THE USE OF SECLUSION AND RESTRAINT IN CHILDREN’S SERVICES

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RESTRAINT USE IN CHILDREN’S SERVICE SETTINGS

- THE CONTEXT OF CARE
  - Hospitals
  - Residential Treatment Centers
  - Schools
  - Juvenile Detention Facilities
  - Juvenile Commitment Facilities

RESTRAINT USE IN CHILDREN: CONTRADICTORY EXPECTATIONS

- THE IMPLICATIONS OF COMMUNITY BASED CARE
  - Children who were previously treated in acute and higher level residential care are now eligible candidates for lower levels of community care
  - This means that more severely impaired children are now found in less restrictive environments
RESTRAINT USE IN CHILDREN’S SERVICE SETTINGS

THE HISTORY OF RESTRAINT AND SECLUSION
“to detain maniacs in constant seclusion, and to load them with chains...is...more distinguished for its convenience than for its humanity or its success.” (Goshen, 1967)
- Primarily in psychiatric settings
- Child management in all settings—psychiatric and otherwise, has always relied on coercion
- “Therapeutic” restraints and treatment theory
- A matter of course and expectation

RESTRAINT USE IN CHILDREN’S SERVICE SETTINGS

THE BEGINNINGS OF REVIEW AND CONTROLS IN THE USE OF RESTRAINT
- Surprisingly late in coming...but sudden widespread concern in media, congress and accrediting bodies in the middle nineties
- Hartford Courant expose in 1998 noted 142 deaths over ten years

USE OF RESTRAINTS IN CHILDREN’S SERVICE SETTINGS

- Health Care Financing Administration (HCFA) issued R/S standards (1999) re: monitoring, training and post-restraint practices
- Children’s Health Act (2000) restricted the use of R/S with children in psychiatric facilities receiving federal funds
- HCFA (now CMS) followed with rules for psychiatric programs receiving Medicaid for patients under 21
USE OF RESTRAINTS IN CHILDREN’S SERVICE SETTINGS

- Joint Commission on the Accreditation of Healthcare Organizations (JCAHO, 2001) set quality improvement standards for hospitals and RTCs
- American Academy of Child and Adolescent Psychiatry (AACAP) set practice parameters (2002) for treatment planning, staff training and de-escalation

THE PROBLEMS WITH RESTRAINT AND SECLUSION WITH CHILDREN:

- Multiple studies citing physical and psychological harm (Selekmman and Snyder, 1996, Finke, 2001, Murray and Selhik, 1992)

THE ARGUMENTS FOR:

- Safety—there are emergencies in which restraint is the safest immediate answer
- Order and program integrity—when one child is out of control the program and other patients / students suffer
- Limit setting as a learning experience
- Containment of emotional distress
- Regression in the service of attachment
USE OF RESTRAINTS IN CHILDREN’S SERVICE SETTINGS

- THE ARGUMENTS AGAINST:
  - Reinforcement of coercive model for achievement of ends
  - Fails to develop internal coping mechanisms for self-management of behavior
  - Circumvents self-calming and soothing
  - Re-traumatization—in one study, 93% of hospitalized adolescents had trauma histories (Lipschitz, 1999).

RERAINT USE IN CHILDREN’S SERVICE SETTINGS

- RE-TRAUMATIZATION
  - In one study, 93% of hospitalized adolescents had trauma histories (Lipschitz, 1999).
  - Trauma histories are > 90% in juvenile detention and commitment facilities
  - The Adverse Childhood Experiences study of a typical community sample reported a rate of 28% child physical abuse and 21% sexual abuse—so schools are clearly populated with children who have experienced trauma

RERAINT USE IN CHILDREN’S SERVICE SETTINGS

- RE-TRAUMATIZATION
  - Re-experiencing and flashbacks
  - Impedes mastery of the victim role
  - Intrudes on the physical integrity of the child
  - Damages treatment alliance
  - Calls in to question safety and trust
  - Impairs self-esteem and self-worth and reinforces a sense of damage and blame
RESTRAINT USE IN CHILDREN’S SERVICE SETTINGS

