

Out of Darkness ...Into the Light



New Approaches
to Reducing the Use
of Seclusion and Restraint
with Wisconsin Children

A joint report from Disability Rights Wisconsin,
Wisconsin FACETS and Wisconsin Family Ties.

SPRING 2009

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ACKNOWLEDGEMENTS

Disability Rights Wisconsin, Wisconsin FACETS and Wisconsin Family Ties wish to thank the following people for their work on this publication. Their efforts were instrumental in the completion of this project: Dianne Greenley, Phyllis Greenberger, Rick Pelishek and Jeff Spitzer-Resnick, Disability Rights Wisconsin; Jennifer Stonemeier, Courtney Salzer and Jan Serak, WI FACETS; Hugh Davis, WI Family Ties; Sarah Mears, Matthew Pesko, and Beth Stockbridge, University of Wisconsin-Madison; Christina Benson, Thor Templin and Carolyn Parkinson, Marquette University Law School.

The authors extend their sincere appreciation and thanks to the parents who shared their stories about the experiences of their children and families in the hope of reaching Wisconsin legislators, other policy-makers and the public about this important issue.

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EXECUTIVE SUMMARY

Out of Darkness...Into the Light New Approaches to Reducing the Use of Seclusion and Restraint with Wisconsin Children

Children with disabilities in Wisconsin schools and treatment settings regularly and needlessly suffer from harmful practices done in a misguided attempt to manage their “challenging behaviors.” They are subject to physical restraints that include being placed in various holds by staff members—adults who sometimes bring a child to the ground face first and pin him or her at the shoulders and legs. Children with disabilities are strapped or tied to chairs or on backboards. They are secluded in locked rooms and, on occasion, deprived of basic needs like food and bathroom breaks.

All of this and more goes on despite research that shows these techniques clearly exacerbate challenging behaviors and do nothing to teach a child appropriate behaviors.

In Wisconsin, children experience seclusion and restraint in schools, residential treatment facilities, psychiatric hospitals, day treatment centers and other programs. Oversight of these practices from state government is insufficient and, too often, the results are tragic.

A Call for Change

Disability Rights Wisconsin, the state’s protection and advocacy agency for people with disabilities, Wisconsin Family Ties, an advocacy and support organization for families of children with emotional or behavioral disabilities, and Wisconsin FACETS, Wisconsin’s parent training and information center, produced and present this report as a call for change. We submit proof of the need for better public policy and state and federal laws that seriously improve the care and treatment of children.

As advocates who work closely every day with and for people who feel the greatest impact from inappropriate use of seclusion and restraint, we offer specific recommendations for strategies that can prevent untold harm to children. Families and children throughout the state also give voice to their experiences in this report.

We summarize information from current literature about the adverse effects of seclusion and restraint on children and outline how other states and programs successfully reduce the use of these measures. The report compares federal law and Wisconsin laws and regulations to progressive laws in other states.

Depending on the setting, Wisconsin’s laws regarding seclusion and restraint of children are nonexistent or out of date. There is no state law or regulation governing the use of seclusion or restraint in public or private schools. A Department of



Angellika died in May 2006 from complications associated with chest compression asphyxiation, the result of restraint use at a day treatment center in northwestern Wisconsin.

Public Instruction directive is the only “order” on the books and it does not have the force of law or sufficient enforcement. The state law that governs the use of seclusion and restraint in residential and community treatment facilities dates to the mid-1970s.

As discussed here, we know much more about the adverse effects of seclusion and restraint use on children and there is dramatic change in the standard of care regarding use of these measures.

Studies Document the Consequences

Numerous studies and cases document the harsh consequences of seclusion and restraint use. Children, including a 7-year-old Wisconsin girl, have died as the result of restraint use. Others have suffered physical injuries, such as broken bones, and psychological harm, including post-traumatic stress disorder.

Research shows that seclusion and restraint use fails to teach a child more appropriate behavior. It also interferes with their chance to develop trusting relationships with school and program staff members.

During the summer and fall of 2008, 26 families responded to a survey conducted by Disability Rights Wisconsin, Wisconsin Family Ties and Wisconsin FACETS. We asked these families to share their stories and concerns about seclusion and restraint use in schools and residential and community treatment programs.

The majority of responses described seclusion and restraint use in schools. School districts reported as having applied seclusion and restraint on children ranged from small rural districts in the far northern part of the state to large urban and suburban districts in southeastern Wisconsin. We also received reports of seclusion and restraint use in one of the state’s mental health institutes, in day treatment programs, a day-care center and residential treatment facilities. The children ranged in age from 3 to 17 years old, and most were in elementary and middle school. Diagnostically, the majority of the children have an Autism Spectrum Disorder. The second largest group has significant mental health problems such as bipolar disorder, ADHD, anxiety or depression.

When parents learned about the seclusion and/or restraint use with their children, many reported feeling “angry,” “horrificed,” “scared,” “frustrated,” and “extremely upset.” They reported seeing a range of effects on their children as a result of the seclusion and/or restraint—including physical injuries, extreme mental health problems, like a suicide attempt and psychosis requiring hospitalization, the development of post-traumatic stress disorder, loss of trust in school and staff, fear of small places, social regression, self-injurious behavior and fear of adults. A number of children needed psychological counseling to help them deal with these issues.

New Models of Intervention

A growing body of experience and literature promotes alternative ways to address challenging behaviors in children and decrease seclusion and restraint use. The Child Welfare League of America (CWLA) developed an approach that incorporates key strategies under seven headings:

- Family involvement
- Supportive leadership
- Consumer-centered organizational culture
- Written policies, procedures and practices
- Staff training
- Reforming the treatment milieu
- Continuous quality improvement.

In addition to these strategies, there is also growing consensus in the literature that Positive Behavioral Interventions and Supports (PBIS) are an effective way to prevent problem behaviors that lead to seclusion and restraint measures. Among supports defined as PBIS are reinforcement of appropriate behaviors, active teaching, clear communication of rules, consistent provision of corrective consequences, and ongoing monitoring of data about student behavior.

Given the significant numbers of children with histories of trauma and violence in their lives, it is critical to develop trauma-informed and sensitive approaches. Trauma-informed care is built on an understanding of the role of trauma and violence in the lives of children and their families.

Strategies seek to do no further harm, to create and sustain zones of safety for children, and promote coping, resilience, strengths-based programming, growth and healing. Failure to recognize the effects of trauma and its impact on behavior creates a situation where programs may retraumatize children through the use of punishment, restrictive measures, multiple placements and inappropriate programming.

At least 20 states have legislation or administrative rules that regulate the use of seclusion and restraint in schools. Wisconsin is not one of them. In addition, there is no federal law governing the use of seclusion and restraint in schools.

Federal legislation does govern seclusion and restraint use in hospitals and certain residential treatment programs. Wisconsin's patient rights law also regulates use of these measures, but it is more than 30 years old and does not meet current standards of care.

