

SECLUSION AND RESTRAINT IN CT SCHOOLS: A CALL TO ACTION

**FROM THE OFFICE OF THE CHILD ADVOCATE
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“Seclusion and restraint are not treatment; they reflect treatment failure.” — Charles Curie, former Pennsylvania Deputy Secretary for Mental Health and Substance Abuse (Pennsylvania Department of Public Welfare, 2001).

“As many reports have documented, the use of restraint and seclusion can, in some cases, have very serious consequences, including, most tragically, death.” — United States Department of Education *Restraint and Seclusion Resource Document 2* (2012).

“There is no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques.” — United States Department of Education (2012).

“Utilization of restraint or seclusion should be viewed as a treatment failure that exacerbates behavioral challenges and induces additional trauma. Recent research indicates that contrary to what was previously thought about these practices, there is very little evidence to indicate that seclusion and restraint practices hold therapeutic value.” — Interagency Autism Coordinating Council, Letter to the Secretary of the Department of Health and Human Services, on Seclusion and Restraint, Sept. 7, 2011.

“Public scrutiny of restraint and seclusion is increasing and legal standards are changing, consistent with growing evidence that the use of these interventions is inherently dangerous, arbitrary, and generally avoidable. Effective risk management requires a proactive strategy focused on reducing the use of these interventions in order to avoid tragedy, media controversy, external mandates, and legal judgments.” — National Association of State Mental Health Program Directors document on risk management.

Over the last 3 years, the Connecticut State Department of Education reported more than **1,313 incidents of a child being injured during a restraint or seclusion, with more than 2 dozen injuries categorized as “serious.”**

PART ONE: Introduction and Summary

Seclusion and Restraint can be Traumatizing and Ineffective

Throughout the country, changes are being called for to reduce or eliminate the use of restraint and seclusion for children in schools. Children who are subject to these practices are often young and diagnosed with developmental or emotional disorders. There is no research to support the use of restraint or seclusion as therapeutic interventions. Data and evaluation confirm that the use of these techniques can be physically and emotionally detrimental to the well-being of children, traumatizing, and can even worsen behaviors practitioners are seeking to reduce.ⁱ Experts caution that seclusion—the forced confinement of a child in a space, possibly with a closed or locked door—is often not understood and perceived as scary by a child and may impair the child’s development of an appropriate and trusting relationship with the provider or teacher.¹

Despite stated goals of protecting staff or providers from injury, programs utilizing restraint and seclusion actually significantly increase the likelihood of staff injury. In 2009, the United States Department of Health and Human Services issued a report emphasizing that the use of seclusion and restraint is dangerous and traumatic *not only to the individuals subjected to these practices, but also for the staff implementing them.*ⁱⁱ

No Federal Laws on Restraint and Seclusion in Schools

Federal laws and regulations limit the use of restraint and seclusion in federally-funded health and mental health programs for children.ⁱⁱⁱ Many of these federal reforms were promulgated following a series of reports in the Hartford Courant in 1998 called *Deadly Restraint*,^{iv} detailing stories of individuals who were harmed or had even died from inappropriate use of restraint. However, despite the increased attention brought to the issue of such practices in the nation’s hospitals and mental health programs, no federal laws were issued to regulate the use of seclusion and restraint in schools.

In 2009, Federal GAO Investigators Reviewed Hundreds of Cases of Alleged Abuse and Death Related to Restraint and Seclusion of Children in Schools

¹ ALLIANCE TO PREVENT RESTRAINT, AVERSIVE INTERVENTIONS, AND SECLUSIONS, PREVENTING THE USE OF RESTRAINT AND SECLUSION WITH YOUNG CHILDREN: THE ROLE OF EFFECTIVE, PROMISING PRACTICES (2011), available at http://challengingbehavior.fmhi.usf.edu/do/resources/documents/brief_preventing.pdf.

New attention was brought to restraint and seclusion practices in our nation’s schools after a 2009 Federal Government Accountability Report was issued, sounding an alarm after investigators reviewed “hundreds of cases of alleged abuse and death related to the use of these methods on school children during the past two decades.”^v The GAO reported examples such as a “7 year old purportedly dying after being held face down for hours by school staff, 5 year olds allegedly being tied to chairs with bungee cords and duct tape by their teacher and suffering broken arms and bloody noses, and a 13 year old reportedly hanging himself in a seclusion room after prolonged confinement.”^{vi} The GAO concluded that it could not find any “site, federal agency, or other entity that collects information on the use of these methods or the extent of their alleged abuse.”^{vii}

2014 Federal Legislation Proposed to Reduce Restraint and Seclusion: *Keeping All Students Safe*

In the wake of the 2009 GAO report, federal legislation was proposed to reduce and eliminate unnecessary restraint and seclusion in schools, ensure practices are limited only to true emergencies, and offer more protection and supports for students and teachers. The U.S. Senate proposed a bill, the *Keeping All Students Safe Act*, introduced on February 24, 2014, which would prohibit each State and local educational agency receiving federal financial assistance from utilizing restraint and seclusion unless the student’s behavior poses immediate danger of serious physical harm to self or others. This bill, co-sponsored by Connecticut Senator Christopher Murphy, has the support of disability advocacy and professional organizations across the country, including the Autism National Committee, the Easter Seals, the American Psychological Association, and the Southern Poverty Law Center.^{viii}

The federal legislative proposal coincided with a 2014 report issued by the Health, Education, Pensions, and Labor Committee outlining the potential dangers of a reliance on seclusion and restraint for children with disabilities in schools.^{ix}

State Laws and Policies Regarding Restraint and Seclusion in Schools Changing Around the Country

Without a federal framework for the use of restraint in schools, states’ laws and regulations vary widely, and continue to be reformed and changed throughout the last two years. States such as Georgia, Ohio, Massachusetts, New Hampshire, and Alaska, to name only a few examples,^x have issued new policies and laws restricting restraint and seclusion, with Massachusetts issuing sweeping changes—limiting restraint, *prohibiting seclusion*, and increasing oversight—in January, 2015.^{xi}

Massachusetts is only the latest state to restrict or prohibit the involuntary confinement of children. New Hampshire, Oregon, Georgia, and others, have

all banned seclusion altogether, and many other states permit seclusion only in the case of imminent harm to self or others.^{xii}

The U.S. Department of Education and the U.S. Department of Health and Human Services have issued guidance and technical support for schools and programs around the country, emphasizing the potential harms and limited utility of restraint and seclusion for children.^{xiii}

Restraint and Seclusion for Children with Autism and other Developmental Disorders

In Connecticut, children with Autism Spectrum Disorders (ASD) are the most likely children to be restrained or secluded in school. Experts have strongly cautioned against reliance on seclusion and restraint for children and adults with Autism. In 2011, the Interagency Autism Coordinating Committee (IACC), authorized under federal law as an advisory committee per the Combating Autism Act of 2006 (P.L. 109-416), issued a public letter to the U.S. Department of Health and Human Services outlining significant concerns regarding the pervasive use of restraint and seclusion for children with autism. The IACC—chaired by Thomas Insel, M.D., Director of the National Institute of Mental Health—stated:

[U]tilization of restraint or seclusion should be viewed as a treatment failure that exacerbates behavioral challenges and induces additional trauma.

In its letter, which specifically addressed seclusion and restraint in schools, the IACC endorsed numerous recommendations for federal agencies including regulatory reform, improved data collection, guidance and technical assistance for providers, concluding:

“[F]ederal legislation is urgently needed to ensure the safety of all students and staff” by requiring standards for monitoring and enforcement of restraint and seclusion practices, as well as prohibition of mechanical, chemical, and high-risk physical restraints . . . “the use of seclusion and restraint in every setting is a critical issue for people with ASD and other disabilities and their families that requires immediate Federal attention.”^{xiv}

There are Effective Measures to Reduce Restraint and Seclusion

The IACC letter referenced above, as well as numerous other publications and reports, document the dramatic decrease in utilization of restraint and seclusion that can be achieved through implementation of evidence-based strategies such as Positive Behavioral Interventions and Supports, the Six Core Strategies, and related trauma and expert-informed behavioral supports. Programs around the country that have utilized such strategies have seen a remarkable decrease in the use of aversive practices *and* problem behavior previously thought to necessitate the use of restraint and seclusion.

Restraint and Seclusion in CT: New Initiative to Improve Practice

In 2012-13, Connecticut created an interagency task-force with participation from the state agencies for education, children and families, mental health, and persons with developmental disabilities, to collaborate regarding the continued reduction of restraint and seclusion in all child and adult-serving programs and facilities.^{xv} This voluntary partnership has resulted in a ground breaking Memorandum of Understanding between seven agencies expressing a shared commitment to the reduction of unnecessary restraint and seclusion. In 2013 and 2014 statewide conferences were held to educate providers regarding evidence-based alternatives that can better support children and adults, and to disseminate information regarding the potential harms of restraint and seclusion.

Currently, CT state agencies and local school districts do not operate under the same legal, regulatory, or practice framework regarding when and how restraint and seclusion can be used as an intervention for children and adults. The inconsistency in approach is due, in no small part, to the existence of federal laws that limit the use of restraint and seclusion in federally-funded programs and facilities but not in schools. Other inconsistencies arise due to different agencies' interpretations or regulations regarding application of Connecticut state law.

As a result, a child with a developmental disability, for example, may be subject to repeated seclusion as a behavior management strategy in his school, but in programs run or contracted by the state agency responsible for serving children and young adults with developmental disabilities (DDS) ***seclusion is prohibited***.