THE EXPERIENCE OF THE CHILD
- Most children view R/S negatively
- Drawings and interviews indicate feelings of fear, abandonment and punishment
- Children witnessing R/S feel troubled and puzzled by the adult’s use of force
- Moreover, the witnesses fear for their own safety and security
- Alienates patients / students from staff

COMPARISONS TO CORPORAL PUNISHMENT
- Although the adult undertakes restraint with motivations of safety, order and instructive discipline, the child experiences it as coercion, humiliation and betrayal
- The comparison between R/S and corporal punishment is apparent in both the motivation and the mechanism
- Activation of the stress-response system is the mechanism by which corporal punishment results in increased rates of child aggression, lying, and evasion, as well as eventual increased spouse abuse and alcoholism

A meta-analysis of corporal punishment research revealed that in 12 of 12 studies the frequency and intensity of corporal punishment was associated with poor mental health measures. Every single study saw an increase in depression, substance abuse, and general psychological maladjustment. (Gershoff, Psychological Bulletin, 2002)

Child corporal punishment also impairs the relationship between parents and children. 13 out of 13 studies found that physical punishment was associated with poorer quality parent-child relationships. (Gershoff, Psychological Bulletin, 2002)
RESTRAINT USE IN CHILD PSYCHIATRIC PROGRAMS

**THE STRATEGY**—Very few believe that restraints can be totally eliminated. The strategy is to reduce them to the absolute necessity.

**THE CIRCUMSTANCES**—Restraints are generally considered legitimate and required when there is a danger of physical injury. This is the situation which is regulated and monitored.

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RESTRAINT USE IN CHILD PSYCHIATRIC PROGRAMS

**METHODS AND MEANS TO REDUCE RESTRAINTS IN ALL PROGRAMS**
- Planning ahead—know your population and patients
- Age appropriate treatment and safety plans
- Diagnosis specific treatment and safety plans
- Specific training for supervisors and staff regarding de-escalation
- Change in treatment philosophy

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RESTRAINT USE IN CHILD PSYCHIATRIC PROGRAMS

**PROBLEM:** Less than 10% of the child treatment population account for 60-70% of the restraints

**RESPONSE:** Special Treatment Reviews should consider planning ahead and program modification
RESTRAINT USE IN CHILD PSYCHIATRIC PROGRAMS

**PROBLEM:** A disproportionate number of restraints begin with a staff person placing hands on a child, often to remove them from the area of confrontation

**RESPONSE:** Never lay hands on an angry child unless there is a clear safety issue

RESTRAINT USE IN CHILD PSYCHIATRIC PROGRAMS

**PROBLEM:** Children under 10 years of age account for about 70% of the physical restraints

**RESPONSE:** Special programming and protocols should be developed for younger children. Do not apply common expectations across the age span.

RESTRAINT USE IN CHILD PSYCHIATRIC PROGRAMS

**PROBLEM:** New staff (those employed under one year) account for 75% of the restraints performed

**RESPONSE:** More training and more intense supervision. Experienced staff should always take the lead.
RESTRAINT USE IN CHILD PSYCHIATRIC PROGRAMS

PROBLEM: It is a common and inevitable experience that some staff are able to negotiate, de-escalate, and redirect children with less coercion and more success than others.

RESPONSE: Personality counts. Those with the gentlest touch should lead the rest of us. Knowing when to draw the line and when to erase the line is often an untrained talent.

RESTRAINT USE IN CHILD PSYCHIATRIC PROGRAMS

PROBLEM: Disturbed children tend to induce and expose conflict in their caretakers. We call it splitting or manipulation when we want to attribute it to the child, but it really involves us.

RESPONSE: Never finish treatment team without a consensus, or at least a plan that everyone agrees to follow. Always be led by information, diagnosis and experience.

RESTRAINT USE IN CHILD PSYCHIATRIC PROGRAMS

PROBLEM: Restraints occur more often during particular times and places.

