were enhanced training for staff, greater oversight and patient monitoring, and more explicit R&S reporting expectations (LeBel, 2008).

R&S Use in Schools

In a manner strikingly similar to the *Hartford Courant* process, the practice of R&S in school settings has come to light with the release of an investigative report by the National Disability Rights Network (NDRN), "School Is Not Supposed to Hurt," (2009). The NDRN's report of R&S abuses cited 50 examples from 38 states of mistreatment of disabled children in public and private school settings. Examples included denying children food, forcing them to sit in their urine, locking them in makeshift seclusion rooms, breaking arms, and killing several children through physical restraint. Because of the lack of a national reporting system and uneven and inadequate state laws, the advocates concluded that these incidents were "the tip of the iceberg" (NDRN, 2009).

The NDRN found that 41% of states have no laws, policies, or guidelines governing R&S use in school, and only 45% of states require or recommend that schools notify parents or guardians if these procedures are used. In addition, the majority of states (nearly 90%) permit prone restraint (face down) use in schools, which many psychiatric facilities and organizations and some countries categorically prohibit (NDRN, 2009; Welsh Assembly Government, 2005). The NDRN also pointed out the irony that federal law protected children from R&S abuse in mental health settings, but not in schools.

The ACLU and HRW followed NDRN's lead and released a joint report a short while later called, "Impairing Education: Corporal Punishment of Students With Disabilities in U.S. Public Schools," documenting that vulnerable children are being harmed in public schools (ACLU/HRW, 2009). The report asserted that corporal punishment, which includes R&S, "is prohibited under international law and in many U.S. settings, including most juvenile correction facilities, yet it continues in public schools" (p. 15) with students with disabilities experiencing a disproportionate amount of this punishment. Children with disabilities comprise 14% of the national student population yet

experience 19% of the corporal punishment occurring in U.S. schools (ACLU∕HRW, 2009, p. 2). They underscored that R&S use in the schools is a violation of fundamental, international human rights protective covenants and cited:

> International instruments, including the UN Convention on the Rights of the Child, the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the UN Convention on the Rights of Persons with Disabilities, prohibit the use of cruel, inhuman, or degrading treatment, regardless of circumstance. Corporal punishment also violates other human rights, including the right to security of person and the right to nondiscrimination. *Corporal punishment infringes on the right to education* (emphasis added; ACLU∕HRW, 2009, p. 7).

In response to the increased scrutiny from the legal advocacy community, the USGAO was asked to investigate R&S practices again, this time in public and private schools. The investigation found "hundreds of cases of alleged abuse and death related to the use of these methods on school children during the past two decades" and cited specific examples of death and injury to children (USGAO, 2009). Following the release of the USGAO report, the Department of Education directed each state "to review its current policies and guidelines regarding the use of restraints and seclusion in schools to ensure every student is safe and protected, and if appropriate, develop or revise its policies and guidelines" before the start of the 2009–2010 school year (Duncan, 2009, July 31). Later, the Department of Education posted a summary of state laws, regulations, policies, and guidelines on its website at http://www2.ed.gov/policy/seclusion/seclusion-state-summary.html. The Secretary of Education indicated that "many states and territories have begun to work with their stakeholders to develop or revise current practices" (Duncan, 2010, February 24).

Legislative efforts. Federal legislators took more strident action and filed two bipartisan bills (H.R. 4247 and S. 2860). The intent of both bills was to create a national minimum practice standard for reducing and preventing R&S use in schools. The House bill, "The Preventing Harmful Restraint and Seclusion in Schools Act" (H.R. 4247), was introduced in December, 2009, amended twice, renamed "The Keeping All Students Safe Act, and referred to the Senate in 2010 (Open Congress, 2010).

The H.R. 4247 bill banned the use of mechanical and chemical restraints, restraints impeding breathing, and "aversives" that compromise health and safety (Butler, 2009). It also required parental notification if R&S are used, data collection, training and certification of school personnel, and that states enact their own policies and procedures within 2 years (NDRN, 2010, p. 5). In addition, the proposed statute required that R&S only be used when there is an imminent risk of physical injury, the procedures end when the emergency ends, and R&S not be included in Individualized Education Programs (IEPs) or behavioral plans to circumvent the bill (Butler, 2009).

Leaders from many organizations, including the Alliance to Prevent Restraint, Aversive Interventions and Seclusion (APRAIS), which represents more than 40 national disability agencies, strongly advocated for H.R. 4247 and the IEP exclusion (Peterson, 2010). The APRAIS leaders maintained the use of R&S denies students' rights to a free appropriate public education (FAPE) and highlighted the inherent "double standard of accountability" of using R&S on both an emergent and planned basis through IEP inclusion (APRAIS, 2010). APRAIS constituents reminded the bill sponsors that IDEA requires IEPs to be based on positive interventions but incorporating R&S into an IEP plans for, and accepts, ongoing educational programming failure and promotes its use by confusing "school staff into thinking that these interventions must be helpful and educational for certain students." Lastly, the APRAIS leaders underscored the need for parity in R&S practice between Education and Health and Human Services particularly given successful R&S reduction that was "pioneered and achieved in the health care and mental health system" (APRAIS, 2010). Despite strong advocacy for excluding R&S from IEPs, educational trade organizations raised considerable objections and stopped the bill's progress (Diament, 2010a).