What is Restraint and Seclusion, and how is Seclusion Different than Time-out?^{xvi}

Seclusion is defined as “the confinement of a person in a room, whether alone or with staff supervision, in a manner that prevents the person from leaving.” Seclusion should be ***distinguished*** from a therapeutic time-out or temporary removal from positive reinforcement. Experts define a “time out” as an “intervention that involves removing or limiting the amount of reinforcement or attention that is available to a child for a brief period of time.” A time out may involve “removing a child from an activity, taking materials or interactions away, or having the child sit out of an activity away from attention or interactions.”²

Physical restraint “means any mechanical or personal restriction that immobilizes or reduces the free movement of a person’s arms, legs or head. The term does *not* include (a) briefly holding a person in order to calm or comfort the person; (b) restraint involving the minimum contact necessary to safely escort a person from one area to another.”

² *Id.*

CT Restraint and Seclusion Laws

CT law prohibits the use of physical restraint for children except as a response to an emergency. Ct law permits the use of seclusion for emergencies *or as a planned behavioral intervention in a child's Individual Educational Plan.*

CT law does **not** limit the use of mechanical restraint to only those devices prescribed by a licensed medical professional.

CT law prohibits the use of life threatening restraint, including methods that restrict airways. However, the statute *does not* expressly state that this prohibition includes prone (face-down) restraints, which done incorrectly or even correctly, may restrict the breathing of a child or adult.^{xvii}

CT law does not expressly require programs utilizing restraint or seclusion to employ evidence-based or trauma-informed strategies to reduce their use or that promote positive school climate and student behaviors.^{xviii}

CT law permits the use of locked seclusion and *does not limit the duration of this intervention to the extent of any purported emergency.* Rather seclusion may continue until the child has “composed” him or herself.

CT has a relatively new reporting requirement regarding the use of seclusion and restraint in schools (PA 12-88), but the State Department of Education has too few resources (though ample will) to investigate and monitor schools’ actual compliance with the law or best practices.

CT law requires that Planning and Placement Teams (PPTs) reconvene after a child has been secluded more than two times in a marking period, unless this requirement has been waived by the PPT.

CT and federal law requires that children whose behavior interferes with their ability to learn have the benefit of Functional Behavioral Assessments (FBA) and Behavioral Intervention Plans (BIPs). CT and federal law also provide for a child to be evaluated in *all areas of suspected disability* to ensure appropriate supports and services.

CT law provides that seclusion may not last, in any case, longer than 1 hour, without written permission from the principal that such ongoing seclusion is necessary to prevent imminent harm.

CT law requires that emergency seclusion or restraints are emergency interventions of last resort, and that efforts to de-escalate and positively manage crisis behavior be utilized prior to restrictive or forceful measures being taken to subdue a child.

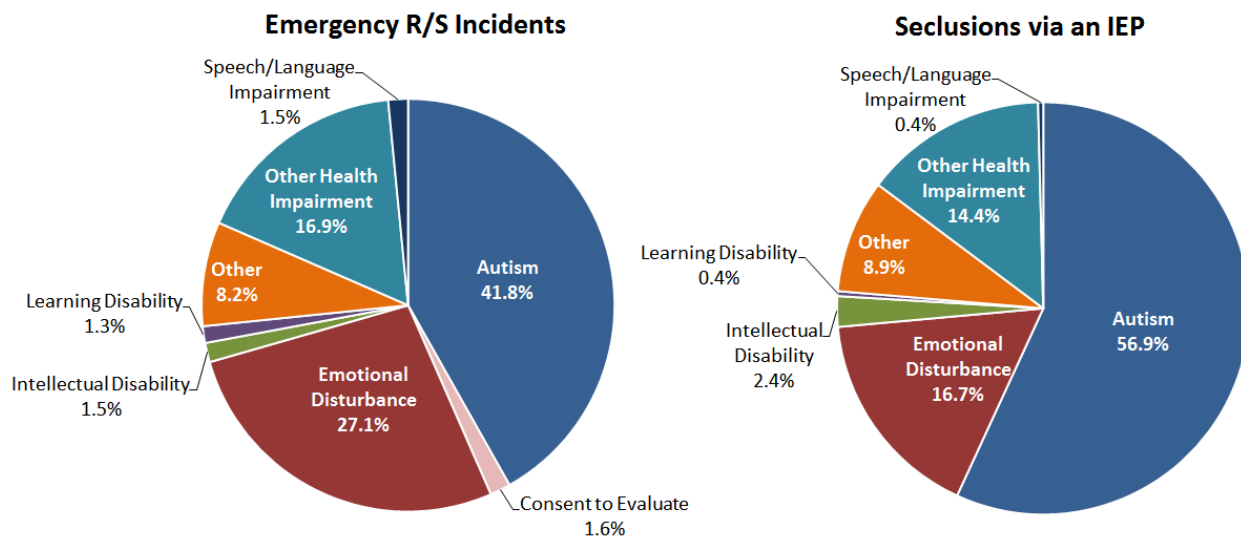
CT law requires detailed documentation in a child’s record regarding the use of restraint and seclusion, including precursors, de-escalation strategies, monitoring of the child during restraint or seclusion, and the effects of restraint or seclusion on the child.

CT Data Regarding Restraint and Seclusion in Schools: Each year more than 30,000 incidents of seclusion and restraint for more than 2,500 students.

The State Department of Education, in the wake of a 2012 legislative mandate, issued three annual reports to the legislature regarding the use of restraint and seclusion in CT schools. These reports, completed with commendable precision and effort by SDE, confirm that restraint and seclusion incidents repeatedly top 30,000 per school year and affect more than 2,500 special education students each year, with many students subject to repeated isolation and restraint.

In the last school year (2013-14), over 1700 of the reported incidents of restraint and seclusion lasted more than 40 minutes (716 of those lasted more than one hour) and 144 children were secluded or restrained more than 50 times.

Children may be *as young as pre-school*, with the majority of restraints and seclusions occurring with elementary school students. Children who are restrained and secluded are most likely to be identified as having an Autism Spectrum Disorder or an emotional disturbance; they are typically male (82%), and disproportionately African-American or Hispanic (53%).^{xix}



**Chart taken from: CONNECTICUT STATE DEPARTMENT OF EDUCATION, ANNUAL REPORT ON THE USE OF RESTRAINT AND SECLUSION IN CONNECTICUT: SCHOOL YEAR 2013-2014 12 (2015).

2014: OCA Investigates Restraint and Seclusion and Schools

To support the work of the state's interagency efforts to reduce restraint and seclusion, and consistent with OCA's obligations under state law to evaluate how state-funded programs and providers meet the needs of our most vulnerable children, in 2014 OCA undertook an extensive review of the use of restraint and seclusion in schools.

OCA examined the data and reports produced by the CSDE, met with state agency officials and leadership, visited numerous educational programs around the state to review practices, and sampled data and student-specific education records from several schools, both public and state-approved private. **OCA's review focuses on the use of restraint and seclusion with elementary-school age children.**

Throughout this review, OCA met with many dedicated and professional educational leaders who were committed to the welfare of their students and the continued improvement of their programs' ability to address children's varied learning needs. Some programs had already begun to establish frameworks to specifically reduce restraint and seclusion, and presented data to the OCA confirming this downward trend. OCA was frequently impressed by the candor and professionalism of programs visited throughout the state, as well as the oft-articulated commitment of educational administrators to continued reform.

OCA Findings: Significant Concern

OCA's findings, based on observations, data reviews, field-work, and response to citizen concerns raise **significant concern** regarding the frequency with which young children with disabilities were restrained or secluded, the lack of documentation or actual compliance with state laws, and the prevalence of unidentified and unmet educational needs for children subject to forceful or isolative measures. Significant concern is also raised regarding the spaces used for seclusion, which have included utility closets, storage closets, and cell-like spaces.

Educational programs varied widely in their ability to provide trauma-informed, expert-driven educational plans for children identified as eligible for special education services due to a diagnosis of Emotional Disturbance. Likewise, school programs often struggled to identify and meet the multi-disciplinary needs of children identified as having an Autism Spectrum Disorder. Some children benefitted from carefully constructed Individual Educational Plans and the provision of related support services. However, other children with either emotional or developmental disorders' educational plans often lacked appropriate supports or services. OCA finds that these deficits contributed to over-reliance on seclusion and restraint for many children with disabilities whose educational files were reviewed as part of this investigation.

OCA notes that a child coming into a program that utilizes restraint and seclusion may already present with significant skill deficits such as delays in communication and social-emotional development, and concurrently demonstrate complex, dysregulated behavior.

A critical theme underlying the recommendations for this report is the need to identify, evaluate and appropriately educate children in all areas of disability, with an emphasis on social-emotional and functional communication development from the youngest possible age. Reducing restraint and seclusion requires that all children benefit from skilled instruction, with attention not only to academics but also to social-emotional learning and positive behavioral supports.

OCA strongly advises that, given the clear commitment of teachers and administrators to serving the needs of children with disabilities, critical reforms cannot be achieved *solely* through revision and updating of state laws, but must necessarily incorporate meaningful technical and resource support for professionals working with our most vulnerable children.

Supporting and enhancing the ability of school communities to work capably with special-needs children *and* their caregivers, is a public policy issue of high and urgent priority. Teachers, administrators, and related providers must have access to the tools they need to assist children at the *youngest ages*, provide guidance to families, and coordinate care with other agencies and community providers. Reliance on seclusion and restraint is a symptom of a *larger systemic challenge*.

Accordingly, OCA is recommending revision to the state's laws regarding restraint and seclusion to accomplish the following:

- 1) Ensure consistency with current research and best practices for children regarding the potential harms of restraint and seclusion;
- 2) Increase monitoring and evaluation of restraint and seclusion; and
- 3) Offer more *support, including training and capacity building, for schools to meet the varied and specialized learning needs of children with and without disabilities*. OCA emphasizes that building capacity and effectiveness does *not always* (though sometimes does) require more dollars over fixed periods of time, but rather requires efficient and strategic planning within available appropriations. Children must be supported in all areas of development from *the youngest possible age*, benefitting from positive behavioral support, functional skill development and social-emotional learning.