What Needs to be Done...Now

Based on the information in this report, Disability Rights Wisconsin, Wisconsin Family Ties and Wisconsin FACETS urge Wisconsin lawmakers and other policy makers to act **now** before more children die or are permanently scarred by the oppressive use of seclusion and restraint. Specifically, we recommend passage of federal and state laws governing seclusion and restraint use in schools. We also advocate substantial revision of Wisconsin's existing law on the use of seclusion and restraint in treatment settings. Changes in law and policy must include these actions:

- Develop programs and policies that emphasize Positive Behavioral Interventions and Support programs for children in schools and residential and community treatment programs;
- Require evidence-based training for staff in schools and treatment programs that

teaches them about Positive Behavioral Interventions and Supports, crisis de-escalation, trauma-informed care, and ways to reduce the use of seclusion and restraints;

- Develop a policy on crisis management and regulation of the use of seclusion and restraint by each school/facility that uses these measures;
- Limit the use of seclusion and restraint to situations where a child's behavior presents an imminent danger of serious physical harm to self or others;
- Provide prompt notification to parents whenever these measures are used;
- Require documentation and reporting of each episode to school/agency administrative and supervisory personnel, parents and the appropriate state agency with oversight;
- Specify who is authorized to allow the use of seclusion or restraint, dictate the length of time these measures are used, the required monitoring and documentation, and implementation of other safety procedures;
- Require mandatory debriefing after each use of seclusion or restraint, including discussion of strategies to prevent future use; and
- Institute data reporting to state oversight agencies and meaningful enforcement mechanisms for use by these agencies when violations of the law occur.

The authors of this report believe all children with disabilities have the right to grow up free from the use of restraint, seclusion or coercive interventions to control their behavior. Wisconsin must act now to replace existing outmoded measures with positive approaches that do not harm children and lead to better long-term outcomes.



Bruising injuries alert parents

Calvin is a child with autism who experienced the use of restraints in both school and treatment settings. When his parents noticed bruising on his arms and chest, they questioned school administrators about unauthorized restraint use. The school subsequently changed its approach and eliminated restraints. In a similar incident at a mental health institute, staff members attributed the boy's bruises to self-injury. The injuries ceased once Calvin's parents confronted those in charge and demanded better documentation of the practices used with their son.

Outlining the Problem of Seclusion and Restraint Use

Children with disabilities in Wisconsin schools and treatment settings regularly and needlessly suffer from harmful practices done in a misguided attempt to manage their “challenging behaviors.” They are subject to physical restraints that include being placed in various holds by staff members—adults who sometimes bring a child to the ground face first and pin him or her at the shoulders and legs. Children with disabilities are strapped or tied to chairs or on backboards. They are secluded in locked rooms and, on occasion, deprived of basic needs like food and bathroom breaks. All of this and more goes on despite research that shows these techniques clearly exacerbate challenging behaviors and do nothing to teach the child appropriate behaviors.

The time has come to bring this practice out of darkness and into the light, to develop better ways of serving children with disabilities.

Their Stories Tell a Hidden Truth

The children’s stories tell a hidden truth about the use of seclusion and restraint in Wisconsin schools, residential treatment facilities, psychiatric hospitals, day treatment centers and other programs: Those in charge impose these harsh practices with little meaningful oversight from state government and, too often, the results are tragic.

This report recounts what many children experience and makes recommendations about how to improve the treatment of children with disabilities and **decrease** the use of seclusion and restraint.

Angie’s story goes to the heart of the issue. A 7-year-old girl with emotional problems due to severe abuse and neglect, Angie died on May 26, 2006, from injuries she received when restrained at Northwest Counseling and Guidance Center in Rice Lake, Wisconsin. Staff at Northwest Counseling restrained Angie on at least nine separate occasions for a total of approximately 14 hours during the month she attended the center. An autopsy ruled her death a homicide by asphyxiation leading to cardiopulmonary arrest from a physical restraint used by a staff member. During previous restraint experiences, Angie complained of dizziness, pain in her legs, ankle and thighs, and eye pain. She did not receive medical evaluation following those restraints.

The treatment Justin received testifies further to the need for change. Justin is diagnosed with autism, speech and language disorders, and fine motor skills de-

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ficiencies. Teachers in the small-city middle school he attended had approval to use a time-out room for brief periods. His parents found out later that Justin experienced long periods of seclusion several times a day. They also learned that staff members used restraint holds on him without their permission. One episode resulted in a broken elbow, with multiple breaks requiring immediate medical attention. Justin's parents believe the seclusion and restraint experiences partly influenced his negative behaviors and say he continues to show aggression and apprehension around others.

Recognize the Unknown

Many other children like Angie and Justin experience seclusion and restraint in Wisconsin's public schools, and residential and community treatment facilities each year. It is unknown how many because there are no legal requirements that the programs report this information to state oversight agencies or, in some cases, even keep this data.

Advocacy organizations for children with disabilities receive calls regularly from parents who report instances of their children placed in locked rooms and/or physically restrained by adults. Many do not realize at first that their children routinely experience such treatment. The situation is made worse by the innocuous terms that describe these practices. Restraints sometimes are referred to as "behavior management techniques" and seclusion rooms identified as "time-out rooms," "safe rooms" or "cool-down rooms."

Parents often learn about these actions inadvertently because there are few legal requirements for notifying them. Instead, they become aware because a concerned staff member takes the time to inform them, or parents might notice a change in their child's behavior—a fear of being in a confined space, pulling away when touched or reluctance to go to school.

Inadequate State Laws

Depending on the setting, Wisconsin's laws regarding seclusion and restraint of children are nonexistent or out of date. There is no state law or regulation governing the use of seclusion or restraint in public or private schools. A Department of Public Instruction directive is the only "order" on the books and it does not have the force of law or sufficient enforcement. The state law governing the use of seclusion and restraint in residential and community treatment facilities dates to the mid-1970s.

Meanwhile, many more facts about the adverse effects of seclusion and restraint use on children have come to light nationally and there has been dramatic change in the standard of care regarding the use of these measures.

Call for Change

Out of Darkness...Into the Light is a call for change in the use of seclusion and restraint on Wisconsin children. Disability Rights Wisconsin, the state's protection

and advocacy agency for people with disabilities, Wisconsin Family Ties, an advocacy and support organization for families of children with emotional or behavioral disabilities, and Wisconsin FACETS, Wisconsin's parent training and information center, researched and developed the report to illuminate the facts behind an issue of fundamental rights and human dignity. We present our findings here as proof of the need for better public policy, and state and federal laws that seriously improve the care and treatment of children.

Specific recommendations in this report offer real strategies for preventing harm to children from inappropriate use of seclusion and restraint. Importantly, it gives voice to families and children across Wisconsin who experience seclusion and restraint.

The report also contains a review of current literature about the adverse effects of seclusion and restraint on children and surveys how other states and programs succeeded in reducing the use of these measures. In addition, we review federal law and Wisconsin laws and regulations, and compare them to progressive laws in other states.

We define the term **seclusion** in this report as “the involuntary confinement of a child alone in a room or area from which he or she is physically prevented from leaving.” **Restraint** is defined as “any physical hold or apparatus that interferes with the free movement of a child’s limbs and body.”

