Restraint and Seclusion in Delaware Schools

The Governor's Advisory Council for Exceptional Citizens (GACEC), Developmental Disabilities Council (DDC) and others are working to prevent injury to our vulnerable students.

With appropriate legislation and adherence to strict, evidence-based principles on behavior modification, we can prevent injustice and medical issues for our children.

SUPPORT TO AMEND TITLE 14 OF THE DELAWARE CODE RELATING TO USE OF SECLUSION AND RESTRAINT IN PUBLIC SCHOOLS.

Background

- The overuse of restraint and seclusion in schools is a pressing issue requiring action. The following briefly outlines the definition of the terms relating to this critical matter:
  - *Chemical restraint* is defined as a drug or medication used on a student to control behavior or restrict freedom of movement that is either not medically prescribed for the standard treatment of a student's medical or psychiatric condition or not administered as prescribed.
  - *Mechanical restraint* is defined as the use of any device or equipment to restrict a student's freedom of movement.
  - *Physical restraint* is defined as a personal restriction that immobilizes or reduces the ability of a student to freely move his or her torso, arms, legs, or head freely. "Physical restraint" does not include physical contact that:
    - helps a student respond or complete a task;
    - is needed to administer an authorized health-related service or procedure; or
    - is needed to physically escort a student when the student does not resist or the student's resistance is minimal.
  - *Seclusion* is defined as the involuntary confinement of a student alone in a room or area from which the student is physically prevented from leaving.
- Per the March 2012 statement by the U.S. Department of Education, ~40,000 children are secluded and restrained every year resulting in greater than 200 deaths. Of this subset, nearly 70% are individuals with disabilities. Incidents like these are grossly underreported and are all too common due to a lack of legislation preventing this practice.
- Additionally, in 2012, the US Department of Education outlined fifteen principles to guide legislation aimed at preventing restraint and seclusion. These principles are as follows:
  1. Every effort should be made to prevent the need for the use of restraint and the need for the use of seclusion.
  2. Schools should never use mechanical restraints to restrict a child's freedom of movement, and schools should never use a drug or medication to control behavior or restrict freedom of movement (except as authorized by a licensed physician or other qualified health professional).
  3. Physical restraint or seclusion should not be used except in situations where the child's behavior poses imminent danger of serious physical harm to self or others and other interventions are ineffective and should be discontinued as soon as imminent danger of serious physical harm to self or others has dissipated.
  4. Policies restricting the use of restraint and seclusion should apply to all children, not just children with disabilities.
  5. Any behavioral intervention must be consistent with the child's rights to be treated with dignity and to be free from abuse.

6. Restraint or seclusion should never be used as punishment or discipline (e.g., placing in seclusion for out-of-seat behavior), as a means of coercion or retaliation, or as a convenience.
7. Restraint or seclusion should never be used in a manner that restricts a child's breathing or harms the child.
8. The use of restraint or seclusion, particularly when there is repeated use for an individual child, multiple uses within the same classroom, or multiple uses by the same individual, should trigger a review and, if appropriate, revision of strategies currently in place to address dangerous behavior; if positive behavioral strategies are not in place, staff should consider developing them.
9. Behavioral strategies to address dangerous behavior that results in the use of restraint or seclusion should address the underlying cause or purpose of the dangerous behavior.
10. Teachers and other personnel should be trained regularly on the appropriate use of effective alternatives to physical restraint and seclusion, such as positive behavioral interventions and supports and, only for cases involving imminent danger of serious physical harm, on the safe use of physical restraint and seclusion.
11. Every instance in which restraint or seclusion is used should be carefully and continuously and visually monitored to ensure the appropriateness of its use and safety of the child, other children, teachers, and other personnel.
12. Parents should be informed of the policies on restraint and seclusion at their child's school or other educational setting, as well as applicable Federal, State, or local laws.
13. Parents should be notified as soon as possible following each instance in which restraint or seclusion is used with their child.
14. Policies regarding the use of restraint and seclusion should be reviewed regularly and updated as appropriate.
15. Policies regarding the use of restraint and seclusion should provide that each incident involving the use of restraint or seclusion should be documented in writing and provide for the collection of specific data that would enable teachers, staff, and other personnel to understand and implement the preceding principles.

What we know:

Evidence in medical literature clearly documents the neglect, harm and adverse effects of seclusion and restraint, specifically the following[1]:

Concerning seclusion:

- Intervention with seclusion fails to teach children appropriate social behavior. The force required to enact techniques of seclusion can actually paradoxically increase aggression (Murray and Sefchik, 1992).
- Research shows that individuals and children with developmental disabilities, mental retardation, and neurologic impairment have a disproportionately higher rate of seclusion than those without (Fryer, 2004).

[1]Information largely based on Menon et. al summary in 2012 copy of *Advances in Mental Health and Intellectual Disabilities,* Vol 6, No. 2, 2012. pp 62-75.

- Seclusion is common on the busiest days in facilities, and increased rates of seclusion are associated with low staff morale, staff conflict, and unsupportive management (Goren, Abraham & Doyle et. Al, 1996)

Concerning mechanical restraint:

- A paradoxical increase in self-injurious behaviors is shown in individuals whose behaviors are attention driven (Spain et al., 1984; Hastings, 1996)
- Advanced agitation and emergence of other behaviors not able to be controlled by mechanical restraint is seen (Kahng et al., 2001; Lerman et al., 1999; Fisher et al., 1997)
- Muscular atrophy, demineralization of bones, and potential shortening of tendons is associated with long term use (Emerson, 1992; Fisher et al., 1997)
- In 2009, Jones and Allen published that the use of mechanical restraint may have a detrimental impact on the child's self and public image, quality of life, and ability to develop relationships

Concerning chemical restraint:

- Recent research dictates that antipsychotics are no more effective than placebo when treating challenging behavior in individuals with disabilities who do not have a co-morbid psychiatric diagnosis (Brylewski and Duggan, 2004; Tyrer et al., 2008).

Concerning physical restraint:

- The adoption of School-wide Positive Behavior Support (SWPBS) and accompanying positive behavioral strategies can lead to dramatic decreases in the routine use of physical restraints and seclusion. For example, the Centennial School of Lehigh University in Bethlehem, PA, an alternative school serving some of the most challenging students decreased the use of physical restraint by 99% and eliminated the use of seclusion time-out with the introduction of SWPBS and positive behavioral approaches.

What can be done:

- Change legislation to increase the safety of our most vulnerable children.
- Adopt the guidelines set forth by the U.S. Department of Education.

[1]Information largely based on Menon et. al summary in 2012 copy of *Advances in Mental Health and Intellectual Disabilities,* Vol 6, No. 2, 2012. pp 62-75.

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