PART TWO: METHODOLOGY

For purposes of this report, OCA conducted field visits and met with administrators and educators at 10 programs across the state. At all programs, OCA reviewed data regarding the use of restraint and seclusion, either with a particular student or with students throughout the grade or program.

OCA also requested the following records from 7 of these programs:

- Policies, procedures, and training records.
- Educational records for elementary school children who were subject to restraint and seclusion during the 2013-14 school year. These records included child-specific Individual Education Plans (IEPs), functional behavioral assessments (FBAs), behavioral intervention plans (BIPS), and incident reports of the use of seclusion and restraint for students.^{xx}

School programs where OCA visited or reviewed additional records included three public schools, two separate schools operated by public school districts, four approved private special education schools (APSEPS), and one specialized school operated by a regional educational service center (RESC). Given the number of students who were identified that were subject to restraint and seclusion during the 2013-14 school year, OCA reviewed records for a random sample of students from each program.

An independent education consultant was secured as a volunteer to the OCA for the purpose of assisting with the review of student-specific data. A total of 70 student records were reviewed, all of whom were restrained or secluded during the 2013-14 school year. The information recorded and reviewed was as follows:

- Number of restraints which occurred with these students during this time period;
- Number of seclusions which occurred with these students during this time period;
- Number of students who were secluded and for whom seclusion was a component of his/her Individualized Education Plan (IEP) or of his/her Behavior Intervention Plan (BIP);
- Number of students who were injured during a restraint or a seclusion;
- Number of students who had an Functional Behavior Assessment (FBA);
- Number of students who had a BIP; and
- Notes regarding the nature of the emergencies which precipitated a seclusion or restraint; the components of IEPs, the correlation between the FBAs and the BIPs; the individualized nature of the BIPS; and any other notes of significance, trends, or issues of concern which might be important in analyzing the data.

OCA also conducted extensive research regarding the utility and impact of restraint and seclusion in mental health and educational programs, and convened with experts in the fields of education, and service delivery to children with Autism Spectrum Disorders or Emotional Disturbance.

Note: OCA's methodology has limitations to the extent that it is a review of 70 student records, and this report is not presenting a scientific, statistical analysis of the duration and frequency of all restraints and seclusions documented in each child's record. Rather, this report seeks to discuss the frequent themes that arise in children's cases, adherence to best practices and state law, with a goal of outlining steps for collaborative reform.

PART THREE: FINDINGS

Aggregate Data

- Number of students, whose records were reviewed in the seven schools examined, who were either restrained or secluded during the 2013-14 school year: **70**
- Number of restraints which occurred with these students during this time period: **approximately 1065^{xxi}**
- Number of seclusions which occurred with these students during this time period: **703**
- Number of students who were secluded and for whom seclusion was a component of his/her IEP or of his/her BIP: **29**
- Number of students who were injured during a restraint or a seclusion: **4 (2 self-injuries)**
- Number of students who were restrained or secluded and *did not have an FBA*: **19**
- Number of students who were restrained or secluded who had an FBA which was not current: **4**
- Number of students who were restrained or secluded and *did not have a BIP*: **12**
- Number of students who were restrained or secluded who had a BIP which was not current: **2**

Case Study: Nia

Nia^{xxii} is a seven year old student who is identified as in need of special education due to a disability of emotional disturbance. She was placed by her school district in an out-of-district placement. Nia has limited reading skills, and multiple academic and social emotional needs. Her IEP includes a goal for Nia to learn to express herself and identify what she needs without aggression. On her IEP, the space next to "Communication" is blank. Nothing is written to indicate whether she needs help or what her challenges are in this area of development. Her IEP includes no reference to support from an occupational therapist, behaviorist, or speech and language provider. She does not have a Functional Behavioral Assessment. Although the record indicated that Nia had undergone multiple evaluations, including a neuropsychological evaluation, an occupational evaluation, and a cognitive evaluation, and that a PPT had reviewed these evaluations, there was no evidence that her IEP was updated to include new goals and objectives or supports indicated by these assessments.

She was subject to restraint and seclusion numerous times for reportedly unsafe behaviors. All incident reports read the same and are generic in description. It is not possible to review the

reports for the purpose of debriefing or identifying trends and strategies for improvement. A majority of restraints occurred while Nia was already in time out.

There was no evidence in the file that a PPT had been convened to review Nia’s IEP despite her extensive educational needs and the frequency of her restraints.

This case raises significant concerns regarding compliance with special education laws and regulations, SDE guidelines for districts, and possible unmet educational needs.

The case outlined above reveals numerous concerns regarding the use of seclusion and restraint. Related concerns raised by OCA’s review are categorically addressed below.

Findings: What Leads to Seclusion and Restraint

According to state law, a child may be restrained only in emergencies. Seclusion may be used in an emergency or as a planned behavioral intervention. Data from the State Department of Education indicates that the majority of restraints and seclusions are due to “emergencies.” OCA’s findings raise a concern about how variably providers are applying this “emergency” label, the lack of documentation regarding the nature of emergencies or the steps taken to avoid, prevent or respond to such situations.

Because seclusion may be used as a planned intervention, students may be confined for failing to follow a direction or for exhibiting negative behavior. OCA’s findings, along with virtually all research on the subject, raise significant concerns about this practice.

Example: Seclusion Used as a Planned Behavior Intervention

“Student’s activity that precipitated seclusion . . . Student was doing work at his desk when a visitor entered the room and said ‘hello.’ The student refused to say hello, then did so with vocal gestural protest.” Student, a 9 year old child with autism, was placed in seclusion pursuant to his IEP.

This same child’s IEP clearly states that seclusion may be used for noncompliance, and that “student ***may be placed in seclusion several times in a given day.***” It should be noted that this child’s educational plan also included positive interventions and skill-building supports. Seclusion in this particular educational program was identified as a closed-door space.

The use of seclusion as a behavior management tool is concerning as research supports the conclusion that seclusion may be traumatic and no research supports the use of seclusion—differentiated from therapeutic time out or brief removal from positive reinforcement—as a therapeutic behavioral intervention.

Student activity/behavior precipitating use of seclusion
 Describe the location and activity in which the student was engaged just prior to the seclusion: student was playing a board game with his classmates in the game room. student lost the game but continually repeated "I won" with ^{vocal/gestural pro}

Describe the risk of immediate or imminent injury to the student or to others, that required the use of seclusion: seclusion was used as part of student's behavior intervention plan

Staff activity/response
 Describe other steps, including de-escalation strategies implemented to prevent the emergency which necessitated the use of seclusion: student was reminded of consequences and given a warning. He was provided with vocal models to repeat.

[Student D] [text above]: "Student was playing a board game with his classmates in the game room. Student lost the game but continually repeated 'I won' with vocal/ gestural protest. Seclusion was used as part of student's behavior intervention." Seclusion is typically less than 10 minutes.

"[Student D] Beginning a new program (sight words), [student engaged in] non-compliance- was told he needed to go to seclusion because he wouldn't do his work."

"[Student D] was in the classroom and was told to collect his things for milk routine. Student engaged in vocal gestural protest and non-compliance. Seclusion was used as a behavior intervention procedure. Student also aggressed to staff after first seclusion." (Emphasis added.)

From a different student (and school's) file: Student was "negatively focused on not being able to use the computer, began spitting on the floor, seclusion used as a behavior intervention as indicated in the IEP. Afterwards, [student was] still agitated and yelling." Seclusion lasted 34 minutes.

Child was "in class running around the room, hiding under desks, pushing chairs and putting other students in danger." Seclusion was used as a behavior intervention as indicated in the IEP. Child was in seclusion for 37 minutes.

Seclusion Used an “Emergency” Response

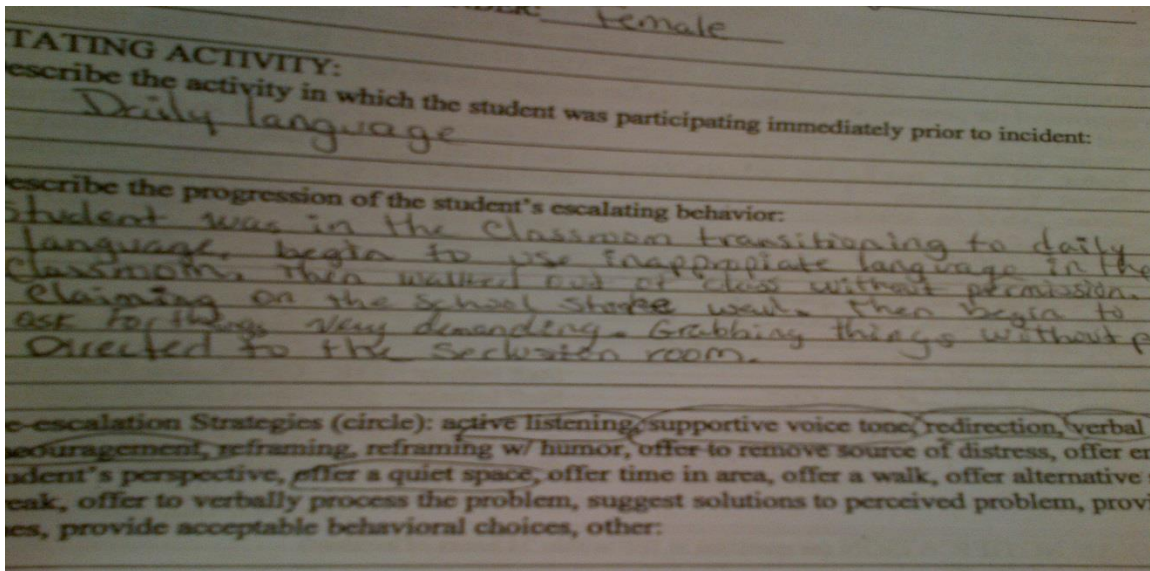
Records reviewed for this report indicate great disparity in how restraint and seclusion practices were utilized as an emergency intervention. Some children were secluded or restrained for disruptive but not dangerous behavior. Children were restrained for attempting to leave a room. Often incident reports described the behavior as an “emergency,” or as the student acting as a “danger to self or others.” Similarly, there were several cases where the nature of the emergency described did not appear to meet the definition of an emergency, such as when seclusion was used “as a precaution,” as a “voluntary seclusion^{xxiii},” or because the “student *could have been* a hazard to self or others.”