What Needs to Be Done...Now

Based on the information in this report, Disability Rights Wisconsin, Wisconsin Family Ties and Wisconsin FACETS urge Wisconsin lawmakers and other policy makers to take action now before more children die or are permanently scarred by the oppressive use of seclusion and restraint. Specifically, we recommend passage of federal and state laws governing seclusion and restraint use in schools. We also advocate substantial revision of Wisconsin's existing law on the use of seclusion and restraint in treatment settings. Changes in law and policy must include these actions:

- Develop programs and policies that emphasize Positive Behavioral Interventions and Support programs for children in schools and residential and community treatment programs;
- Require evidence-based training for staff in schools and treatment programs that teaches them about Positive Behavioral Interventions and Supports, crisis de-escalation, trauma-informed care, and ways to reduce the use of seclusion and restraint;
- Develop a policy on crisis management and regulation in the use of seclusion and restraint by each school/facility that uses these measures;
- Limit the use of seclusion and restraint to situations where a child's behavior presents an imminent danger of serious physical harm to self or others;
- Provide prompt notification to parents whenever these measures are used;
- Require documentation and reporting of each episode to school/agency administrative and supervisory personnel, parents and the appropriate state

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agency with oversight;

- Specify who is authorized to allow the use of seclusion or restraint, dictate the length of time these measures are used, the required monitoring and documentation, and implementation of other safety procedures;
- Require mandatory debriefing after each use of seclusion or restraint, including discussion of strategies to prevent future use; and
- Institute data reporting to state oversight agencies and meaningful enforcement mechanisms for use by these agencies when violations of the law occur.

The authors of this report believe all children with disabilities have the right to grow up free from the use of restraint, seclusion or coercive interventions to control their behavior. Wisconsin must take action to ensure that Angie's story, Justin's story and the stories of other children featured in this report never occur again. Nothing less than the long-term health and well being of our children are at stake.

The Effects of Seclusion and Restraint on Our Children and Youth

Parents across the state entrust their children's care, education, treatment and protection to educators, paraprofessionals, mental health professionals and other treatment facility staff. Children in Wisconsin subject to seclusion and restraint practices instead face the risk of physical injury, psychological harm and death in settings where their parents expect them to be safe. School and treatment staff members often use seclusion and restraint in the hope such measures will reduce episodes of unwanted behavior. On the contrary, research shows children learn nothing about appropriate behavior when secluded or restrained.

Among all individuals with disabilities, children especially are subject to these unsafe practices. Not only do children as a group experience more exposure to seclusion and restraint, they do so at a greater risk for injury.⁵ There also is considerable variation in how seclusion and restraint is applied,⁶ and the decision to use these measures "nearly always is arbitrary, idiosyncratic, and generally avoidable."⁷

Furthermore, staff members working together often disagree about whether or not to use seclusion and restraint in certain situations, perhaps as a result of inadequate training or lack of consistent statewide requirements. Especially troubling is the fact that inexperienced professionals consistently make the most restrictive recommendations in terms of seclusion and restraint.⁸

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Tracking the Consequences

Numerous studies show the harsh consequences of seclusion and restraint use. We explore the data behind the most serious results to help quantify the immeasurable human cost of these activities.

- **Death** The most serious consequence of seclusion and restraint practices is the very real prospect of death. It is widely estimated that between 50 to 150 deaths occur in the United States each year due to seclusion and restraint.⁹ The U.S. General Accounting Office (GAO) says the full extent of the risk is unknown because there are no mandated reporting systems.¹⁰ Knowledgeable advocates question how dangerous specific restraint positions are. For example, the prone restraint is found to be a "hazardous and potentially lethal restraint position."¹¹ Death as a result of seclusion or restraint tactics also results from dehydration, choking, asphyxiation, strangulation, cardiac arrest and blunt trauma.¹²

Where professionals once considered seclusion and restraint therapeutically useful, it is now a consensus that none of the theories supporting the utility of restraint and seclusion received careful and systematic empirical evaluation.

• **Physical Injury** Excessive amounts of physical injury occur during seclusion and restraint encounters, to both the children *and* staff members. The Child Welfare League of America conducted an extensive study at seven sites and found that children suffered physical injury in 3.8 percent of all reported emergency physical interventions, 4 percent of seclusion incidents, 3.5 percent of physical restraint incidents and 8.8 percent of mechanical restraint incidents. Staff members also sustained injuries in 6.6 percent of all emergency interventions.¹³ Telling evidence of this consequence appears in the pages of a risk management guide sent to behavioral health facilities and risk managers. It states: “Each use of restraint or seclusion poses an inherent danger, both physical and psychological, to the individual who is subject to the interventions and, frequently, to the staff who administer them.”¹⁴

One young student in a suburban school district in Wisconsin experienced restraint procedures at school that were not part of an Individualized Education Program (IEP) or Behavioral Intervention Plan (BIP). The parents knew about the restraint but not that it was used for hours at a time on their son. When they noticed bruising of his arms and chest, they intervened with the school administration.¹⁵

• **Psychological Harm** Literature on the subject makes clear the psychological harm children suffer who experience seclusion and restraint. Children report nightmares, intrusive thoughts, avoidant responses and mistrust, even *five* years after the experience.¹⁶ In a survey of patients transferred out of a hospital, those who encountered instances of seclusion and/or restraint were more likely to say they did “not want to go back to the hospital,” compared to those who did not experience seclusion or restraint.¹⁷ Qualitative interviews of these patients describe vicarious trauma, staff alienation and direct trauma.

Even more troubling is the use of seclusion and restraint with children who have a history of past traumas, such as physical or sexual abuse. A review of patient histories found that exposure to traumatic events severely enhances the risk of harm from seclusion and restraint by as much as seven times. Clinicians view these experiences as revictimization and retraumatization during inpatient treatment.

Finally, where professionals once considered seclusion and restraint therapeutically useful, it is now a consensus that none of the theories supporting the utility of restraint and seclusion received careful and systematic empirical evaluation.²⁰ The prevailing thought now is there exists no evidence whatsoever that such measures have therapeutic value.

Several seclusion examples help depict the potential of its negative impact on children and young people. Six students with disabilities experienced episodes in locked seclusion rooms with lights turned off in a rural Wisconsin school district in 2005. Katie was one of the students and her story illustrates the psychological harm that can occur. A staff aide at the school went on record as saying: “No one was outside the door and the door was locked with a deadbolt on the outside. I could hear Katie crying and kicking the wall inside... I found Katie curled up in the fetal position behind the door, in the dark.”²¹

One parent describes the room at a rural Wisconsin school where teachers secluded her elementary-aged son as a “dungeon.” It was a 10 x 6-foot concrete room

locked and boarded on the outside. Teachers did not conduct periodic observations to check on the student's welfare, forcing him to urinate and defecate on the floor for lack of a bathroom. The parent says her son continues to avoid locked rooms and has nightmares of the experience. He has since been diagnosed with a post-traumatic stress disorder.²²

• **Fail to learn appropriate behavior** Some professionals may consider seclusion and restraint a sound practice for eliminating future aggression and violence. The truth is that overall, 50 to 81 percent of seclusion and/or restraint episodes happen to children who experience them repeatedly, demonstrating that the practice does not change behavior.²³ In a series of classroom observations, researchers found that physical restraint applied in direct response to specific problem behavior only increased the rates of those behaviors.²⁴ Finally, the results of a thorough investigation of schools in California showed the behaviors prompting use of seclusion and restraint rarely posed an imminent risk of serious physical harm.²⁵

Rather than seclusion and restraint, children with serious communication, social and behavior challenges need constructive, research-based approaches founded on Positive Behavioral Interventions and Supports. This approach examines the underlying causes of a child's behavior and designs positive interventions that help the child learn effective, appropriate ways to behave and interact with others.²⁶ More than two decades of research show there is strong evidence of positive alternatives for addressing serious behavior challenges—like self-injury, aggression and property damage—effectively.