A few months later, Senators Christopher Dodd (D-CT) and Richard Burr (R-NC) introduced a modified version of the "Keeping All Students Safe Act" (S. 3895) before the fall Senate recess, which offered compromise language that would have allowed R&S to be included in a student's IEP under certain conditions. After the modified bill was filed, its main sponsor, Senator Dodd, retired, which left cosponsor, Senator Burr, seeking another Democratic cosponsor to continue to present this as a bipartisan bill (Diament, 2010b). By the close of the 111th Congress, a new cosponsor was not identified, and neither H.R. 4247 nor S. 3895 was enacted.

In April 2011, the "Keeping All Students Safe Act" bill was refiled by Representative George Miller and cosponsored by 19 legislators. The bipartisan bill, now known as H.R. 1381, is identical to H.R. 4247 and would require schools to: (a) establish policies and procedures to keep all students and school personnel safe; (b) provide school personnel with the necessary tools, training, and support to ensure the safety of all students and school personnel; (c) ensure data are collected and analyzed on physical R&S; and (d) identify and implement effective evidence-based models to prevent and reduce R&S in schools (GovTrack, 2011).

The new bill was referred to the Committee on House Education and the Workforce. It is currently being reviewed by the Committee's subcommittee on Early Childhood, Elementary, and Secondary Education (Sherman, 2011).

Current Status of R&S Use in Schools

Since issuing its groundbreaking, "School Is Not Supposed to Hurt" (2009) report, NDRN released an update to its initial findings (NDRN, 2010). The legal advocates acknowledge grassroots efforts and the federal government's mobilization by taking up national standard legislation, but they report that states are slow to address their own R&S practices (NDRN, 2010). Since 2009, "only two states (Minnesota and Missouri) and six departments of education (Maine, Maryland, Nevada, Pennsylvania and Tennessee) have enacted or improved their laws to prevent and reduce the use of restraint and seclusion in schools" (NDRN, 2010, p. 3) despite Secretary Duncan's assertion that many states were revising their policies and practices (Duncan, 2010, February 24).

The impact of the legal advocates' and USGAO reports and proposed legislation on R&S use in individual schools or specific states is not known; however, one expert reported, "There is anecdotal evidence (newspaper reports, nonscientific survey data, individual teacher reports, etc.) that both restraint and seclusion are quite widely used in public schools at the present time" (Shaughnessy, 2008). A recent *New Haven Independent* publication supports this perception and identified data from the two states (California and Connecticut) that are required to report their R&S use annually (Shaddox, 2010). California reported 21,000 episodes of "behavioral emergencies" in 2009, and Connecticut reported 18,000 R&S events during the same period of time (Shaddox, 2010). A fundamental problem in recognizing the scope of the R&S problem, according to Maryann Lombardi, a parent-advocate from Connecticut who campaigned for reform in R&S use and transparency in reporting, is that parents still have no idea that R&S are used in the schools. She said, "Many parents around Connecticut are not even aware that schools have restraint and seclusion rooms, often little more than converted closets. . . It's not like they are going to wave a banner over it on open house night" (Shaddox, 2010). Mrs. Lombardi reportedly only learned that her son, Gianni, who has autism and does not speak, was regularly placed in seclusion after another parent informed her (Shaddox, 2010).

Currently, there is little reported data on R&S use in school settings, no national data system, and the professional literature in education has only recently begun to examine the extent of use of these high-risk procedures in schools (Peterson, 2010; Ryan & Peterson, 2004; Ryan, Peterson, & Rozalski, 2007; Ryan, Peterson, Tetreault, & van der Hagen, 2008; Ryan, Robbins, Peterson, & Rozalski, 2009). With no unified standards or reporting system, federal, state, and local education officials are hampered in their capacity to be able to conduct comparative analyses or create a context to evaluate R&S use (NDRN, 2009; Peterson, 2010; Ryan et al., 2009).

The Adverse Effects of R&S

Restraint and seclusion are emergency safety measures of last resort and should only be used in response to behavior that is considered violent, out of control, or imminently dangerous to the self or others. Risk for adverse effects and abuse increases when R&S is (a) used in lieu of less risk-laden, more effective therapeutic, trauma-sensitive, noncoercive prevention and intervention strategies and environments to manage agitation or aggression; (b) intermingled with treatment or educational goals, discipline, and punishment; or (c) exceeds the foreseeable risks associated with the behavior it is attempting to contain (Mohr & Nunno, 2011; Nunno, 2009).