The lack of specific documentation is a critical finding given that research and best practices confirm the importance of leadership review, data collection, analysis, and debriefing for reducing reliance on restraint and seclusion and meeting children’s needs.

Often, documentation is generic about what led to the use of restraint and seclusion. For example, one student’s incident report stated, under nature of emergency that led to the seclusion: “AGG.” (Authors assume this references the term “aggression.”) Other incident reports from the same student’s file—dozens of seclusions— frequently use the same language from one report to the next, without description or variation: “risk of injury to instructor, non-redirectable aggression.”

Other Examples of “Emergency” Incidents

“Child [A] began swinging her coat at staff, student was told if she continued her direction, she is going to have a seat in the [seclusion] room.”



Text above: “student was in the classroom transitioning to daily language, began to use inappropriate language . . . walked out of class without permission . . . climbing on the school [store?] wall. Then began to ask for things, very demanding. Grabbing things without permission. Directed to the seclusion room.”

Seclusion may be used as a precaution, but then characterized as an emergency.

“Student was physically aggressive towards property . . . as well as making threats and [inappropriate] comments which was likely to cause an altercation.” Student was placed in seclusion.

“Student was taunting other students and throwing bean bags which could have led to an altercation.”

Seclusion reports may also present signs of a child in extreme distress, raising additional concerns about the possibility that isolation will escalate that distress.

“Student was physically aggressive towards staff . . . as well as smearing fecal matter in the restroom.”

The following incident notation echoes the research findings that restraint is a futile tool to modify behavior:

A young child in an alternative public school program tried to walk out of time-out multiple times, with “staff attempting to redirect him several times.” Student placed in a restraint. After the restraint, the report

describes the child's disposition: "Student was fine, but continued to try and walk out the room."

NOTE: the above incident report states that the child is restrained for trying to walk out of 'time out.' OCA's records review raises a question as to whether this program and other programs may be using the term "time-out" inappropriately. When a child is involuntarily confined in a room (as the note that the child was restrained for trying to leave suggests) this is, as a matter of law, seclusion. Time-out is a therapeutic removal from positive reinforcement or activity.

Lack of Documentation as Required by State Law

State law requires documentation regarding precursors, de-escalation strategies, monitoring and the child's disposition post-seclusion or restraint. This information was often missing or was inadequate. The failure to document what has occurred makes it extremely difficult to later debrief with the parent and the educational team and to devise appropriate prevention and response strategies which do not include potentially harmful emergency measures.

For example, incident reports related to **Student D's seclusions** above, are often vague about what behaviors precipitated the use of seclusion:

"In classroom, putting away lunch box."

Another incident report stated that the activity preceding the use of seclusion was "in nurse's office doing milk program" and "in classroom doing work."

"Student was in the classroom finishing a break, getting ready for a new program. Staff directed him to put toy away. He refused." This was documented as "non-compliance, and aggression."

These examples are not used to indicate that this student, or other students, never exhibit very challenging or even injurious behavior, but without adequate documentation, it is impossible to discern if the problem in cases such as these was insufficient documentation or whether the incident truly constituted an emergency.

From a different program: "[S]tudent was making inappropriate comments and threats to other students." Child was placed in seclusion for 11 minutes. The incident report stated that the child was diagnosed with Autism. The child's IEP, however, stated that he was identified as having Emotional Disturbance. Virtually all incident reports regarding the restraint or seclusion of this student stated the same thing, without

differentiation: “Student was physically aggressive towards staff and property.”

In many cases it was not clear as to the specific de-escalation strategies which were used to prevent an emergency use of seclusion and restraint. Reports may simply state “see BIP,” or “staff support offered.” It is not clear if the failure to describe the specific de-escalation strategies used was due to inadequate incident documentation or reflective of a lack of specific positive behavioral supports utilized.

Evidence-based strategies for reduction of restraint and seclusion, such as the Six Core Strategies, emphasize the need for leadership review of data regarding utilization and trends. This key element is not possible with many of the records OCA reviewed for this report. However, some programs visited for this review utilized a comprehensive framework for data collection and analysis and were able to review trends and chart improvement in preventing restraint and seclusion.

Findings: Use of Physical and Mechanical Restraint with a Young Child

Raymond, a 4 year old boy identified as having Developmental Delay was placed in a specialized public school program. His IEP documents social-emotional learning needs and states that “due to his social emotional delay, [Raymond] requires specialized instruction in order to enhance his participation within the preschool setting.”

Raymond was subject to restraint for the following reasons:

“Student was on the rug with a puzzle and threw the pieces on the floor and across the room.”

“Student was in the class running around while the rest of class was getting prepared for reading . . . he then tried to hit another student.”

Very concerning, Raymond’s IEP states that school personnel may place Raymond in a “rifton chair” “as needed.”

A Rifton chair is adaptive equipment with straps and a belt for children with physical disabilities and who may need help with posture and sitting. Rifton chairs should not be used to restrain a child for behavioral reasons or otherwise substituted for therapeutic interventions. Raymond’s IEP does not indicate that he is diagnosed with any physical challenges or that there is a medical need for such a restraint. Rather, Raymond’s IEP states that his fine and gross motor skills are “age appropriate.”

Example of a Rifton Chair:



It is important to note that this use of a mechanical restraint is permitted by state law, which does not limit the use of mechanical restraints to medically prescribed devices. The law does not, however, permit use of such a mechanical restraint as a *behavioral modification tool*.

Findings: Inadequate or no Functional Behavioral Assessments for Some Children

State and federal law require that children be evaluated and supported in all areas of disability, and children whose behavior interferes with their ability to learn should have the benefit of an Individualized Functional Behavioral Assessment (FBA) and Behavior Intervention Plan (BIP). These documents should be expert and data-driven, and created with the input of the entire PPT. Quality, positive behavioral support driven behavior plans are critical to improving educational outcomes for children with and without disabilities.

Guidance from the CSDE regarding the Identification and Education of Students with Emotional Disturbance (2012) describes an FBA as:

[A] problem solving process designed to address a student's behavior when that behavior impedes the learning of the student with a disability as well as the learning of his or her peers [The FBA] it is intended to guide the PPT in making data-based decisions about how to assist students, by looking beyond the observable behavior and focusing on the function or the "why" of the behavior.^{xxiv}

The CSDE Guidelines identify a Behavior Intervention Plan (BIP) as an empirically-supported intervention strategy and emphasize its individualization. The Guidelines note:

After conducting an assessment of the function of the behavior, an individualized, positive behavior support/BIP should be developed by (a) identifying an appropriate alternative behavior to replace the problem behavior and meet the same function, (b) devising a behavior support plan that describes the ways in which the environment is rearranged to make the replacement behavior more efficient, effective, relevant and durable than the problem behavior, (c) monitoring for fidelity of implementation and (d) taking data to guide the modification and eventual fading of the plan.^{xxv}

There were 19 children whose records were reviewed for this report and who had no FBA. 12 children had no behavioral intervention plan.

Many of the BIPS that were available for review did not appear to be individualized, but rather reflected a school-wide behavior system or a menu of behavioral options. While a school-wide behavior management system is essential in the prevention and management of student behavior, and a menu of behavioral options is useful to the PPT in its development of an individualized BIP, neither is prescribed to an individual student's needs.

T is a 9 year old student with multiple disabilities who has been placed by his school district in an out-of-district program. T was restrained 11 times. There is no evidence that an FBA was conducted for this student. Absent an FBA, no individualized or effective behavioral intervention plan could have been developed.

Findings: Many Student Records Reflect Unmet Needs

Many of the students subject to restraint or seclusion had several needs beyond social-emotional and behavioral challenges. Often these children demonstrated deficits in expressive and receptive language, including pragmatic language; sensory issues; fine motor issues; and low academic achievement. Some children presented with significant cognitive deficiencies. Children with critical thinking and communication deficits need specific, evidence-based or research-informed strategies to address these learning needs.

Although some IEPs reviewed for this report addressed students' myriad learning needs through provision of related services or other supplementary aides and supports, often there was limited evidence of the consideration of the impact of children's communication, processing, sensory, or cognitive deficits on his or her social-emotional and behavioral growth. Children with complex behavioral health or developmental disorders will need educational plans that provide research-based curriculum in multiple areas, delivered by highly skilled, well-trained teachers and related professionals. A child who has communication and cognitive deficits, for example, and who is

restrained or secluded but is not receiving intensive speech and language supports, has unmet needs.

Case Review: Marcus

Marcus is a 12 year old student, identified as eligible for special education due to an identified disability of "Other Health Impairment." Marcus attends a specialized program run by the public school in his town. His IEP notes that he demonstrates "social and emotional issues [which] prevent him from accessing the general curriculum without interventions and supports." Marcus's IEP also notes that he "enjoys engaging in activities that help others. [He] has improved in his understanding of his mood swings and his ability to identify his mood in the moment."