• **Impede development of trusting relationships with staff** A growing body of research indicates that trusting relationships are a prerequisite to therapeutic efficacy and learning. In fact, scholars across a wide spectrum now conclude that, “relationships, in effect, are the intervention.”²⁷ “Youth . . . who survive the system keep reporting the same thing: The most valuable memory they carry with them . . . is their relationship with a particular . . . staff member . . . who helped them through a tough scenario.”²⁸

Many children who exhibit challenging behaviors have been subject to physical or psychological trauma. “Unfortunately, the defining experiences of [these children] is that of feeling unsafe. [They] develop a pervasive mistrust of the adults with whom they interact. It stands to reason then, that the first imperative in working with these children is creating a safe place for them.”²⁹ Children who experience seclusion and restraint often lose their trust in adults and feel unsafe in a school or other environment. As a result, they miss the therapeutic opportunity of developing a trusting relationship with staff members responsible for their care and safety.

Children who experience seclusion and restraint often lose their trust in adults and feel unsafe in a school or other environment. As a result, they miss the therapeutic opportunity of developing a trusting relationship with staff members responsible for their care and safety.

Telling the Stories: Seclusion and Restraint Use in Wisconsin

Disability Rights Wisconsin, Wisconsin Family Ties and Wisconsin FACETS developed a questionnaire on the use of seclusion and restraint in Wisconsin to gain a better understanding of the problem through the experiences of families and children across the state. We distributed the survey to families at various conferences and meetings and over the Internet. Appendix A of this report includes a copy of the survey tool.

The questionnaire gathered information, including:

- Profiles of individual children, their age and disability;
- Where the use of seclusion or restraint reportedly took place and how these measures were used;
- Whether an IEP, Behavior Intervention Plan or treatment plan included the use of seclusion or restraint;
- How the parents learned of the use and their reactions when they did;
- What impact the measures had on the child;
- Whether the parents knew if the school or treatment center kept records, if the program had a policy on the use of seclusion or restraint, or made any attempts to measure the impact of the use on the child;
- Whether there were any complaints filed and if so, what was the outcome.

This is not a scientific survey and we did not ask the schools or treatment facilities to corroborate the stories. Instead, the stories illustrate the experiences of a significant number of families from across the state and provide important perspective on the issue of seclusion and restraint use.

Survey Responses: Snapshot of Concern and Anger

During the summer and fall of 2008, 26 families responded to the survey, sharing their stories and concerns about use of seclusion and restraint in schools and residential and community treatment programs. The vast majority of responses concern instances of these measures practiced in schools. School districts those parents reported as having applied seclusion and restraint on their children ranged from small rural districts in the far northern part of the state to large urban and suburban districts in southeastern Wisconsin.

Respondents also reported about the use of seclusion and restraint in a state mental health institute, in day treatment programs, a day-care center and resi-

When parents learned about the seclusion and/or restraint use with their children, many reported feeling “angry,” “horrified,” “scared,” “frustrated” and “extremely upset.”

Kyle



Angellika

dential treatment facilities. The children ranged in age from 3 to 17 years old. Most of them were in elementary and middle school.

The majority of the children profiled in survey responses have the diagnosis of an Autism Spectrum Disorder. The second largest group has significant mental health problems such as bipolar disorder, ADHD, anxiety or depression. Many of the children were diagnostically complex.

When parents learned about the seclusion and/or restraint use with their children, many reported feeling “angry,” “horrified,” “scared,” “frustrated” and “extremely upset.” Parents reported seeing a range of effects on their children as a result of seclusion and/or restraint use. These include extreme mental health problems, like a suicide attempt and psychosis requiring hospitalization, the development of post-traumatic stress disorder, loss of trust in school and staff, fear of small places, social regression, self-injurious behavior and fear of adults. A number of children needed psychological counseling to help them deal with these issues.

Close-Ups: Inside the Issue of Seclusion and Restraint Use

What follows is a summary of stories taken from the surveys. We identify the children by a first name only or, in some cases, by a different name to protect confidentiality.³⁰ We also removed the names of school districts, treatment programs and staff members identified in the responses in order to focus on the children and the issues. (See Table 2 in Appendix B for a compilation of information from the surveys.)

KYLE has a diagnosis of autism. He experienced the use of restraints from kindergarten through fifth grade at a suburban school. His mother believes he was restrained one-to-two times per week, including being physically held down on a mat by a male teacher. In middle school, he was secluded in a room with a pressure lock. Kyle’s IEP (Individualized Education Program) specified the use of “time out” only in response to aggressive episodes for a period of five minutes, or until he calmed down. His parents discovered Kyle actually underwent seclusion for approximately 75 percent of the day, on a daily basis. His mother reports her son exhibits increased anxiety, a decrease in social skills and more difficulty working due to the seclusion.

TEAG has autism, seizures and cognitive disabilities. He attends high school in a mid-size Wisconsin city. When Teag started coming home with bloody knuckles at the age of 17, his parents asked for a copy of his behavioral file. School authorities told them that when Teag became uncontrollable in the classroom, the teacher placed him in a seclusion room. Described as a “carpeted closet,” the room is a 5 x 5-foot space without windows or a doorknob. His parents discovered that Teag bit his knuckles as a way to deal with his frustration at school. They report he uses biting as a coping method to this day.

ANGELLIKA was an outgoing, fun little girl who was happy most of the time. She was described as “very sweet and loving.” Angie also struggled with emotional and

behavioral problems brought on by significant neglect, physical abuse and sexual abuse, and exacerbated by numerous out-of-home placements. In April 2006, she began receiving services at a day treatment facility in Rice Lake. Less than two hours into her first day at the facility, staff members placed Angie in a prone restraint for 85 minutes. Over the next few weeks, she spent at least 20 hours in seclusion and 14 hours in prone restraint. On May 25, 2006, Angie became unresponsive while in restraints. She died the following day, age 7.

DONOVAN has bipolar disorder, cognitive delays, learning disabilities and sensory dysregulation. He experienced numerous restraints and seclusion at a suburban school when he was 7 years old. After discovering this fact in the fall of 2001, Donovan's mother wrote a formal letter demanding the school stop using such techniques on her son. Nonetheless, following Thanksgiving break, school authorities placed Donovan in a 4 x 4-foot white room with fluorescent lights and a desk. During the first day, he received three bathroom breaks and remained in the room during lunch where he ate by himself. The plan was scheduled to last the full week, but Donovan was so traumatized from one day of seclusion, he deteriorated quickly. The boy became psychotic and unable to sleep. He threatened to kill his family and told his mom he needed to go to the hospital, saying, "You can't keep me safe." After waiting five days for a bed to open at a hospital, Donovan was admitted for two weeks. It took him another three months to recover from the episode and for several months afterwards he protested vehemently returning to the school. He still struggles to trust the school.

CHRISTINA has an emotional/behavioral disorder label. She experienced frequent use of restraint at a mental health day treatment facility in a rural part of the state when she was 11 years old. Two staff members either held Christina in a chair or placed her face down on the floor with one staff member on each side of her and another sitting on her back to hold her down. These measures lasted from minutes to hours depending on how long it took for Christina to calm down. Christina reports feeling scared and traumatized from these restraint measures. She also feels confused because staff members put her in restraint for non-aggressive behavior like swinging her feet, talking or fidgeting. Christina started to receive counseling as a result of these restraint procedures.