A range of injuries can result from R&S use including physical and psychological trauma (Mohr, Petti, & Mohr, 2003). Many deaths have also directly resulted from R&S use (NASMHPD, 2011) and from seclusion-related neglect and suicide (USGAO, 2009). There are several mechanisms of injury, death, and physical and psychological trauma to both staff and children associated with the use of R&S. Most often, deaths from physical restraint result from asphyxia (Joint Commission on Accreditation of Healthcare Organizations, 1998; Mohr et al., 2010; Nunno, Holden, & Tollar, 2006), which occurs when there

is an airway obstruction owing to compression to the neck, chest, or abdomen; blockage of the nose or mouth; or clogging of the airway by vomitus or excessive saliva. A more detailed discussion of the other methods of death attributable to R&S is beyond the scope of this article, and interested readers are directed to original articles for in-depth discussions (see: Mohr et al., 2003; Nunno et al., 2006; O'Halloran & Frank, 2000). Seclusion-related deaths most frequently result from injuries sustained during the physical restraint that lead to placement in the seclusion room, aspiration or asphyxiation, or hanging. Seclusion deaths also result from neglect and failure to monitor the person who is being contained in the secure environment (NASMHPD, 2011).

Adverse effects (injury or death) as risks associated with the use of R&S are considered low-probability but high-consequence events. The probability or likelihood that someone will die from a restraint procedure is low if we consider the number of restraints that are performed in a year. For example, the state of Massachusetts, which requires child–adolescent community-based residential programs to report R&S use, identified 65,150 restraint episodes, which occurred in 2008 and resulted in 2,322 injuries to youth and 1,890 injuries to staff (Garinger, 2009). The incidence of injuries to children was substantially higher (23%) than injuries to staff. Moreover, Massachusetts's data and R&S literature indicate that youth are restrained and secluded more often than adults in treatment settings (LeBel et al., 2004; NASMHPD, 2011; Weiss et al., 1998). If Massachusetts's R&S use is comparable to other states' use, the number of restraints in youth treatment settings could exceed 3.36 million events per year with more or less corresponding injury rates. Given the Harvard Center for Risk Analysis's estimate of 50–150 R&S deaths per year (Weiss et al., 1998), injury would seem to be a relatively high occurrence effect, while death is a relatively low-frequency event. Many organizations have minimized if not mitigated injuries to youth and staff as well as the risk of death by effectively replacing R&S with prevention strategies, new workforce training, and staff skill development (LeBel, 2010; NASMHPD, 2011).

In polemic discussions regarding the use of R&S, proponents often argue for their use and tend to focus on the most likely outcomes, steering clear of unlikely, low-probability outcomes, especially low-probability catastrophic events, and ignoring what may be possible. Two examples of this kind of thinking appeared in letters to the editor of *Psychiatric Services*. One was in response to the general issue of restraint reduction (Pinninti & Rissmiller, 2001), and a second was in response to the journal's special section on R&S reduction (Liberman, 2006). In the first instance, the authors inferred that, because they had never had a death in their facility from restraints, it was a low-probability event (Pinninti & Rissmiller, 2001). In the second instance, the author called efforts at R&S elimination fatuous and an ideological strait jacket, ignoring the successes that have been achieved and displaying insensitivity to the thousands of patients to whom "strait jacket" has been more than a metaphor (Liberman, 2006).

Slovic, Fischhoff, and Lichtenstein (1980) conducted extended empirical studies and concluded that, even though it is possible to quantify perceived risk, cognitive limitations and misleading experience cause uncertainty and misjudgments. In addition,

biased evaluations of risks may be because of unfamiliarity with an event, overconfidence about judgments, and the divergence of opinions about risk (Slovic et al., 1980).

The point is that low-probability events, such as death resulting from R&S, are not unimportant events that can be reasonably ignored. As March (2010, p. 106) states, low-probability events teach individuals and organizations that the risks associated with these events "are less than they are." People and policy makers are interested in what is *likely* to happen, not in the whole range of things that *might* happen. As a result, the focus tends to be on a probability-weighted average *expected* impact. Outcomes of extremely low probability, whether they have very low or very high impacts, are simply ignored—ignored at the peril of death or serious injury.

The Significant Challenges Facing Public Schools

School systems face significant challenges. Currently, more than 50 million children are enrolled in U.S. primary and secondary education and are being served by 99,000 public schools that have collectively experienced a rising enrollment rate of 26% over the past 14 years, and those numbers are expected to continue to rise (Department of Education, 2010). In addition, revised federal education law, specifically the Individuals with Disabilities Education Act 2004 (IDEA-04), requires that all children with disabilities be provided a FAPE in the least restrictive environment necessary to meet their needs. Mainstreaming children with divergent needs is becoming the norm and challenging public school systems' capacity to function and educate youth safely and effectively—particularly in the face of decreasing fiscal resources, reduced capacity to fund specialized services, a shortage of special education teachers, and a lack of highly trained educators to work with students with special needs (NDRN, 2009; Ryan & Peterson, 2004; Shaughnessy, 2008).

Exacerbating school systems' challenges is the IDEA-04 implementation conundrum. The statute is silent on R&S use and their place in IEPs for children with special educational needs. But the Department of Education's interpretation of IDEA-04 leaves educators with a mixed message: "IDEA emphasizes the use of positive behavioral interventions and supports to address behavior that impedes learning; however, IDEA does not prohibit the use of mechanical restraints or other aversive behavioral techniques for children with disabilities" (Jones & Feder, 2010, p. 6). This has been recognized by some as tacit permission to use R&S in the schools—particularly with students with special needs (ACLU/HRW, 2009; NDRN, 2009, 2010).