RESPONSE: Regularly review restraint reports for trends. Review:

- What staff was involved?
- When did it happen?
- Where did it happen?
- What were the circumstances and precipitations?
- Who was the child—specifics and demographics?
PHILOSOPHY OF CHILD TREATMENT

- Restraints are not therapeutic in themselves
  - The history of treatment for conduct disorders
  - Regressive treatments
- Obedience is overrated
  - No child is in residential care for disobedient behavior
  - Behavior control is not treatment in itself, and…
  - The point of treatment is not behavior control

RAISING THE BAR FOR RESTRAINTS

- How few restraints can be performed, and how can this come about?
  - If an eight year old is screaming and slamming doors?
  - If a fourteen year old is cutting or head banging?
  - If a six year old is running in traffic?
  - If a four year old is running with scissors?
- If the goal and expectation becomes a restraint-free environment, what changes need to take place philosophically and in the treatment plan of individual children?

PHILOSOPHY OF CHILD TREATMENT

- Staff should be trained to provide services additional to structure, supervision, and redirection
- Staff expectations should be directed toward specific treatment goals rather than behavioral goals
RESTRAINT USE IN CHILD PSYCHIATRIC PROGRAMS

REVIEW: IN WHICH CASES ARE RESTRAINTS MORE LIKELY?
- Young age
- Compromised mental status—psychosis or dissociation
- History of abuse and neglect

To teach us how to live without certainty, and yet without being paralyzed by hesitation, is perhaps the chief thing that philosophy, in our age, can do for those who study it. (Bertrand Russell)

Legal Parameters for Use of Restraint & Seclusion in Public Schools in New Mexico
Gail Stewart, J.D.
(505) 244-3779
FEDERAL LAW

- No federal laws regulate use of Restraint or Seclusion in public schools
  - IDEA
  - Section 504 and the Americans with Disabilities Act
  - Proposed “Keeping All Students Safe Act”

STATE LAW

- New Mexico
  - NM has nonbinding, suggested guidance memoranda. These guidelines are not statutes or regulations and do not mandate protections for children. They are easily changed, requiring neither a legislative or rulemaking process.

  - NM suggests restraint notice used prior to restrictive, less dangerous methods are ineffective. It cannot require this; however, NM has only guidance. NM has no similar suggestions for seclusion.

  - NM forbids locked seclusion under its fire code. NM permits doors to be blocked by furniture or equipment, and denies children access to locked rooms for other reasons (e.g., placing a child who uses a wheelchair in a room and taking away their wheelchair).

  - NM does not require parental notification or suggestions for less restrictive, less dangerous methods.

LOCAL SCHOOL DISTRICTS

- Written policies specific to children with disabilities
- Unwritten practice
NEW MEXICO PUBLIC EDUCATION: some basic facts

- 89 school districts, ranging in size from to 94,000 students (Albuquerque)
- to fewer than 100 students (five or more school districts)
- minimal technical assistance from PED
- within each school district, site-based management for each school

42,000 children with identified disabilities in New Mexico public schools

- Intellectual disability 1,896
- Hearing impairment 910
- Speech or Language impairment 9,185
- Visual Impairment 177
- Emotional Disturbance 2,041
- Orthopedic Impairment 261
- Other health impairment 3,664
- Specific Learning Disability 18,832
- Dual blindness 6
- Multiple disabilities 830
- Autism 1,799
- Traumatic Brain Injury 180
- Developmental Delay (ages 6-9) 2,644

States Limiting Restraint to Emergencies Threatening Physical Danger (Aug 2013)

- Green (medium): By law (statute/regulation), restraint limited to emergencies threatening physical danger for all children.
- Green (dark): By law (statute/regulation), restraint limited to emergencies threatening physical danger for children with disabilities.
- White: State does not by law limit restraint to emergencies threatening physical danger.

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Restraint/Seclusion: States Requiring Parental Notification (August 2013): Students with Disabilities

- **Purple (medium):** By law, school must take steps to notify parents on same day of restraint/seclusion or within 1 calendar day. Eight states of these active states require a fuller written report to be mailed to parents within a few days.
- **Black (dark):** School must follow certain procedures.
- **Cyan (lightest, slashes):** Law has other notification provisions. IN (as soon as possible), PA (within 10 days or by next IEP meeting), NY (no specific deadline), NC (only very limited number of things must be reported to parents, others need not be reported, one school has no IEP due to lack of law).
- **White:** No laws regarding parental notification.