ZACHARY has autism and is non-verbal. He participates in an early childhood special education program at an urban elementary school. At age 3, Zachary experienced being restrained in a Rifton chair for up to 45 minutes a day out of a three-hour school day. A Rifton chair has a belt and is designed for children who need support to sit. Zachary's parents feel their son suffered trauma from this use of restraint. He fears adults now and does not trust school staff members. His mother filed a complaint about her son's treatment with the Department of Public Instruction. After an investigation, DPI ordered the school district to stop using the chairs for behavioral restraint and to obtain teacher training about positive behavioral interventions, crisis intervention, autism and appropriate use of seclusion and physical restraint.

Donovan



Zachary

CALVIN is a child with autism. He experienced the use of restraints from age 6 to 7 at a suburban elementary school. His parents knew about the practice but were unaware it was used as long as an hour at a time. When they noticed bruising on Calvin's arms and chest, they quickly intervened and the school switched to "cool-down" strategies without restraints. The boy's parents also believe he was restrained at a mental health institute, receiving full-body bruises as a result. According to Calvin's parents, the bruises and finger marks did not reappear after they discussed the situation with the facility and insisted on better documentation.

Calvin



JENNA is 16 years old and has bipolar disorder, ADHD, anxiety and depression. She has experienced seclusion and restraint at various treatment facilities throughout her life. In one instance, her parents report, Jenna was secluded in a room for 24 hours straight during a placement at a mental health institute. At a mental health care crisis center in September 2006, staff members placed her in four-point restraints (mechanical restraint of both arms and legs at once) for two hours. While at a day treatment program from June 2005 to January 2006, Jenna routinely experienced both "half downs" and "whole downs" as part of her treatment. In a "half down," the girl had to sit in a chair bent forward at her waist while staff members held her arms straight out from her sides. They placed her face down on the floor for a "whole down" and positioned themselves across her shoulders and the backs of her knees. The use of such restraint procedures left Jenna feeling a loss of self-esteem. She also suffers from post-traumatic stress disorder, and chronic back pain.

JACOB has an anxiety disorder and experienced restraint measures on a weekly basis during kindergarten and first grade at a suburban school. He frequently came home crying, saying that the teachers "put his face in the dirt" while stating, "it was for his own good." Following a restraint episode, Jacob often was reluctant to go back to school. His parents suggested alternative non-coercive measures to address his behavior, but school administrators did not act on their request. Jacob's mother reports that when she filed a complaint about mistreatment of her son by a certain teacher, the state sided with the school and the teacher, in turn, called county social services to investigate her. The following year, the school used fewer restraints and Jacob's behavior markedly improved.

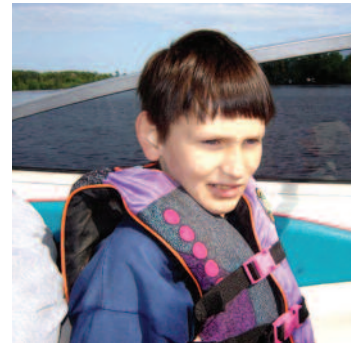


Deven

DEVEN is diagnosed with pervasive developmental disorder, bipolar disorder, anxiety disorder and ADHD. He experienced the use of seclusion and restraint at two different rural elementary schools when he was 10 to 12 years old. In one situation, his grandmother discovered that staff members laid on Deven until police arrived. The police then handcuffed him and bound his legs with duct tape. His grandmother feels because of this treatment, other kids see Deven as "crazy" and ostracize him. Deven also experienced seclusion while at a residential treatment facility where staff members locked him in an empty room. Deven receives psychological treatment to help him recover from the trauma of these experiences. His grandmother reports that Deven continues to distrust and fear adults in school settings, and also fears treatment facilities.

NILES is a 13-year-old boy with autism, a non-verbal learning disability and seizure disorder. Against his mother's wishes, Niles is subject to seclusion procedures at a rural middle school. Teachers seclude him with increasing frequency in a room with a tile floor, a ceiling light and a hard wooden door with a small window. The only furniture in the room is a mat or a beanbag chair. Niles' mother feels her son would not need seclusion if the staff used methods to calm him during intense times. She reports that Niles is increasingly more aggressive and anxious about small places. The boy also lost interest in activities he once enjoyed, like playing at the Burger King playground.

Niles



CHELSEA experienced seclusion and restraint numerous times at a mental health institute and residential care center between the ages of 14 and 17. Her parents describe the encounters as "take downs, [isolation in a] seclusion room, and restraint board with straps." They say staff members applied these measures on average two to three times per week. Seclusion and restraint policies at each place state that the facility uses such measures only in an emergency, if a resident is a danger to herself or others. Both Chelsea and her parents feel she was put into seclusion and restraint because of "noncompliant behavior" not emergency situations. Chelsea reports these measures left her feeling angry and scared.



Chelsea

FRANK has a complex diagnosis of ADHD, bipolar disorder, autism, ODD, RAD, Post-Traumatic Stress Syndrome and, most recently, traumatic brain injury. Frank experienced seclusion from first to third grades. His teachers secluded him for hours or half days in a room described as a "carpeted closet." When asked, Frank's parents gave verbal permission for the school to use seclusion, believing the teachers were "the experts." As a result, they knew at the time their son was subject to seclusion but did not learn until later to what extent or about the deteriorating conditions of the over-used seclusion room.

JUSTIN has a diagnostic label of autism. While attending middle school in a small Wisconsin city, Justin experienced periods of seclusion in a time-out room—a measure his parents authorized for brief periods. They learned instead that he was secluded for long periods of time, several times per day. They also discovered that school staff members used restraint holds without their permission. Justin's elbow was broken in multiple places during one restraint episode, requiring immediate medical attention. Justin's parents believe the seclusion and restraint experiences partly influence his negative behaviors now. They note he continues to show aggression and apprehension around others.



Frank

ANDREW is a child with Asperger Syndrome and ADHD. His IEP when attending a suburban middle school specified the use of a safe room or quiet space when he became upset. His grandmother reports that instead of following these provisions, an adult who was not on the school staff tackled Andrew to the floor, took him into a room and bullied him. The confrontation resulted in scrapes and bruises on the boy's arms and psychological harm, for which he is now receiving therapy. Andrew expresses fear now at going to a "big school" because of the wide

halls, the confusion and ridiculing peers. The experience makes his transition to high school uncertain. He currently attends a therapeutic day school where he has been successful.

BENJAMIN has diagnoses of Lennox-Gastaut Syndrome, cerebral palsy and autism. He attends a rural middle school where, during his sixth-grade year, staff members restrained Benjamin in a wheelchair for entire school days despite the fact that he is ambulatory. The staff promised to use the practice only for “extreme fatigue,” but each time his parents visited the school, Benjamin would be in the wheelchair. He became agitated at times and tried to get out of the chair because he did not want to be restrained. According to his parents, the school district tried limiting their visitation to the school to prevent them from learning if Benjamin was restrained.

Billy felt scared, angry, unsafe and distrustful of staff. He was embarrassed and traumatized by the experience, and is fearful now of being in small rooms with the door closed.

SAM has autism and epilepsy. He experienced multiple restraint procedures at a rural school when he was an adolescent. School authorities restrained Sam frequently for non-compliance or acting on an obsession or compulsion, like touching a button on the teacher’s shirt. Staff members forced him to the floor and held his arms and legs. The use of restraint caused Sam’s behavior to deteriorate and increased the incidence of restraint. His mother reports that Sam showed more aggression at school and at home, often crying and seeking consolation. He continues to fear the room and the teachers involved in the restraint measures. Sam also suffers long-term effects from the experience, such as post-traumatic stress disorder and depression.