With a broad mission and increasing demands on educators, it is not surprising that the most common request for assistance from teachers is related to behavior and classroom management (Center on PBIS, 2004). Schools are under pressure to respond to behavioral challenges quickly and expediently. According to Reese Petersen, an education expert, "Poorly trained and underresourced programs may be more likely to use restraint and seclusion as basic behavior management strategies rather than the way they are intended to be used" (Shaughnessy, 2008) and, as a result, fail to address the factors contributing to the behavioral problem (Mohr et al., 2010).

A resource that may help school systems develop the capacity to manage students' behavioral needs is Positive Behavioral Interventions and Supports (PBIS; Arthur, 2008). This model initially appeared in the 1997 reauthorization of IDEA and was emphasized in IDEA-04. It is a decision-making tool intended to promote prosocial student behavior, a prevention framework to address students' behavioral needs, and a range of evidence-based interventions applicable to all students (Arthur, 2008; Horner & Sugai, 2004). To encourage PBIS use and support school systems in its implementation, the federal Department of Education's Office of Special Education (OSEP) created and funds a National Technical Assistance Center on Positive Behavioral Interventions and Supports (http://www.pbis.org/about_us/default.aspx). Developers of the model believe that it may be useful in reducing R&S, even though it was not developed for this purpose and most schools have not implemented PBIS or measured the impact on their R&S use (Horner & Sugai, 2009). The Austin, Texas, school district, however, did measure the impact of implementing positive behavior supports and reportedly decreased its restraint use from 1,007 to 790 episodes in 2 years (Ramshaw, 2009). According to the special education director, Janna Lilly, "Our numbers were very high . . . we're not out of the woods . . . but our numbers are now lower than other districts with fewer special education students" (Ramshaw, 2009, p. 3).

Lessons Learned

If R&S continue to be used in school settings, schools could benefit from the lessons learned from the mental health and child welfare systems' experience of public scrutiny, subsequent research, and practice advancement over the past decade (Arthur, 2008). Those lessons learned include recognizing that R&S are high-risk procedures that have the potential to cause severe physical injury, death, and emotional trauma (Mohr et al., 2003; Nunno et al., 2006; USGAO, 2009; Weiss et al., 1998); have little to no therapeutic effect (Day, 2000, 2002, 2008; Shaughnessy, 2008); can be countertherapeutic when children are removed from a therapeutic or learning environment (Mohr et al., 2003); and can be greatly reduced, if not eliminated, in other child-serving settings (NASMHPD, 2011). Moreover, allied treatment disciplines have raised their standards of practice to reflect this new understanding (Arthur, 2008). Educators will be challenged to justify routine use of R&S in a school setting when active, successful efforts are underway in other youth services to reduce and prevent their use altogether (LeBel, 2010; NASMHPD, 2011).

Another important lesson learned is recognizing and accepting responsibility for R&S use and untoward outcomes, such as serious injury or death, which can lead to litigation and result in serious civil and criminal penalties to staff who participate in R&S and substantial liability and financial judgments against an organization (Kennedy, 2008; Kennedy & Mohr, 2001; LeBel, 2010; Mooney, 2008). To mitigate some risk, school administrators should review their R&S policies and procedures with their local school boards and advocate for strong local and state regulations to inform and govern their practice (Peterson, 2010).

If a school system determines that R&S procedures will be used when a situation poses an immediate life safety risk to a

child or others, then R&S should not be used as a part of a child's IEP or behavioral support plan, a means of punishment, or a method to enforce rule compliance. Restraint and seclusion use for nonemergent circumstances is forbidden in mental health and residential services and cannot be included in a youth's individual treatment plan (CMS, 2008; Joint Commission, 2010). As life safety measures, R&S are not "a program, treatment, therapy, or service" (APRAIS, 2010, p. 1) and, if used, reflect a failure in the treatment process (NASMHPD, 1999a; NASMHPD, 2011; Smith et al., 2005). Many disability leaders and education professionals believe R&S use is not only education failure but incorporating R&S into an IEP is tantamount to a "planned emergency" and an oxymoron (APRAIS, 2010, p. 1).

Because R&S procedures are potentially lethal, they should be used with strict guidelines and accountability, safeguards against their misuse, and clinical and training supports that are reviewed and approved by medical, psychological, legal, and parent advocacy groups at least annually (Peterson, 2010). Each episode of R&S should receive careful review and scrutiny with the goal of preventing future use. Restraint and seclusion data at the local, state, and national level should be regularly reported and annual aggregate data should be publicly disseminated to better understand the extent of use and training and resource needs (Mohr & Nunno, 2011).