Marcus's educational file indicates frequent use of seclusion as a response to disruptive behavior. For example, if Marcus "bangs on desk and window," he is secluded. (Seclusion in this program is locked, closed-door confinement). When in time out, Marcus was "singing loud" and "banging on desk and window." He was placed in seclusion for twenty minutes. Marcus was in the hallway and wouldn't move, and when asked to move he started to "yell and bang on the wall." He was placed in seclusion where he was "yelling and screaming and banging on walls and door." Marcus was often placed in seclusion using a "two person transport." The door would then be closed, with Marcus left screaming and yelling to be let out. Sometimes Marcus's banging and punching the walls included hurting his own hands and head. On multiple occasions, the school personnel warned Marcus, while he was in seclusion, that they would have to call 911 or take him to the hospital. On at least one occasion, Marcus had to be restrained while in seclusion because he wouldn't stop banging his head.

The frequent use of hands-on transports and seclusion raise questions about the appropriateness of Marcus's IEP and whether the school environment is able to provide a trauma-informed, positive behavioral approach to support this youth, whose behavior may escalate into self-injurious gestures after being placed in seclusion. Marcus's records also do not reflect that a PPT was reconvened to address or modify the supports and services that he may have needed.

Without a PPT, there is limited opportunity to meaningfully assess the impact of restraint and seclusion for a student, the appropriateness of current service delivery or school placement, or provide an opportunity for the parent to be informed, ask questions, and contribute critical information.

Case Review: Devon

Devon is an 11 year old student who says that he wants to do work. His teachers say that he is a "very engaging student, that he asks questions about things he is curious about and that he has a good sense of humor. He is motivated to learn." Teachers note that his anxiety can

impact his attention and abilities in school. Devon has documented delays in all academic areas and his intellectual functioning falls within the extremely low range. His IEP notes that Devon is delayed in receptive, expressive, and pragmatic language. His educational classification is "multiple disabilities." He is reading at the first grade level but enjoys "listening to stories." However, despite the range of significant disabilities affecting Devon's progress, and his significant deficits in communication, Devon is provided only ½ hour of speech and language supports each week. Despite Devon's documented sensory needs and visual-motor deficits, he receives no occupational therapy. Seclusion is included in Devon's IEP, but there is no evaluative data available to support the need for seclusion as a behavior intervention strategy.

Case Review: Javier

Javier is a 4th grader diagnosed with Autism. According to his educational plan, he displays "many developmental and emotional needs." After being suspended for 5 days from his public school, his educational team decided to move to him to a state-approved private special education school. Javier's IEP notes that he needs to learn to "communicate his needs to staff in an age appropriate manner, using his words 80% of the time," and that he will "verbally express feelings of frustration, anxiety and anger without aggressive behavior." Despite his diagnosis of Autism and the identified goal for Javier to improve his ability to communicate, Javier's IEP indicates that his communication ability is "age appropriate," and his educational plan contains no communication goals, and incorporates no speech and language services.

Javier's IEP, however, specifically permits the use of seclusion as a behavior intervention strategy. He is frequently placed into seclusion for dysregulated behavior. Frequently, Javier engages in suicidal gestures once placed in seclusion. He is often picked up by his guardian after such incidents.

"J was verbally threatening staff and was directed into a seclusion room. He attempted to leave the area and pushed staff. He made suicidal threats." While in seclusion, J had to be restrained. He was assessed by a nurse and clinician and then went home with his mother.

"J left the classroom without staff permission . . . staff verbally attempted to redirect him, but J repeatedly hit, pushed and spit on staff." Javier was taken to the seclusion room, which "led to a [restraint]."

"J refused to participate in math class. Staff verbally attempted to direct him to the task at hand, but J began throwing materials and spit on staff." He was taken to the seclusion room.

"J refused to participate in class and left the classroom without permission. He then attempted to pull the fire alarm." He was secluded.

"Student was in the seclusion room because student was not following directions, not safe. [While in seclusion] J began to charge staff and say that he was going to choke himself." Restrained. Went home with mom.

A number of times when Javier was placed in seclusion, he engaged in suicidal gestures such as:

- ***“Tied sock around neck.”***
- ***“Hands around neck... Strangling self.”***
- ***“Putting coat around neck.”***
- ***Threatening self: “I want to die.”^{xxvi}***
- ***“Tied shoelace around neck.”***

Javier’s case review raises significant concerns regarding possible unidentified or unmet educational needs, and escalating suicidal behavior while in seclusion. Very concerning, is that Javier’s Behavioral Intervention Plan calls for closed door seclusion if he engages in unsafe behavior-- despite his documented propensity for engaging in suicidal gestures while in closed door seclusion.

Javier’s IEP classifies him as Autistic, which per SDE and clinical criteria requires a finding that he has deficits in communication. Yet, his IEP states that communication development is “age appropriate” and there is no direct service from a speech or language specialist. The IEP contains no reference to sensory issues or occupational therapy support, and the IEP does not reflect the participation of a certified behavior analyst.

Provision of appropriate, research-based and data driven interventions will be essential to reduce reliance on restraint and seclusion for a child with Autism.

Unmet educational needs may result in the inappropriate behavior of students. For example, if a student has difficulty understanding others, he or she may misread social cues or appear defiant. If a student has difficulty expressing himself, he may not be able to convey his needs and inevitably he acts out in frustration.

If a student is afflicted with sensory integration difficulties, he may be overstimulated by an environment. Without the employment of sensory strategies to ameliorate that overload, the student may display an inappropriate behavior in order to reduce stimuli.

All students have an innate desire to learn and to achieve. Focusing on behavior in isolation misses the opportunity to use good teaching and relevant curriculum to engage students in their instruction as a means to reduce inappropriate behaviors and to build their self-esteem as their competencies increase and their confidence improves.

The law requires that *all* suspected areas of disability are considered and addressed by the PPT.^{xxvii} Although only one disability can be identified as the *primary disability* (e.g., Autism or Emotional Disturbance), the existence of other areas of disability or other areas of concern that impact learning must be noted in the Present Levels of Performance section of the IEP and addressed by goals and objectives, services and supports.

Findings: Conformance of Seclusion Rooms to Regulatory Standards

OCA's review raised concern regarding the tremendous variability in the seclusion spaces that children are placed in around the state. OCA observed seclusion spaces that varied from door-less, comforting spaces, to brick utility closets, storage closets, and padded rooms. While some spaces included comforting and sensory materials, many did not.





Additionally, OCA is concerned about the adequacy of a current state regulatory requirement which allows for seclusion rooms to be locked, but does *not provide adequately for the safety of a locked-in student during an emergency*. The current regulations require a fire marshal modification prior to the installation of a locking mechanism on a seclusion door and requires a connection to the fire alarm system so that the locking mechanism is released automatically when a fire alarm is sounded. However, regulations *do not provide for protection for the student in a locked seclusion in all circumstances*. Specifically, the regulations state that “the locking mechanism to be used shall be a device that shall be readily released by staff as soon as possible but in no case longer than within two minutes of the onset of an emergency.”^{xxviii}

Allowing a student to remain in a locked seclusion room for up to two minutes during an emergency—as permitted by current state regulations—raises significant concern about his or her safety.

Findings: Lack of Compliance with Connecticut Law

Pertinent state laws regarding or relevant to the use of seclusion and restraint for children in schools are outlined in the Introduction of this report. OCA’s findings include numerous examples where a child’s educational records failed to demonstrate a school program or district’s compliance with state law.

A. Failure to Comply with State Requirements Regarding Inclusion of Seclusion as a Behavior Intervention Strategy in an IEP

Connecticut law outlines what information must be considered before seclusion may be incorporated into the IEP. In many cases reviewed for this report, these regulations were not followed. Specifically, the law requires that if the PPT determines that seclusion is an appropriate behavior intervention and should be included in the IEP,^{xxix} the decision must be based upon the results of a Functional Behavior Assessment (FBA) and other information determined relevant by the PPT. If such a determination is made, the PPT must include the assessment data and other relevant information which was used as the basis for this decision in the IEP. In cases reviewed for this report, this documentation was often missing.

Robbie is 7 years old. His IEP states that he enjoys classroom jobs and responsibilities. He is eager to please, follows single-step directions, and can answer [who, what, where] questions.” Robbie struggles with tantrum like outbursts . . . [and] difficulty verbalizing the need for a break or a concern he has.” His “social emotional behaviors interfere with his ability to learn. He has weaknesses in all academic areas and is not reading.” R is identified as having “ADD/ADHD.” When he gets frustrated he kicks and hits. Robbie’s IEP does not include direct support or consultation from a behaviorist or social worker. He is provided ½ hour of speech

and occupational support. There is no evidence that an FBA was conducted or that there was any assessment data to support the use of seclusion. The only goal on Robbie’s Behavior Plan is that he will “express anger with non-aggressive words rather than physical actions or aggressive words.” Proposed interventions to support the goal include “seclusion.”

Example of Seclusion used “per Robbie’s IEP”: Robbie was at the “kitchen.” He struck another student. Robbie was separated from the other student and placed in seclusion for 40 minutes.

B. Failure to Comply with State Requirement to Reconvene the Educational Team After More than Two Seclusions as an Emergency Intervention Occur

CT law requires that PPTs reconvene after a student has been secluded as an emergency intervention more than two times in a marking period. A PPT may waive this requirement in writing.^{xxx}

In many cases reviewed for this report, PPTs were not reconvened after repeated emergency use of seclusion, nor was there evidence that the PPT had agreed to waive this meeting as required by law.^{xxxii} The mandate to reconvene is critical to analyzing why a child is struggling and what else can be done to help him or her, with the input of the parent or guardian.

Charlie is 10 year old student with a disability of emotional disturbance who was secluded as an emergency intervention 49 times. No PPT was convened to review these incidents of seclusion or the appropriateness of his IEP.

J is an 11 year old student with a disability of autism who was secluded as an emergency intervention 31 times. No PPT was convened to review these incidents of seclusion or the appropriateness of his IEP.