What does physical restraint in NM schools look like?

- **Who:** children with disabilities; “Teams” and “team calls”
- **What:** CPI-“trained” restraints as well as ad hoc physical intervention which includes
  - prone restraints and mechanical restraints (tape, Rifton chairs, etc.)
- **When:** precipitated by noncompliant behavior (including refusal to do academic work), “escalations” or “running”

Physical Restraint

- **Where:** most often in self-contained special education classrooms from which other students have been removed; often “invisible” to parents and others outside the classroom because room is isolated, door is closed, window is covered
- **Why:** Restraint is a planned intervention included in students’ behavior plans (although referenced by euphemistic and unclear terms) for which hundreds and hundreds of educators are “trained” each school year
New Mexico Due Process Hearing Testimony

Q: And when you – when you restrain him, is it more than one person who’s assisting you, or are you doing it on your own?
A: It starts out with me. And then sometimes we usually have to call — I have to call for backup, because he’s kicking, and he’s head-butting and I can’t do it all.

Q: Do you think the behavior intervention plan is working right now?
A: I think the choices — my opinion is, you know, the distractions work and sometimes aren’t. When he is held down, he doesn’t like that. It appears that you know, he screams and hollers more. But to keep him safe right now, I don’t know what else to do, because I’m not — I’m not going to let him go and bang his head.

Q. You have observed that the holding down increases his anxiety and hollering?
I’ve observed that.

Q  And is it correct that sometimes there’s up to four adults holding him down?
A. Four — three; usually three.
Q. And [the student] weighs about 40 pounds?
A. Yes.
Q: Have you considered that it might be scary for him to be held by three people?
A: Yeah. And we explain to him that — you know, we always say, We’ll let you go, or We’re doing this to keep you safe. We try distractions all the while. And sometimes out of the blue, you know, we’ll say, Do you want to go for a walk? We’ll get the wagon. And he’ll just say, “Yes,” and up he goes. You just — you never know what’s going to work.

Q: Do you think the behavior intervention plan is working right now?
A: I think the choices — my opinion is, you know, the distractions work and sometimes aren’t. When he is held down, he doesn’t like that. It appears that, you know, he screams and hollers more. But to keep him safe right now, I don’t know what else to do, because I’m not — I’m not going to let him go and bang his head.

Q: Do you have a psychologist on staff?
A: Yes.
Q: Has that person been called in to observe the student?
A: No.
Q: At what point would you request that a psychologist be called in to consult.
A: Today or tomorrow, some — any time.
Q: As the classroom teacher, a great bulk of this falls on your shoulders; is that right?
A: Yes.
Q: All right. The behavior intervention plan appears to be less and less successful as the school year goes on. Is that correct?
A: It appears to, yes.
Q. All rights. So at what point will the district determine that you need to have a new plan?
A. I guess I can call an IEP.
Q. We can look at the actual plan. But do you recall that the plan provides that more than 20 minutes of MANDT restraint is contraindicated for the child?
A. Yes.
Q. And have there been several occasions in the school year where [the student] has been restrained for 45 minutes or more?
A. We usually call the mom after 20. And we continue to MANDT him until he calms down or mom comes, to keep him safe. Yes, it could go 45 minutes.

Seclusion: By Law, State Either Bans Seclusion or Limits to Emergencies Threatening Physical Danger (Aug. 2013)

Red (darker): By law, state bans seclusion: all children (Ga), children with disabilities (Pa, WA, TX).
Green (lighter): By law, state restrictions seclusion to emergencies threatening physical danger. Laws in FL, LA, and Pa for children with disabilities. Other states apply their laws to all children.
White: State lacks law either banning seclusion or limiting it to physical danger emergencies.
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What Does Seclusion in NM Look Like?