Core Strategies to Reduce and Prevent R&S Use

To reduce and prevent R&S use and create a safe, supportive child-serving system, school systems could adopt the Six Core Strategies©. This is a no-cost, public domain curriculum developed by NASMHPD's Office of Technical Assistance and funded by SAMHSA as a part of the National Call to Action to Eliminate R&S in 2003 (NASMHPD, 2011). The Six Core Strategies© are the product of a thorough review of the extant literature, meetings with national experts who had direct experience successfully reducing and in some cases eliminating R&S, and listening to and respecting the input of mental health consumers who experienced R&S in treatment settings (Huckshorn & LeBel, 2009).

The Six Core Strategies© are: leadership, using data to inform practice, using individualized crisis prevention tools, workforce development, debriefing, and youth and parent participation (NASMHPD, 2011). The core strategies are a template for creating organizational culture and practice change and are imbedded in a prevention-oriented, trauma-informed care framework (Huckshorn & LeBel, 2009). The curriculum has been widely taught, nationally and internationally, and formally evaluated. The evidence suggests that the Six Core Strategy© training curriculum meets the criteria for inclusion on SAMHSA's National Registry of Evidence-Based Programs and Practices (Human Services Research Institute, 2009; NAMHPD, 2010). Reports from many organizations reflecting different service settings are emerging in the professional literature regarding successful R&S reduction efforts and, in some cases, eliminating R&S altogether (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011; Barton, Johnson, & Price, 2009; LeBel et al., 2010; Lewis, Taylor, & Parks, 2009; NASMHPD, 2011).

Leadership

The presence of effective and strong leadership at all levels of an organization or system is correlated with successful facility-based initiatives to change culture and practice including preventing, reducing, or eliminating R&S (Anthony & Huckshorn, 2008; Bullard, Fulmore, & Johnson, 2003; Colton, 2008; NASMHPD, 2011). Leadership sets the vision and clarifies the values that build the unifying principles governing an organization's or school's system of care or philosophy of learning (Anthony & Huckshorn, 2008; Suess, 2008). In school systems, like treatment facilities, the vision and values of leadership guide whether the resolution of problematic behaviors arising from interpersonal interactions, faulty instructional design, or inadequate educational structures and processes will be reactive or proactive, punishing or corrective (Morrissey, Bohanon, & Fenning, 2010; Nunno, 2009). Leadership also shapes the basic organizational culture that supports and sustains positive behavioral approaches over punitive approaches (Anthony & Huckshorn, 2008; Nunno, 2009; Suess, 2008). If R&S are accepted as necessary methods of controlling student behavior in reactive or punishing school cultures, then the potential for misuse of R&S, physical and emotional injuries, and risk of death increases (Mohr & Nunno, 2011; Nunno, 2009).

Using Data to Inform Practice

Creating a baseline R&S data set and collecting and reviewing data on an ongoing basis are essential components of another core strategy—using data to inform practice. Data are essential to measuring the scope of a problem, evaluating the effectiveness of interventions to prevent or reduce the problem, and tracking changes over time (NASMHPD, 2011). Data establish organizational benchmarking and help evaluate the efficacy of effort, particularly the development of positive, supportive educational services (Dunlap, Goodman, McEvoy, & Paris, 2010; PBIS, 2004; Ryan et al., 2008; Suess, 2008). Collecting and reviewing R&S data at the organizational or schoolwide level, as well as student-specific occurrences, constitute prudent risk management and educational service planning (Dunlap et al., 2010; PBIS, 2004; Ryan et al., 2008; Suess, 2008).

Typical R&S data sets in child welfare or health care settings include aggregate elements such as the total number of R&S episodes per month and the total duration of these events. Individual-specific information is also collected such as the harmful behavior that precipitated the decision to use R&S; the individual's age, date, time, and location where R&S occurred; duration of event; the staff involved; any staff or child injuries; and practices or strategies used to prevent the behavioral crisis (NASMHPD, 2011, Peterson, 2010; Ryan et al., 2008). Analyzing this type of information also identifies the need for supervision, training, and clinical resources to prevent or de-escalate future episodes of aggression and violence (NASMHPD, 2011).

Using Individual Crisis Prevention Tools

Individual crisis prevention tools, specifically individualized crisis prevention plans and sensory interventions, help to identify the behavior support needs, methods, and intervention

strategies to prevent, de-escalate, and manage problematic and dangerous behaviors (Donat, 1998, 2003; LeBel et al., 2010; Mohr et al., 2010; NASMHPD, 2011). Individual crisis plans are an important risk-reduction measure used in facilities to reduce R&S use and to avoid the need for these procedures altogether (Mohr et al., 2010; NASMHPD, 2011). Individual plans guide staff responses when a child is exhibiting acute, problematic behavior—they are not an explicit plan on how or when to use R&S (NASMHPD, 2011).