BILLY has autism, apraxia and is non-verbal. When he was 9 years old, school authorities kept Billy in a seclusion room for the entire school day under the supervision of a school aide. His parents describe the room as a “storage closet” with metal shelving, a mat on the floor and no ventilation. Billy felt scared, angry, unsafe and distrustful of staff. He was embarrassed and traumatized by the experience, and is fearful now of being in small rooms with the door closed. His parents transferred Billy to a new school because of this experience. Unfortunately, the new school wrote restraint usage into Billy’s IEP without his parents’ understanding; they thought that “crisis prevention intervention” meant action taken in the case of a fire or tornado. A visitor to the school observed a non-certified aide applying restraints to the boy and informed his parents.

JOE has post-traumatic stress disorder, ADHD and bipolar disorder. Before his diagnosis, Joe’s mother reports he was subject to seclusion in his elementary school to a degree she was not aware. She describes the seclusion room where her son was placed as a “dungeon”—a 6 x 10-foot concrete room, locked and boarded with a two-by-four piece of wood. There was no observation by staff members and Joe had to urinate and defecate on the floor for lack of a bathroom. His mother knew the school used a time-out space, but did not know of the stark setting until Joe had been routinely sent to the room for four years. He continues to avoid locked rooms and has nightmares of the experience. In one counseling

session he cut out scary pictures from a magazine and said they reminded him of the time-out room.

JOSH has Asperger Syndrome. He regularly experienced exclusion, seclusion and restraints between the ages of 8 and 12 in a small-town school. School authorities did not discuss these measures with his parents and the truth only came to light when non-teachers told them. Once Josh's parents knew, the school wrote the restraint and seclusion plan into his IEP. Josh's parents objected to the school using such techniques at numerous IEP meetings and 16 mediation sessions. They filed complaints, and asked an autism consultant and pediatrician to write letters protesting the use of these measures. The school did not budge and refused to make a change in the IEP. After arguing the issue for years, Josh's parents removed him from the school. Josh suffers long-term effects from the use of restraint and seclusion. He receives occupational therapy for related back problems and subsequently received a diagnosis of post-traumatic stress disorder. His parents report Josh has lost his sense of safety and dignity.

ADAM is a young boy with Asperger Syndrome who lives in a rural part of Wisconsin. At age 4, Adam experienced a restraint episode when a male worker at a day-care center held him down with a fist in Adam's stomach after the boy refused to take a nap. His mother reports that Adam felt scared, angry and traumatized.

EASTON has Asperger Syndrome and sensory integration disorder. A private suburban elementary school he attended did not allow him to return because of his behavior problems. On several occasions, school authorities locked or cornered Easton in a room as a consequence for his behavior. When he was 5, staff members forcibly removed Easton from a school assembly and put him in the principal's office after they caught him crumpling a piece of paper. The boy was trapped in a corner for an hour and a half after he charged the locked door because he wanted to return to the assembly with his peers. According to his parents, school administrators referred to Easton as a "monster." He expressed feelings of a loss of safety, embarrassment, and loss of trust in the school staff and his parents.

JASON has ADHD and bipolar disorder. He attends a rural elementary school. Jason's father was called to pick up his 9-year-old son from school because of an incident in the classroom. Upon arriving at the school, school authorities took him to a small, padded room where he found his son curled up and crying. Jason did not speak for hours and later that night, he attempted to take his own life for fear of having to return to school. That night, he was admitted to a hospital psychiatric unit.

BOBBY is diagnosed with ADHD, reactive attachment disorder (RAD), anxiety disorder and other disabilities. He experienced extensive use of seclusion and restraint while attending an elementary school in a mid-size Wisconsin city. School authorities used the seclusion room with the boy almost every day for six months. His caregiver reports that Bobby is a "no-touch" kid. By restraining him, she believes

Adam



Easton

school staff caused him to become increasingly anxious. Bobby is now home schooled.

MARK has Down syndrome and esophageal atresia. His parents agreed to a request from the rural elementary school Mark attended to use a time-out room, believing “the school staff knew what they were doing.” They later learned the school secluded Mark in a basement room and, in some cases, physically carried him down. His mother reports that Mark feels angry, scared and embarrassed, and no longer respects his aide. Mark’s mother blames herself because she gave permission for the school to use time-outs.

ALEX is a 10 year old with ADHD. He experienced use of restraint several times at a suburban elementary school he attended. In one incident, a teacher attempted to restrain him by wrapping her arms around him in “bear hug fashion.” As Alex became increasingly agitated, the teacher called on four or five more people to hold his arms and legs. They restrained the boy in this position for approximately 20 minutes while the school called his mother to take him home and told her he was suspended. Alex felt upset and unsafe after the incident. He did not want to talk about it with his mother and began to cry. Alex’s mother feels that using restraint makes the situation much worse.

These Stories Happen Here

In settings where
their protection
should be the highest
priority, children
with disabilities face
serious psychological
and physical harm.

These stories should shock us. They are stark and unsettling—all the more so because, reportedly, they happened here and continue to take place regularly in Wisconsin schools and treatment facilities. In settings where their protection *should be* the highest priority, children with disabilities face serious psychological and physical harm.

Schools and facilities across the state—of every size, well or poorly funded—incorporate use of seclusion and restraint in their policies. We find these aversive procedures in classrooms where children are segregated or in classes with their non-disabled peers. Education experts and disability advocates for children with disabilities know there are better ways to interact with and help children with challenging behaviors. The following chapters describe some of these alternative approaches in detail.

Models of Intervention: How We Can Eliminate or Reduce the Use of Seclusion and Restraint

A growing body of literature warns of the adverse effects of seclusion and restraint—a fact supported by testimony from many credible sources. The time is now to identify alternatives to what many in the field consider counterproductive measures with the potential to do great harm.

To that end, professionals with the Child Welfare League of America (CWLA) introduced key strategies all schools, hospitals, mental health centers, residential treatment facilities, foster and group homes, and day treatment facilities can implement to help improve outcomes for the youth they serve. CWLA organizes these comprehensive strategies under seven headings that include family involvement; supportive leadership; consumer-centered organizational culture; written policies, procedures and practices; staff training and professional development; reforming the treatment milieu; and continuous quality improvement.³¹

Workable Alternatives

These workable alternatives represent effective best practices that rely on existing resources. They also challenge institutions and programs to rethink outmoded ideas about treating or caring for children with disabilities. We expand on each of the CWLA strategies here.

Family Involvement

For youth who are subject to seclusion and restraint, family is a critical first level of support. Parents need to be aware of any problem behaviors in their child that trigger emergency situations. They are the experts on the child and often can shed light on why he or she acts in a particular manner. Family plays an important role in all aspects of prevention, de-escalation, and the debriefing that occurs after an emergency intervention.

Supportive Leadership

Strong and supportive leadership from administrators committed to reducing use of seclusion and restraint in educational and treatment settings is fundamental to changing the status quo. These individuals set the tone for the entire organization and need to make the safety of children under their care a first priority. Adminis-

A growing body of literature warns of the adverse effects of seclusion and restraint—a fact supported by testimony from many credible sources.

A Better Way

These strategies are alternatives that tap existing resources to treat and care for children with disabilities.