- **Who:** children with disabilities; educational assistants
- **What:** isolation in small "closet" rooms with possibly no natural light, no window view, no airducts/ventilation, no furnishings or toys/books; often linoleum floor/wall; often visible/audible/olfactory signs of student’s distress; forced isolation is typically enforced until compliance with pre-set criteria (e.g. 5 minutes of silence, etc.)
- **When:** precipitated by noncompliant behavior (including refusal to do academic work); uncontrolled movement and/or noisy outbursts

Seclusion

- **Where:** “Time out” rooms built within the self-contained special education classrooms with doors that may lock; or, sometimes impermanent creation (e.g., barricades made of shelves, filing cabinets, or adults physically blocking the child’s ability to move out of the assigned area)

Seclusion

- **Why:** Seclusion is a planned intervention included in students’ behavior plans (although referenced by euphemistic and unclear terms); many schools in New Mexico have designated “time out” rooms although school districts do not seem to inventory specific locations or collect data about how and how often time out rooms are used by staff
Role of Parents

- Parents do not know that restraint and seclusion are planned interventions.
- Parents do not know what these aversive techniques consist of or how often they are used.
- Parents are often in disbelief even when told by their children.
- Under current law, a Parent cannot forbid use of these aversives by school staff.

Red flags for parents

- Parents are called to school to intervene or pick up the child who is “having a bad day.”
- Child resists going to school.
- Child is very angry and/or physically “ramped up” after school.
- Finger mark / hand mark bruising.
- School suggests a shorter school day will be “better” for child.
- CPI crisis intervention, physical management, therapeutic hold, Crisis team or time out room mentioned in Behavior Plan or IEP.

New Mexico Timeline

- 2003 NMPED releases written non-binding guidance on Seclusion.
- 2004 last reauthorization of the IDEA (federal special education law) - no mention of restraint or seclusion.
- 2006 NMPED releases written non-binding guidance on Restraint.
- May 2009 following its public school survey, Pegasus Legal Services for Children asks NMPED and others to develop legislation on restraint and seclusion for consideration by 2010 legislature.
NEW MEXICO TIMELINE

- Sept. 2009: LESC staff report on “Restraint & Seclusion of Students”
- Nov. 2009: NMPED Secretary names a “Restraint & Seclusion Work Group”
- July 2011: State of New Mexico law prohibits use of corporal punishment in public schools (NMSA §22-5-4.3(B) (7/1/2011))

NEW MEXICO TIMELINE

- Jan. 2014: New Mexico has still failed to consider or pass legislation which prohibits or in any way regulates use of Restraint & Seclusion in our 89 school districts

R/S and Children In State Custody

- Tara Ford
- Pegasus Legal Services for Children
  - 3201 4th St. NW
  - Albuquerque, NM 87107
  - (505)244-1101
  - tford@pegasuslaw.org
What Can We Do?

Front Line Staff
Child Welfare/Juvenile Justice
- Ask about R/S
- Talk to parents about R/S
- Recognize child’s behavior as communication that something is not working
- Ask about positive behavior supports

Parents and Foster Parents
- If the school is complaining about the child’s behavior, ask if the school is subjecting the child to R/S
- Ask for help if you don’t understand the child’s educational needs
- Ask for adults to focus on positive supports for the child
Lawyers

- **Parents’ Lawyers**: Make sure parents are being provided with necessary information to understand what is happening with their children at school
- **Children’s Lawyers**: If a child is subject to R/S investigate whether the child’s legal rights are being violated
- **CYFD lawyers**: Make sure Department staff is asking about R/S when child is having behavioral concerns at school

CASA/CRB

- Recognize that children who are subject to R/S may exhibit behaviors as a result (not all behaviors related to reason the child is in custody)
- If a child is having behavior problems at school, ask about R/S
- Remind parties to advocate for positive behavioral supports

Judges

- If the child presents in your court with behavior problems in school, make sure parties are investigating whether the child is subject to R/S
- Ask how use of R/S may impact the issues before the court
Remember

- Restraint and seclusion harm children
- Restraint and seclusion are not inevitable
- Restraint and seclusion are not treatment

When Kids Are Struggling ——