Crisis prevention plans are typically simply written, readily available to staff, and updated frequently (Couvillon, Bullock, & Gable, 2009; Donat, 1998, 2003; Dunlap et al., 2010; Hanley, Iwata, & McCord, 2003; NASMHPD, 2011). Most plans include an assessment of the child's problematic behavior, which identifies known antecedents to behavioral distress and early behavioral warning signs that there is a problem (NASMHPD, 2011). They also include sensory interventions and specific de-escalation interventions and strategies to calm the child and avoid the use of R&S. Crisis prevention plans may also identify preexisting medical problems, psychiatric conditions, or a history of traumatic experience, which may contraindicate certain behavioral supports or strategies. In the event that crisis planning and de-escalation efforts fail and R&S is used as a life safety measure of last resort to manage an extreme behavioral emergency, then R&S techniques and methods should be reviewed, in advance, with the parent or guardian and consent obtained (Couvillon et al., 2009; Donat, 1998, 2003; Dunlap et al., 2010; Hanley et al., 2003; NASMHPD, 2011).

Sensory interventions are another useful prevention tool to soothe agitated youth that can be integrated into a crisis prevention plan and used in the classroom (LeBel & Champagne, 2010). By incorporating occupational therapy practices and assessing children's sensory needs and sensitivities to sight, sound, smell, touch, pressure, and movement, simple strategies can be developed to support youth who have difficulty regulating their body and behavior (LeBel & Champagne, 2010; NASMHPD, 2011). Including these interventions in a prevention plan can help avert a crisis and keep the youth in the classroom learning. Many strategies can be implemented in the classroom such as weighted lap pads and balance ball chairs to help fidgeting youth feel grounded and stay focused; headphones for children who are easily overstimulated by noise; frequent movement breaks during difficult tasks (hop/skip/jump/chair push-ups); increasing or dimming lighting to change the amount of visual stimulation; and creating areas in the classroom to promote quiet and calming such as a place to lie down, rock in a rocking chair, or listen to soothing music (LeBel & Champagne, 2010; NASMHPD, 2011). Offering sensory supports in the school also gives teachers new tools to offer children instead of punishing disruptive behavior and helps children learn the skills of self-calming and behavioral regulation (LeBel & Champagne, 2010).

Individual crisis prevention plans should be developed collaboratively with parents, the child, and key personnel (i.e., teachers, teacher aides, guidance staff, occupational therapists, school nurses, social workers, clinicians, safety officers) for youth who exhibit high-risk behavior. An inclusive planning approach fosters enhanced communication, effective integration of the different perspectives, and synergy in the crisis response, if it occurs (NASMHPD, 2011). The goal of the plan is always to prevent,

reduce, and eliminate the need for external control and to help the child learn the skills necessary to regulate his or her behavior (NASMHPD, 2011).

Many schools, like some residential programs, leave crisis planning and management to behavior specialists who are not part of the classroom setting (Peterson, 2010). While there are advantages to this approach, it sidesteps input from teachers and teacher aides who often spend the greatest amount of time with the children and are the first to observe problematic behavior in the classroom. Teachers and teacher aides may also have the best relationship with the child and be able to keep a small problem from escalating further and requiring additional de-escalation strategies.

Other professionals working in the school setting may also be helpful crisis prevention resources. Some schools have social workers or other clinical staff on staff or out-stationed from local mental health agencies. Involving those with experience in crisis prevention and managing behavioral challenges, particularly as "first responders," can help to support youth remaining in the classroom, prevent behavioral crises, and avert the possible use of external assistance, which could potentially disrupt a child's education through psychiatric hospitalization or placement in a specialized treatment setting (Peterson, 2010).

A professional often forgotten in the discussion of R&S in schools is the school nurse (Mohr et al., 2010). School nurses are in short supply and work under a tremendous burden. A single school nurse cares for, on average, 971 students. In 13 states, the ratio is more than 2,000–1. (For more information, see the National Association of School Nurses website: http://www.nasn.org/.) But they are well positioned as onsite, medically trained staff to assume a leadership role in preventing R&S in the classroom (Mohr et al., 2010). Having well-educated school nurses readily available in the schools could have a significant impact in preventing and reducing R&S use (Mohr et al., 2010).

Workforce Development

Workforce development is the crux of R&S prevention and reduction. Initiatives to change practice can be lead by dynamic leaders, but without a skilled workforce to implement the new methods and tools, sustainable change cannot be made (Anthony & Huckshorn, 2008; Hodas, 2005; Huckshorn, 2007). Because the most common request for assistance from teachers is related to classroom behavior management (PBIS, 2004), teaching staff need ongoing education on supporting youth with problematic behavior in the classroom. Currently, teachers have little formal training in managing classroom behavior, particularly in managing increasingly divergent needs of children served in the public schools (Morrissey et al., 2010; Shaughnessy, 2008). It is not necessary for teachers and aides to learn an extensive array of behavioral support skills, but teachers do need to have conflict resolution and crisis prevention and de-escalation skills to prevent classroom crises and implement individualized plans for children in their care (Peterson, 2010; Ryan & Peterson, 2004). Minimally, all staff members in a school environment should have basic training in conflict de-escalation and what to do when there is a behavioral crisis (Peterson, 2010).