- **Family involvement** – a critical first support for all children
- **Supportive leadership** – high-level commitment to reduce seclusion and restraint practices
- **Consumer-oriented culture** – see and serve all children as individuals
- **Written policies, procedures and practices** – implement regulations and require reporting
- **Training and professional development** – prepare staff members to use safe, appropriate responses
- **Reform treatment milieu** – change the environment in support of positive approaches
- **Continuous quality improvement** – monitor program goals and services regularly

trators also belong at the forefront of modeling effective prevention and de-escalation techniques for the rest of the staff to follow.

Consumer-Centered Organizational Culture

Understanding the unique context and individual circumstances of each child is central to serving their needs effectively and safely. Schools, residential treatment facilities, mental health centers and other institutions that serve children with disabilities must develop a consumer-centered organizational culture. Examples of how to include consumers in the care process and reduce the occurrence of seclusion and restraint include providing individualized youth management plans;³² youth involvement in advance directives and debriefing;³³ and the use of a coping questionnaire to assess youth preferences for dealing with agitation.³⁴

Written Policies, Procedures and Practices

It is important to document all operating principles related to use of seclusion and restraint in writing to ensure the entire organization knows and can reference the exact protocol. The Government Accounting Office (GAO) takes this notion one step further: It advises that all states implement regulations and reporting procedures for every facility that uses or has the potential to use restraint and seclusion techniques.³⁵

Staff Training and Professional Development

Preparing staff members to respond appropriately and safely in situations that require an intervention is an important investment in human resources. Training and professional development related to implementation of alternative emergency interventions, such as positive behavioral supports, crisis intervention and de-escalation, is the most-cited strategy in the literature. Administrators also need to hold staff members to a competency standard inherent in the training. Adequate support, opportunities for practice, training refreshers and proper supervision all make an important difference. One study found that, indeed, staff training is a consistent way to dramatically diminish seclusion and restraint.³⁶ Other strategies mentioned in this area include providing effective staff-patient ratio;³⁷ staff training at de-escalation;³⁸ education of staff concerning the identification of patients at risk;³⁹ and the acquisition of behavior management, prevention and early intervention skills.⁴⁰

Reform the Treatment Milieu

Environment has a powerful influence on outcomes for children with disabilities. Reforming the treatment milieu is critical in establishing and communicating a coercion-free, non-punishment based treatment philosophy. CWLA proposes a four-step prevention process staff members can follow to reduce the use of seclusion and restraint.

1. allow youth autonomy, and show them respect and compassion during regular care to prevent problem behavior;
2. execute de-escalation techniques by identifying triggers, early warning signs and successful intervention strategies individualized for each youth;
3. exhaust all other alternatives to reduce the danger of a situation;
4. limit the duration of emergency seclusion or restraint by trained staff, and always follow up with a debriefing and written report of the incident, including parental notification.

Continuous Quality Improvement

Besides establishing ongoing efforts to improve the quality of service, administrators need to disseminate the results to ensure a sustainable, consistent approach to safe and effective emergency treatment procedures. They also need to evaluate program goals regularly and at specific intervals. The GAO also recommends specific reporting procedures.⁴¹

Implement a Positive Approach

In addition to instituting these strategies, there is a growing consensus in the literature that positive behavioral supports are an effective way to prevent problem behaviors that lead to seclusion and restraint measures. The techniques, also known as Positive Behavioral Interventions and Supports (PBIS), emphasize implementation of primary supports for all children in a facility, secondary supports for groups of children with greater needs and tertiary supports of greatest intensity for individual students.⁴²

Among supports defined as PBIS are reinforcement of appropriate behaviors, active teaching, clear communication of rules, consistent provision of corrective consequences and ongoing monitoring of data about student behavior.⁴³

Children with serious communication, social and behavioral challenges benefit from this positive approach. PBIS teaches desired behaviors and useful skills. It fosters healthy emotional development and interactions with others. Practitioners and disability advocates across the spectrum view PBIS as an effective, evidence-based practice that helps moderate even the most dangerous and disruptive behavior while it focuses on the vision of quality of life.

Given how many children have histories of trauma and violence in their lives, it is critical to develop trauma-informed and sensitive approaches.⁴⁴ Trauma-informed care is built on understanding the role of trauma and violence in the lives of children and their families.

Strategies seek to do no further harm, to create and sustain zones of safety for children, and promote coping, resilience, strengths-based programming, growth and healing.⁴⁵ Failing to recognize the effects of trauma and its impact on behavior creates a serious situation. Uninformed programs may re-traumatize children through the use of punishment, restrictive measures, multiple placements and inappropriate programming. If programs develop trauma-informed and sensitive approaches, it is likely they will see a significant decrease in problematic behaviors.

Calvin, a boy with autism, experienced restraint use in school when he was 6 and 7 years old that left him with bruises on his arms and chest.



Practitioners and disability advocates across the spectrum view Positive Behavioral Interventions and Supports as an effective, evidence-based practice that helps moderate even the most dangerous and disruptive behavior while it focuses on the vision of quality of life.

Schools,⁴⁶ residential treatment centers⁴⁷ and other systems of care for children⁴⁸ are starting to implement approaches based on these concepts.

Success Stories from States and Facilities

The CWLA strategies outline methods for reducing seclusion and restraint use, but do they work? We highlight here dramatic results reported in various studies that track the organizational implementation of any or all of these strategies as policy.

A school that serves individuals with emotional and behavior disabilities recorded a 69 percent decrease in physical restraint, 77 percent decrease in seclusionary time-out minutes, and a 38 percent drop in assaults in the first year after implementing a program that included established expectations, social skills curriculum, procedures for teaching positive behaviors, low-level responses to low-level misbehavior and individual behavior plans.

- In its own comprehensive study of how implementing the seven strategies affected outcomes, CWLA found that seclusion rates fell by 29 percent, use of mechanical restraints fell by 61 percent, there was a 49 percent reduction in the use of physical restraints and an 8 to 9 percent reduction in the duration of these encounters.⁴⁹
- A psychiatric facility serving children implemented behavioral management training for their staff and recorded a decrease in seclusion from 10.7 to .3 episodes/month, a decrease in physical restraint from 23.3 to 4.0 episodes/month and a decrease in duration of any locked episode from 36.5 to 16.8 minutes. The number of aggressive incidents and injuries to staff or patients also decreased significantly, as did the proportion of patients receiving sedation medication.⁵⁰
- A school that serves individuals with emotional and behavior disabilities recorded a 69 percent decrease in physical restraint, 77 percent decrease in seclusionary time-out minutes, and a 38 percent drop in assaults in the first year after implementing a program that included established expectations, social skills curriculum, procedures for teaching positive behaviors, low-level responses to low-level misbehavior and individual behavior plans. The following year, the school completely eliminated physical restraint and seclusionary time-out.⁵¹
- A study of psychiatric inpatients whose facility initiated a program focused on better consumer-centered care, among other things, found similar results. Patient seclusion decreased from 3.1 to 1.0 patients/month, patient restraint decreased from .35 to .32 patients/month, and there was a decrease in duration for both seclusion and restraint. Elopements and fights instigated by the patients also decreased significantly.⁵²
- A study of the economic impact of seclusion and restraint at state facilities after the State of Massachusetts began an initiative to reduce or eliminate the use of these practices on children found the rates of seclusion and restraint for children were five to six times higher than the rate for adults. The initiative, spearheaded by the Massachusetts State Mental Health Authority, included goal-setting, planning, data collection, monitoring, feedback and technical assistance. The results from one adolescent inpatient service included in the study are encouraging: a 92 percent reduction in cost attributed to restraint use correlated with a 91 percent reduction in number of restraints. Reducing seclusion and restraint allowed

staff members to devote time and resources to more cost-effective measures of treatment and care. This study also found a 7 percent reduction in staff injuries and 98 percent reduction of staff days missed due to restraint-related injury. Finally, evidence pointed to higher Global Assessment of Functioning (GAF) scores for consumers upon discharge, decreased recidivism and an 80 percent reduction in staff turnover. Massachusetts saw seclusion and restraint episodes decreased statewide by 72.9 percent in children units, 59 percent in mixed children and adolescent units and 47.4 percent in adolescent units during a 22-month period. The use of involuntary medication decreased by nearly half in each of these units at the same time. These results are quite convincing of the efficacy of a state-based program to reduce seclusion and restraint occurrences.⁵⁴