Most records reviewed did not reflect this waiver or adherence to the requirement to reconvene.

C. Failure to Comply with State Law Requirement that Seclusions Lasting More than One Hour are Specifically Approved in Writing

In several incidents, there was a failure to document that written authorization of the school principal or his/her designee was obtained when incidents of restraint lasted more than one hour, as required by state law.^{xxxiii}

Yanaira is a 10 year old student who was placed by her school district in an out-of-district program. She has an educational disability of emotional

disturbance. Seclusion was indicated as a behavior intervention on her IEP. On 8 occasions, the seclusions lasted more than one hour, specifically, 1 hour and 5 minutes; 1 hour and 10 minutes; 1 hour and 22 minutes and 1 hour and 20, 1 hour 52 minutes, 1 hour 25 minutes, 1 hour 5 minutes and 1 hour and 10 minutes. There was no documentation in the record that written authorization was obtained from the Principal or his/her designee to extend the seclusion for over an hour.

Likewise, a concern was noted that seclusion did not always end when the emergency ended, though again state law only requires that a student's seclusion end when he or she is "composed."

One young student's record indicates he was placed in seclusion and then minutes later was "able to settle." The child remained in seclusion. Fifteen minutes later the record continued to indicate that the child was calm. During this period of time, the child was "coloring," "asked to use the bathroom, [left and came] back." Seclusion continued during this whole period of time.

Given the overwhelming research that seclusion may be traumatic for children, significant concern is raised regarding lengthy isolation, particularly for young children with limited emotional resiliency and communication skills.

D. Failure to Ensure Notifications to Parents of Incidents and to the CSDE of Injuries

In some instances, it was difficult to discern if parents were notified of the incidents of restraint and seclusion.^{xxxiii} In the example below there was no documentation that an injury which occurred during restraint or seclusion was reported to CSDE, as required by law.^{xxxiv}

Per a school's incident report: "Student incurred self-inflicted injuries and the nurse was notified. The school nurse met with [student] and nurse provided appropriate care." The same document states that the emergency safety intervention did not result in an injury necessitating a report to SDE.

Findings: Precursors and Responses to Restraint or Seclusion

Restraints or Seclusions Occurring During or After Seclusion

Research shows that the use of involuntary isolation can actually *escalate* a child's behavior, traumatizing or scaring them. In some cases reviewed for this report, incidents of restraint occurred *after* students had been placed in isolation, whether time-out or seclusion.

Natalie is an 8 year old child who is identified as a student in need of special education due to the disability of emotional disturbance. She was placed in an out-of-district program by her responsible school district. Over the course of five months, she was restrained 26 times and secluded as an emergency 12 times for a total of 38 occurrences of the emergency use of restraint and seclusion. 34 of the 38 uses of emergency seclusion or restraint occurred while the student was already in time out/seclusion.

Javier is a 7 year old child who is identified as a student in need of special education due to being identified as having an Autism Spectrum Disorder. He was placed in an out-of-district program by the school district. On more than 6 occasions, Javier engaged in suicidal gestures or ideation after being placed in seclusion.

Marcus is a 12 year old student, identified as eligible for special education students due to an identified disability of "Other Health Impairment." On numerous occasions after being placed in seclusion for dysregulated or non-compliant behavior, Marcus engaged in self-injurious behaviors: banging his body or his head against parts of the seclusion room.

The repeated examples of children engaging in self-injurious behavior while in seclusion evokes research confirming that seclusion may be harmful and traumatic.

Convening of PPTs in Response to a High Frequency of Restraints

There were several students who had a high frequency of restraints and no evidence that a PPT reconvened to review the adequacy of the child's services or behavioral intervention plan.

Connecticut law does not currently require a PPT to reconvene after repeated use of restraint, though such convening is required for repeated use of seclusion. However, good practice should include a review of restrictive or isolative measures and an assessment of current support strategies. Additionally, the federal Individuals with Disabilities Education Act (IDEA) requires that the student's IEP be reviewed if there is any lack of progress towards the child's annual goals and objectives, to address the child's anticipated needs or "other matters."^{xxxv} A student having to be repeatedly restrained would seem to constitute an "other matter" for which a PPT would convene to review a student's IEP.

Miguel is an 8 year old student with OHI, ADHD/ADD who has been placed by his school district in an out-of-district program. He was restrained 10 times in about a six week time period. A PPT did not

convene to review these incidents. Miguel has significant difficulties in reading, writing and math fluency and is significantly below grade level. His IEP indicates that language difficulties may impact his ability to communicate in the classroom. He also has occupational therapy needs. His FBA indicates that he gets anxious around academics because he thinks he is not good at school.

PART FOUR: RECOMMENDATIONS

As a result of OCA’s review and the concerns present regarding the frequency of restraint and seclusion for children with disabilities and the lack of documented compliance with Connecticut laws, OCA presents the following recommendations to ensure the safety of young children and the restricted use of restraint and seclusion.

During the last two decades many professional disciplines have worked to limit the use of restraint and seclusion for persons with special needs. There are currently several evidence-based strategies to reduce a program’s reliance on restraint and seclusion, that emphasize *leadership, training, ongoing quality assurance, and data-driven positive behavioral supports and interventions.*^{xxxvi}

Connecticut law does not currently require educational programs to employ evidence-based or trauma-informed strategies to reduce these problem behaviors that lead to restraint and seclusion. We can change this, but we must also offer programs the support they need to implement these strategies. In so doing, we must recognize that seclusion and restraint are symptoms of a larger need: improving our collective capacity to support children and their caregivers in identifying and meeting children’s specialized learning, developmental, and mental health needs. Adults may restrain and seclude a child when they don’t know what else to do.^{xxxvii} There is ample research around the country that restraint and seclusion too often lead to harm, including abuse or neglect, and there are a number of effective strategies for positive behavioral interventions that reduce even highly problematic behavior.

These recommendations outlined below are consistent with research and recent approaches being taken around the country.

A. In-Service and Pre-Service

1. That all CT school districts (LEAs), regional education service centers (RESCs), and approved private special education programs (APSEPs) be required to attend a professional development seminar that specifically outlines these laws which govern the use of restraint and seclusion in schools for students with disabilities. It is recommended that this seminar also outline the specific responsibilities of the LEAs, RESCs and APSEPs for the implementation of these laws and regulations. It is recommended that teams from each of these organizations include the

Superintendent of schools for LEAs, the Chief Administrator for APSEPs and the Executive Director from the RESCs as a required member of the team;

2. Most research shows the harmful effects of restraint and seclusion for not only those subjected to the practices, but also for those conducting them.^{xxxviii} Additionally, many students who have experienced trauma in the home experience behavioral problems, which in turn interferes with their education. Educators must receive training and support regarding the effects of trauma on children and their education.^{xxxix} It is recommended that the CT Restraint and Seclusion Interagency Task Force work with the Council for State Personnel Development (CSPD), CSDE, and the State Education Resource Center (SERC) on the development of training for CT educators on the effects of trauma on children's education and on the Six Core Principles for the reduction of the use of seclusion and restraint.^{xl} The goal is for every state educator to receive in-service training in both of these areas by the end of the 2016-2017 school year;
3. That CT's Higher Education Department work with the CSDE in the inclusion of courses on the effects of trauma on children's education and on the Six Core Strategies in all pre-service education programs in CT's universities and colleges by the 2016-2017 academic year. This includes pre-service programs for general educators, special educators, and administrators;
4. That regional trainings in the conducting of FBAs and in the development of BIPS are conducted by SERC during the 2015-2016 school year and that all school districts, APSEPs and RESCs, be required to send at least one representative to one of these trainings. These trainings should be conducted by individuals with expertise in FBA/BIP development.

B. Legislative Changes

5. Protect All Children from Unnecessary Restraint and Seclusion

Ensure state statutes and applicable regulations regarding the use of restraint and seclusion refer to *all* children, and not just children with disabilities. C.G.S. Sections 46A-150 et seq.

6. Prohibit the Planned Use of Seclusion as Part of a Child's Individual Education Plan

As virtually all research confirms potential harmful effects of involuntary seclusion, and there is no research to support the use of seclusion (or restraint) as effective or therapeutic behavior modification techniques,^{xli} CT law should not permit the inclusion of seclusion—differentiated from therapeutic time out from positive reinforcement contingencies—in a child's Individual Education Plan.

To the extent that seclusion and restraint are permitted, it should only be as an emergency intervention.^{xlii} A recent 2013 study conducted by Freeman and Sugai found that a “clear consensus of states believe that restraint and seclusion procedures should be used only as a last resort in cases of emergency.”^{xliii} The duration of restraint and seclusion shall be only until such time as the risk of imminent harm remains.

7. Clarify Prohibition on Life Threatening Restraints

Ensure that existing statutory ban on the use of life threatening restraints specifically references limitations on the use of prone (or face down) restraint or any type of restraint medically contra-indicated for an individual child.

8. Prohibit Use of Non-Medically Prescribed Mechanical Restraint

No mechanical restraints should be permitted unless medically necessary. For instance, certain devices may be prescribed for physical/therapeutic reasons (e.g., Rifton chair for stability).

9. Ensure Seclusion Spaces Unlock in the Event of Emergency

Prohibit the use of locks on seclusion doors unless such locks are pressure sensitive or automatically release in the case of an emergency.

C. PREVENTION AND BEST PRACTICES: Mandatory De-Briefing to Address Use and Prevention of Restraint or Seclusion

10. Debrief and Plan

Require that the educational team, specifically, the PPT if the student is currently identified as in need of special education or has been referred for consideration of eligibility, convene in the event a student has been restrained or secluded more than twice in a thirty-day period. The purpose of convening is to 1) conduct or revise a functional behavioral assessment; 2) create or revise a behavioral intervention plan; and 3) consider referral for special education eligibility, if the child is not currently identified as a student with a disability. The educational team shall include meaningful parental participation, the consultation of a Board Certified Behavior Analyst (BCBA or BCBA-D), and a certified school social worker or school psychologist, or licensed mental health professional.