Preceding basic training in conflict management, staff skill level should be assessed. In schools, this would include assessing teaching personnel and other onsite staff such as behavioral specialists, administrators, counselors, social workers, psychologists, and school nurses. An analysis of these results, along with incident data and needs identified in individual behavioral support and crisis prevention planning, serves as the basis for ongoing training. Training should emphasize evidence-based skills that prevent, de-escalate, and manage problematic behaviors that teachers and aides are most likely to confront (Peterson, 2010). For strategies to be effective and used in the classroom, training experts recommend overlearning, practice in low-stress learning environments prior to a more rigorous structured field practice, and ongoing coaching so that the behavior support and crisis prevention skills can be used competently when they are needed (Holden & Curry, 2008; NASMHPD, 2011; Suess, 2008).

Debriefing

It is also important to acknowledge the distress and fear that accompany aggressive or violent events that lead to R&S. Any R&S technique that prevents a person from moving or going in a direction or manner of their choice is likely to trigger an escalation of aggressive and violent behavior (Jones & Timbers, 2002). Experiencing or witnessing these events can generate strong emotions, fears, and anger (NASMHPD, 2011; Snow, 1994). Therefore, all directly or indirectly involved in an episode of R&S—the child and his or her family, the staff, and the witnesses require followup and debriefing to provide support, reassurance, a clear explanation of the events, and a plan for preventing recurrence (Peterson, 2010). Debriefing with the child and his or her family and debriefing with personnel should be conducted within 1–2 days after the event (NASMHPD, 2011; Peterson, 2010). Typically, these debriefing sessions are conducted separately (NASMHPD, 2011; Peterson, 2010). A sympathetic approach, together with early consultation, is important for individuals who need help coping with their distress and fears (Mayou & Farmer, 2002).

Managers and administrators who lead debriefings with staff should conduct these review sessions as a root cause analysis and examine the antecedents to the crisis, crisis management and the decision to use R&S, and the sequellae to the episode (Peterson, 2010). Debriefing sessions should be nonjudgmental and not assign blame but instead impartially focus on why the episode occurred and how it could have been managed differently (NASMHPD, 2011; Peterson, 2010). Essential questions embedded in the event analysis include, but are not be limited to, the "setting conditions," whether the individual crisis prevention or a behavioral support plan was followed, whether the plan was effective or needs to be modified or updated, whether the staff were trained and supervised appropriately, and whether the behavioral and educational expectations for the youth were realistic and achievable (Paterson, Leadbetter, Miller, & Crichton, 2008; Peterson, 2010).

In accredited residential treatment programs and health care organizations, a debriefing is not only important but is required. The Joint Commission (2010) is the largest accrediting body of health care organizations in the United States and recognizes that debriefing is an essential tertiary prevention strategy to minimize the harm done and attempt to prevent recurrence. When conducted correctly with the staff, child and family, and others involved, the process analyzes the contributing factors that lead to R&S use, identifies workforce or youth-specific issues, and begins to repair the damage done to interpersonal relationships between the staff who implemented the R&S and the youth who was subjected to it (NASMHPD, 2011). Debriefing is an analytic, educational tool that is strongly correlated with preventing and reducing R&S use (NASMHPD, 2011).

Youth and Family Participation

Youth and family involvement and participation is another core strategy. Inclusion is an essential component in creating a positive, supportive, and transparent organizational culture and preventing high-risk procedures in a school system (Peterson, 2010). Before R&S is even considered, it is important to discuss with the youth and his or her family what triggers behavioral difficulties, what warning signs might be displayed, and what strategies and preferences the youth and his or her family recommend be implemented if a crisis occurs to inform staff and quell problems in early stages of manifestation and avert a serious problem (NASMHPD, 2011).

If R&S are used in a treatment program, the facility has a professional duty to obtain informed consent from the youth and the youth's family. Even children as young as 6 or 7 can and should be part of the process when a procedure carries a risk to their physical or emotional health (Mohr & Nunno, 2011). Consent and assent can be denied, and there should be contingencies developed in the event of denied consent or assent. However, informed consent is dynamic and can be obtained at one point in time but may not be relevant at another (Mohr & Nunno, 2011). For example, parental consent can be obtained at the beginning of the first grade but not be relevant during the fourth grade because the child's developmental and physical status is likely to have changed and therefore presents a different set of conditions that modify the risks involved in R&S. Informed consent should be revisited every time there is a substantial change in the child's individual crisis or behavioral support plan and/or every time R&S is used (Mohr & Nunno, 2011).

Similarly, consent and assent are important to review and obtain from parents or guardians and the child if R&S are used at school. Specific guidance for parents regarding R&S use in the schools was developed by TASH, a well-established and respected advocacy organization serving people with different disabilities and challenges. A pragmatic guidebook focused on three broad content categories—prevention, vigilance, and response—was recently published and disseminated via its website (http://tash.org). This resource offers specific action steps for parents or guardians to take if they are concerned about R&S use in their child's school.

However, inclusion of parents and youth in preventing R&S extends beyond a review of the procedures and obtaining authorization. Actively involving families and children in organizational activities, committees, and functions promotes transparency, enhanced communication, and better outcomes

for youth (Caldwell & LeBel, 2010). Many organizations that have successfully reduced their use of R&S attribute their practice change and transformation to active, meaningful consumer involvement in the change process (Caldwell & LeBel, 2010; Huckshorn & LeBel, 2009; NASMHPD, 2011).