11. Prevention and Best Practices: Evidence-Based Prevention

A school district or program engaged in the use of restraint or seclusion must also implement evidence-based strategies for positive behavioral supports and the reduction of restraint and seclusion.^{xliv} Such strategies, policies, and practices must be in writing and available on the district or approved program's website and in their policy and procedures manual.

The state should consider requiring evidence-based, tiered prevention and intervention models for encouraging positive behavioral development in all publicly-funded school programs.

12. Leadership Review

School or program leadership must review school-wide restraint and seclusion data on a monthly basis, and send to the superintendent of schools, for the purpose of mutually assessing whether it is necessary or appropriate to modify the school's restraint prevention and management policy, including the need to train staff regarding positive behavioral interventions and supports.

13. Quality Assurance

Data submitted to SDE regarding the use of restraint and seclusion pursuant to P.A. 12-88 shall include confirmation of monthly leadership data reviews and that the laws and regulations regarding restraint and seclusion, including the obligations for parental notification and educational team debriefings, are occurring.

14. Oversight and Support for Schools Through Capacity Building

A unit should be established within the Bureau of Special Education of the CSDE to oversee and support the use of positive behavioral supports and other effective strategies to reduce problem behavior and restraint and seclusion in schools. The SDE will also be charged with reviewing and reporting regarding statewide efforts to 1) reduce restraint and seclusion in schools, and 2) meet the varying developmental and social-emotional needs of children in schools through the use of evidence or research-based instruction, school-wide positive behavioral supports, data collection and reporting, staff training, and capacity building. The unit shall provide feedback and request performance improvement plans from districts or educational programs as necessary and appropriate.

Schools must have the tools they need to implement evidence-based, tiered prevention and response interventions which include an emphasis on social emotional learning and positive behavioral supports. Schools must also have the capacity to skillfully build children's skills in multiple areas of development, with an

emphasis on functional skills and communication. The state must help school districts in this critical capacity building and incentivize and facilitate positive developmental supports from the earliest ages—from birth to three to preschool to kindergarten.

As one step to assist districts in capacity building, OCA advocates for the creation of a Positive Behavioral Supports and Best Practices Committee to advise and support the work of the State Department of Education in the following ways: The committee shall collaborate with the State Department of Education to further the goals outlined in this section, including (1) identify strategies for increasing schools' capacity to effectively meet the needs of children with developmental and social emotional disabilities or learning needs and reduce the use of restraint and seclusion; 2) identify and recommend relevant evidence-based training programs and professional development for school staff; 3) identify federal funding sources that can be leveraged to support statewide implementation of strategies to reduce restraint and seclusion and meet the specialized learning needs of children with varying disabilities; and 4) develop a blueprint and self-assessment tool to guide and assist districts with increasing capacity to meet children's social-emotional, developmental, and other specialized learning needs in a manner that is consistent with best educational practices, maximizes available funding, and is research-based and cost-effective.

The committee may consult with any stakeholders necessary to carry out the provisions of this section, and may request from the State Department of Education such information and assistance as may be necessary to complete its work.

The committee shall report annually regarding progress towards goals of this Section, including recommendations for legislative, regulatory, and budget actions to further reduce the use of restraint and seclusion and meet the needs of children with developmental disabilities and social-emotional learning needs.

The State Department of Education shall provide technical assistance to schools and districts to develop school action plans to reduce the use of restraint and seclusion, disseminate information regarding model protocols and practices, update its website to include all relevant information, including best practices and other information related to the reduction of restraint and seclusion, and host regional trainings for schools and districts.

ⁱ Janice LeBel et al., *Restraint and Seclusion Use in U.S. School Settings: Recommendations From Allied Treatment Disciplines*, 82 AM. J. OF ORTHOPSYCHIATRY 75 (2012); LV Gust and N. Sianko, *Can Policy Reform Reduce Seclusion and Restraint of Schoolchildren*, 82 AM. J. OF ORTHOPSYCHIATRY 91 (2012) (arguing that the use of restraint and seclusions should be eliminated from the school system because of the coercive atmosphere the practices create); Stephan Haimowitz, *Restraint and Seclusion: A Risk Management Guide* (2006), available at <http://www.power2u.org/downloads/R-S%20Risk%20Manag%20Guide%20Oct%2006.pdf> (detailing the harms of restraint and seclusion while providing alternatives of their use); W.K. Mohr et. al., *Adverse Effects Associated with Physical Restraint*,

48 CANADIAN J. OF PSYCHIATRY 330 (2003); L.M. Finke, *The Use of Seclusion is Not an Evidence-Based Practice*, 14 J. OF CHILD AND ADOLESCENT PSYCHIATRIC NURSING 186 (2001). While there is some data that a temporary removal from positive reinforcement can support changes in children's behavior, there is *no* evidence to support the use of involuntary isolation as a therapeutic intervention for children with disabilities.

ⁱⁱ USHHS, *Promoting Alternatives to the Use of Seclusion and Restraint in Mental Health Residential Facilities* (2009). See also W.K. Mohr & J.A. Anderson, *Faulty Assumptions Associated with the Use of Restraints with Children*, 14 J. OF CHILD AND ADOLESCENT PSYCHIATRIC 141 (2001) (perception that seclusion and restraint is beneficial has been challenged and refuted).

ⁱⁱⁱ Public Law 106-310, Children's Health Act of 2000 (Sections 3207 and 3208). These restraint and seclusion requirements amend Title V of the Public Health Service Act (§ 42 USC 290aa *et seq.*) by adding Section 591 and 595. You may access the law online.

^{iv} E.M. Weiss, et al., *Deadly Restraint: A Hartford Courant Investigative Report* (Oct. 11-15, 1998), available at <http://www.charlydmiller.com/LIB05/1998hartfordterms.html>. See also 42 C.F.R. Part 482 – Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights (detailing rights for patients and policies for the use of restraint and seclusion for individuals in a mental health facility).

^v U.S. GOVERNMENT ACCOUNTABILITY OFFICE, SECLUSIONS AND RESTRAINTS: SELECTED CASES OF DEATH AND ABUSE AT PUBLIC AND PRIVATE SCHOOLS AND TREATMENT CENTERS (2009), available at <http://www.gao.gov/new.items/d09719t.pdf> (found that the "highest number of children secluded and restrained were those with disabilities whom the parents had not given consent for these practices").

^{vi} *Id.*

^{vii} *Id.*

^{viii} COMMITTEE ON EDUCATION AND WORKFORCE: DEMOCRATS, SUPPORTS OF THE KEEPING ALL STUDENTS SAFE ACT (May 9, 2013), available at <http://democrats.edworkforce.house.gov/blog/supporters-keeping-all-students-safe-act>.

^{ix} HEALTH, EDUCATION, LABOR, AND PENSION COMMITTEE, *Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficult to Remedy: A Review of Ten Cases* (2014), available at <http://www.help.senate.gov/imo/media/doc/Seclusion%20and%20Restraints%20Final%20Report.pdf>.

There is no evidence that physically restraining or putting children in unsupervised seclusion in the K-12 school system provides any educational or therapeutic benefit to a child. *Id.*

^x The **Ohio** Department of Education Policy on Positive Behavior Interventions and Support, and Restraint and Seclusion, issued directives in 2013 that prohibits the use of restraint or seclusion except when there is an immediate risk of physical harm to the student or others. Every use of restraint or seclusion shall be documented and reported in accordance with the requirements set forth in policy. *Id.* In **Alaska**, the state requires that crisis intervention training for schools be provided and for schools to report incidents of restraint and seclusion and to notify parents that day. Schools may only restrain if child presents imminent danger, less restriction interventions fail, and the individual conducting the restraint has been trained in crisis intervention. Schools cannot use mechanical restraint, restrict child's breathing, or place child on stomach or back. HB 210 – Effective October 2014, <http://www.legis.state.ak.us/PDF/28/Bills/HB0210A.PDF>.

^{xi} Final Regulations on Physical Restraint, 603 CMR 46.00 and 603 CMR 18.00 (2014).

^{xii} For example, **New Hampshire** doesn't allow seclusion for children with disabilities. N.H. REV. STAT. ANN. §§ 126-U:1-126-U:13. In November 2010, New Hampshire enacted a statute restricting the use of physical restraint for all children. N.H. RULES FOR THE EDUCATION OF CHILDREN WITH DISABILITIES §§ 1102.01, 1113.04 - 1113.07. **Georgia** prohibits the use of seclusion and physical restraint in public schools and educational programs except if student is an immediate danger to himself or others or if unresponsive to less intensive behavioral interventions. 160-5-1-.35 –SECLUSION AND RESTRAINT FOR ALL STUDENTS.

^{xiii} US DEPARTMENT OF EDUCATION, RESTRAINT AND SECLUSION: 2012 RESOURCE GUIDE iii (2012), available at <http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf> ("restraint or seclusion

should never be used except in situations where a child’s behavior poses imminent danger of serious physical harm to self or others, and restraint and seclusion should be avoided to the greatest extent possible without endangering the safety of students and staff”). See also Arne Duncan, *Letter from Education Secretary Arne Duncan to the Council of Chief State School Officers (CCSSO)* (2009), available at <http://www2.ed.gov/policy/elsec/guid/secletter/090731.html> (advising that states and schools review their policies on seclusion and restraint in order to reduce their use); U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES: SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES, *THE BUSINESS CASE FOR PREVENTING AND REDUCING RESTRAINT AND SECLUSION USE* (2011), <http://store.samhsa.gov/shin/content//SMA11-4632/SMA11-4632.pdf> (asserts that restraint and seclusion are violent, expensive, largely preventable, adverse events).

^{xiv} IACC (*Interagency Autism Coordinating Committee*) *Letter to the Secretary on Seclusion and Restraint*, Sept. 7, 2011, http://iacc.hhs.gov/publications/2011/letter_seclusion_restraint_090711.shtml#ref6 (last visited Jan. 29, 2015).

^{xv} Signatories include the Department of Developmental Services, the Department of Mental Health and Addiction Services, the Department of Children and Families, the Department of Education, the Office of the Child Advocate, the Office of Protection and Advocacy, and the Connecticut Judicial Branch: Court Support Services Division.

^{xvi} C.G.A. § 46a-150 *et seq.*

^{xvii} C.G.A. § 46a-150 does prohibit the use of “life threatening restraint,” which could include prone restraint. But the statute does not expressly ban prone restraint, whether weight or non-weight bearing in application. Because of this statutory gap, the interagency agreement signed in 2013 and referenced in this introduction, creates a voluntary commitment from signatories to prohibit or limit the use of prone restraint.

^{xviii} CT law requires programs utilizing restraint and seclusion to ensure providers are trained in appropriate restraint techniques and de-escalation strategies. There is no express requirement as to what constitutes an appropriate or effective de-escalation or prevention strategy.

^{xix} CONNECTICUT STATE DEPARTMENT OF EDUCATION, *ANNUAL REPORT ON THE USE OF RESTRAINT AND SECLUSION IN CONNECTICUT: SCHOOL YEAR 2013-2014* (2015).

^{xx} Although OCA only requested records for students in grades K through 5 who had been secluded or restrained during the 2013-14 school year, eight records of students outside of this grade range were submitted and reviewed.

^{xxi} One student accounted for more than 700 of the restraints reviewed and another student accounted for more than 100 reviewed restraints. Many of these restraints were of short duration.

^{xxii} Names changed throughout report to protect identity of students and maintain confidentiality.

^{xxiii} Voluntary seclusion would technically not meet the state statutory definition of seclusion, which presumes that a child is not free to leave confinement without permission. C.G.A. § 46a-150.

^{xxiv} CONNECTICUT STATE DEPARTMENT OF EDUCATION, *IDENTIFICATION AND EDUCATION OF STUDENTS WITH EMOTIONAL DISTURBANCE* 51 (2012), available at http://www.sde.ct.gov/sde/lib/sde/pdf/publications/edguide/ed_guidelines.pdf.

^{xxv} *Id.* at 114.

^{xxvi} There was documentation of assessment by nurse or clinical staff after *some* of these incidents.

^{xxvii} 34 C.F.R. § 300.304 (b) (4).

^{xxviii} R.C.S.A. § 10-76b-8(h)(5) (2012).

^{xxix} R.C.S.A. § 10-76b-8(b) (2012).

^{xxx} R.C.S.A. § 10-76b-8(e)(1) (2012).

^{xxxi} *Id.*

^{xxxii} R.C.S.A. § 10-76b-8(d) (2012).

^{xxxiii} R.C.S.A. § 10-76b-9 (2012).

^{xxxiv} R.C.S.A. § 10-76b-11 (2012).

^{xxxv} 20 U.S.C. § 1414(d)(4)(A) (2004).

^{xxxvi} In a study, Donat reviewed initiatives of a public psychiatric hospital to reduce restraint and seclusion over a 5 year period. These initiatives included “changes in the criteria for administrative review of incidents of seclusion and restraint, changes in the composition of the case review committee, development of a behavioral consultation team, enhancement of standards for behavioral assessments and plans, and improvements in the staff–patient ratio.” Donat found that the most significant variable that lead to a 75% reduction in seclusion and restraint practices was “changes in the process for identifying critical cases and initiating a clinical and administrative case review.” D.C. Donat, *An Analysis of Successful Efforts to Reduce the Use of Seclusion and Restraint at a Public Psychiatric Hospital*, 54 *Psychiatr Serv.* 1119 (2003). Ashcraft and Anthony also found that programs based on strong leadership direction, consumer debriefing, policy and procedural change, staff training, and regular feedback were successful at reducing seclusion and restraint. Ashcraft & Anthony W, *Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services*, 59 *Psychiatr Serv.* 1198 (2008). According to the U.S. Department of Education 2012 Resource Guide, “[b]uilding effective behavioral supports in schools also involves several ongoing interrelated activities, including (1) investing in the whole school rather than just students with problem behavior; (2) focusing on preventing the development and occurrence of problem behavior; (3) reviewing behavioral data regularly to adapt school procedures to the needs of all students and their families; and (4) providing additional academic and social behavioral supports for students who are not making expected progress.” US DEPARTMENT OF EDUCATION, *supra* note xiii.

^{xxxvii} ALLIANCE TO PREVENT RESTRAINT, AVERSIVE INTERVENTIONS, AND SECLUSIONS, PREVENTING THE USE OF RESTRAINT AND SECLUSION WITH YOUNG CHILDREN: THE ROLE OF EFFECTIVE, PROMISING PRACTICES (2011), *available at* http://challengingbehavior.fmhi.usf.edu/do/resources/documents/brief_preventing.pdf.

^{xxxviii} See ALLIANCE TO PREVENT RESTRAINT, AVERSIVE INTERVENTIONS, AND SECLUSIONS, PREVENTING THE USE OF RESTRAINT AND SECLUSION IN SCHOOLS: ADDRESSING A NATIONAL EPIDEMIC THROUGH THE KEEPING ALL STUDENTS SAFE ACT (2014) (“The use of restraint or seclusion poses an inherent risk to the physical safety and psychological health of everyone involved; it is never risk-free.”); STOP HURTING KIDS, *Debunking the Myths of Restraint and Seclusion* (2013), <http://stophurtingkids.com/wp-content/uploads/2013/05/Debunking-the-Myths-about-Restraint-and-Seclusion-in-Schools.pdf> (debunks myths that restraint and seclusion decreases injury for students).

^{xxxix} *The Nonviolent Crisis Intervention Training Program and Positive Behavioral Support*, CIP (2008), *available at* <http://www.crisisprevention.com/CPI/media/Media/Resources/alignments/PBIS-Alignment-2013.pdf> (encouraging forms of nonviolent intervention strategies for children, especially those who have suffered trauma); ALLIANCE TO PREVENT RESTRAINT, AVERSIVE INTERVENTIONS, AND SECLUSIONS, STOP ABUSIVE BEHAVIOR CONTROL: QUESTIONS AND ANSWERS ABOUT APRAIS (2014) (provides suggestions for training for staff to eliminate restraint and seclusion).

^{xl} The 6 Core Strategies Method has been proven effective in decreasing student’s disruptive behavior while significantly decreasing and limiting the use of seclusion and restraint. See Janice Lebel, et al., *An Organizational Approach to Reducing and Preventing Restraint and Seclusion Use with People with Acquired Brain Injury*, 34 *NEUROREHABILITATION* 671 (2014) (“The Six Core Strategies provide a prevention based framework to anticipate challenge, intervene early, and analyze the factors that contribute to maintaining the cycle of violence if S/R is used.”); Kevin Huckshorn, *Six Core Strategies for Reducing Seclusion and Restraint Use* (2006), http://www.nasmhpd.org/docs/NCTIC/Consolidated_Six_Core_Strategies_Document.pdf.

^{xli} See ALLIANCE TO PREVENT RESTRAINT, AVERSIVE INTERVENTIONS, AND SECLUSIONS, *supra* note xxxvii (“All children experience trauma from the use of restraint and seclusion; however, children with significant disabilities are at increased risk if they are not able to fully understand or communicate what happened, how they feel, or report injury or pain as a result of restraint or seclusion. They may acquire post-traumatic stress syndrome or exhibit new challenging or dangerous behaviors.”); US DEPARTMENT OF EDUCATION, *supra* note

xiii (“There continues to be **no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors** that frequently precipitate the use of such techniques.”).

^{xlii} ALLIANCE TO PREVENT RESTRAINT, AVERSIVE INTERVENTIONS, AND SECLUSIONS, PREVENTING THE USE OF RESTRAINT AND SECLUSION WITH YOUNG CHILDREN: THE ROLE OF EFFECTIVE, PROMISING PRACTICES, *supra* note xxxvii, at 5 (“Given the availability of effective alternatives, it is strongly recommended that programs serving young children work to eliminate the use of restraint and seclusion. In the authors' opinion, seclusion should not be used with young children under any circumstances. Restraint should also be avoided, although it is acknowledged that a brief instance of supportive restraint may be necessary under emergency circumstances, such as when a child’s behavior produces immediate and serious risk of injury to the child or others.”); Autism National Committee, *2009 Position on Restraints*, <http://www.autcom.org/articles/Position4.html> (use of restraints should only be done in an emergency situation).

^{xliii} J. Freeman and G. Sugai, *Recent Changes in State Policies and Legislation Regarding Restraint or Seclusion*, 79 EXCEPTIONAL CHILDREN 427 (2013).

^{xliv} OSEP Center on Positive Behavioral Interventions and Supports, *Considerations for Seclusion and Restraint Use in School-Wide Positive Behavior Supports* (2009), http://www.pbis.org/common/cms/files/pbisresources/Seclusion_Restraint_inBehaviorSupport.pdf (arguing that schools should use positive behavioral supports for early intervention to eliminate use of seclusion and restraint in schools); ALLIANCE TO PREVENT RESTRAINT, AVERSIVE INTERVENTIONS, AND SECLUSIONS, *supra* note xxxvii (“There is widespread agreement that the best way to deal with behavioral challenges is to implement a multi-faceted program for: (a) promoting desirable social-emotional behaviors and (b) preventing the development and occurrence of disruptive, violent and other inappropriate responses.”).