Conclusion and Recommendations

The education community is facing the challenge of national scrutiny and public outrage at R&S use in schools and classrooms. The mental health and child welfare fields endured a similar crucible 10 years ago—one that compelled them to move forward together with support and direction from the federal government. Since then, new federal and accrediting body standards have been implemented (CMS, 2008; Huckshorn & LeBel, 2009; Joint Commission, 2010), Core Strategies© to reduce or prevent R&S have been identified, training curricula have been developed, new methods have been learned, practice has changed, and significant R&S reductions have occurred throughout the United States (NASMHPD, 2011).

Proposed federal legislation governing R&S use in schools was filed and recently refiled as H.R. 1381. The bill establishes national, minimal standards for R&S use in schools. These standards were endorsed by more than 100 organizations and recommended as a prudent benchmark for schools to develop their own best practice parameters (Peterson, 2010). The specific requirements of H.R. 1381 include:

- Prohibiting school personnel from using mechanical restraints, chemical restraints, physical restraint, or physical escort that restricts breathing and aversive behavioral interventions that compromise health and safety;
- Prohibiting school personnel from imposing physical R&S unless the student's behavior poses an imminent danger of physical injury to the student or others, less restrictive interventions would be ineffective in stopping such imminent danger of physical injury, and school personnel continuously monitor the student;
- Physical R&S may only be used by school personnel trained and certified by a state-approved crisis intervention training program or other school personnel in the case of a rare and clearly unavoidable emergency circumstance when school personnel trained and certified are not immediately available owing to the unforeseeable nature of the emergency circumstance;
- Physical restraint or seclusion ends immediately upon the cessation of the conditions leading to restraint or seclusion;
- States, in consultation with local educational agencies and private school officials, ensure that a sufficient number of personnel are trained and certified by a state-approved crisis intervention training program to meet the needs of the specific student population in each school;
- The use of physical restraint or seclusion as a planned intervention shall not be written into a student's education plan, individual safety plan, behavioral plan, or individualized education program. Local educational agencies or schools may establish policies and procedures for the use of physical restraint or seclusion in school safety or crisis plans, provided that such school plans are not specific to any individual student; and
- Schools shall establish procedures to be followed after each incident involving the imposition of physical restraint or seclusion upon a student, including immediate parent notification (written and verbal; GovTrack, 2011).

Leaders from education, child welfare, and mental health communities have an important opportunity to come together; to learn from each other; and to share successful strategies, create practice reforms, and produce fundamental change to reduce and prevent R&S use with children across child-serving settings. In an ideal world, the different disciplines would adopt common practice standards; definitions of R&S; and standardized methods for data capture, collection, and reporting. This would promote a level of data and practice harmonization that has not been achieved before and allow for true "apples to apples" comparison and the development of synchronous practices across services—something that youth and families have advocated for (NASMHPD, 2011; NDRN, 2009, 2010). In the absence of having common R&S practice, standards—sharing information, data, better practices, and emerging innovations—remain the best methods to promote common understanding and more effective approaches to supporting youth in distress regardless of the setting they are in (LeBel, 2010).

Underscoring the need for cross-agency collaboration is the proposed federal legislation (H.R. 1381) and recently enacted or pending legislation in some states previously cited. Some of this legislative activity was informed by leaders and advocates from allied treatment disciplines (APRAIS, 2010; Commonwealth of Massachusetts, 2010; NASMHPD, 2011). The new R&S standards for schools will require educators to rapidly study the issue; make practice decisions; and prepare their staff, families, and youth for the changes that result.

Adopting the Six Core Strategies© for reducing or preventing R&S is a reasonable next step for schools to consider. These prevention-focused strategies are fundamental organizational change constructs and not setting-specific (NASMHPD, 2011; Thompson, Huefner, Vollmer, Davis, & Daly, 2008). This comprehensive, no-cost curriculum is readily available and adaptable (NASMHPD, 2011). The core strategy framework has been successfully implemented in a range of settings serving different populations, including public and private schools (Commonwealth of Massachusetts, 2010).

Education and Health and Human Services have similar missions. The purpose of schools is to educate children and to prepare them for a future. The purpose of health and human services is to solve medical or social problems and help children recover to lead productive lives. Educators and members of the healing arts depend on accurate assessments to solve the problems that children present. Just as the same set of symptoms can suggest the presence of different conditions to different treaters, educators can view learning problems differently and recommend different remedies. Inherent in every discipline is the tendency to be reductionistic and approach problems from a siloed perspective, dividing issues into discrete discipline-specific categories and remedies. These recommendations reflect our different disciplines and collective experience in this area and

are a humble attempt at bridging the professional silos, seeking a common frame of reference, and expanding the perspective of our mutual challenge to reduce and prevent R&S use in child-serving settings. Further discussion and comment is essential in what will likely prove to be an exigent, ongoing public policy challenge.

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