- The state of Pennsylvania made a commitment to eliminating seclusion and restraint beginning in 1997 when it declared it would revise state standards. The state implemented a comprehensive set of reduction strategies including: quarterly performance measures; public accountability; creation of an admission assessment tool; risk management reporting; uniform policy development; innovative medical practices; patient rights and advocacy; patient and staff debriefing; active treatment concepts; staff empowerment and culture change, and rigorous research. The results are compelling. This public commitment resulted in an overall 90 percent reduction in incidence and a 95 percent reduction in hours of restraint and seclusion.⁵⁵

Economic Impact

State of Massachusetts saw measurable change after decision to reduce or eliminate use of seclusion and restraint on children:

- 92% reduction in cost of care after restraint use reduced by 91%
- 7% fewer staff injuries due to seclusion/restraint activity
- 98% reduction in sick days due to seclusion/restraint activity
- Involuntary medication decreased by almost half in units with significant reduction in seclusion/restraint

The Wisconsin Approach: Laws, Policies and Initiatives that Address Seclusion and Restraint

A closer look at the assortment of official laws and policies that address seclusion and restraint in Wisconsin reveals the ambiguities that exist in implementing them. We examine current laws, policies and initiatives followed in educational and treatment settings, weighing how effective they are when applied to children with disabilities and their families.

In the Schools: Stopping Short of What's Necessary

In contrast with a growing number of states, Wisconsin has no statute or administrative regulations regarding seclusion and restraint use in schools. Department of Public Instruction (DPI) directives serve instead to define the appropriate use of seclusion and restraint in special education programs.⁵⁶ While these directives contain a number of useful provisions, they do not have the force of law.

Specifically, the DPI directives focus on developing positive approaches to modify student behavior. They state that seclusion and restraint “should be used only as a last resort when the student’s behavior is an immediate danger to the student and/or others, and when other interventions have been unsuccessful.” There is useful information in the directives about duration of use, incorporating language about seclusion and/or restraint use into an Individualized Education Program (IEP) and/or Behavioral Intervention Plan (BIP), which rooms to use for seclusion, an explanation to the student about potential use of the practices, and recommendations on developing policies/procedures and keeping data.

However, there are a number of deficiencies in the directives. They require staff training on the appropriate application of restraint and de-escalation prior to use, but do not require such training for the use of seclusion.

The directives do not require de-briefing after an incident of seclusion or restraint to determine what happened and whether there was another approach that might produce a different outcome. They mention parental notification but do not require it. They do not specify who has the authority to decide about the use of seclusion or restraint. There is no requirement to collect data on the use of seclusion or restraint, nor is there any requirement to report that data to district administrators or DPI.

A number of statewide education organizations recently developed a course of training on appropriate use of seclusion and restraint.⁵⁷ Unfortunately, this training does not discuss the *impact* of seclusion or restraint on children or the use of

In contrast with a growing number of states, Wisconsin has no statute or administrative regulations regarding seclusion and restraint use in schools.

positive behavior supports to avoid the use of seclusion or restraint. It does not mention parental notification after the use of these measures or the necessity of a de-briefing. Rather, the training focuses on the *when and how* of seclusion and restraint use. Another shortcoming is the fact the training course is not an annual requirement for all school staff members statewide.

Regulating the Practice at Institutional, Residential and Community Treatment Programs

A patient rights law in Wisconsin covers all persons who receive services for mental illness, developmental disabilities or substance abuse through institutional, residential and community providers.⁵⁸ The statute includes provisions on the use of isolation (i.e., seclusion) and restraint.⁵⁹

Specifically, Sec. 51.61(1)(i), Wis. Stats. provides that these measures be used only in (1) emergency situations when it appears an individual may do physical harm to him or herself or to others, or (2) as part of a treatment program.⁶⁰ The law also limits use of isolation and restraint to circumstances when less-restrictive measures are ineffective or unfeasible, and for the shortest time possible.

Only physicians may order restraint and a physician or psychologist may order isolation. Providers must obtain a written order within one hour of initiation of use and institute regular and frequent monitoring of the individual's condition. Each facility using isolation or restraint must have written policies that protect the safety and dignity of the person subjected to these measures.

An administrative code that requires case-by-case approval from the Wisconsin Department of Health Services (DHS) prior to use in a community program (HFS 94.10, Wis. Admin. Code) further defines this statute. Lawsuits, a state-regulated grievance procedure or complaints to state licensing agencies serve to enforce it.⁶¹

In addition, licensing codes that govern children's programs contain requirements regarding the use of restraints and seclusion. For example, the codes for individual and group foster care and shelter care facilities prohibit placing children into locked enclosures or the use of mechanical restraints.⁶² The group foster care code also explicitly prohibits the use of prone restraints.⁶³ The code for residential care centers extensively regulates restraint, seclusion and time out; use is limited to situations of imminently dangerous behavior.⁶⁴

Wisconsin's statutes and regulations governing use of seclusion and restraint on children and adolescents in various treatment settings are not consistent, do not contain provisions for adequately monitoring compliance and fall far short of the best practices described in the previous chapter. These laws and rules fail to promote preventive measures. They do not require parental notification or set standards for duration, and they lack requirements for reporting and debriefing. Chief among the deficiencies is the fact Wisconsin statutes allow seclusion and restraint use when included in a treatment program, despite the fact such measures are not therapeutic.

DHS is undertaking an initiative to reduce the use of seclusion and restraint. A Departmental memo states that seclusion and restraint are not treatment inter-

Wisconsin's statutes and regulations governing use of seclusion and restraint on children and adolescents in various treatment settings are not consistent, do not contain provisions for adequately monitoring compliance and fall far short of the best practices

ventions but safety interventions of the last resort.⁶⁵ The Department put together a work group that is developing training and technical assistance plans for children's mental health providers to help them increase the use of Positive Behavioral Interventions and Supports and trauma-informed care, and cut back on the use of seclusion and restraint.

DHS and the Wisconsin Department of Children and Families recently issued a memo listing a number of prohibited practices in the use of physical restraint with children. Examples include maneuvers that do not protect the head adequately, and actions that place pressure on the chest, abdomen, head or neck, or that use pain as an inducement to obtain compliance or control. The memo states that facilities licensed or regulated by these departments serving children and adolescents may not use these measures.⁶⁶

However, to date there has been little DHS movement to review and rewrite the state statute on restraint and isolation so that it meets federal requirements as set forth in the Children's Health Act of 2000 and Medicaid and Medicare regulations.



Kyle has a diagnosis of autism. He experienced many instances of seclusion and restraint from kindergarten through 5th grade, episodes that left him with feelings of anxiety and difficulty interacting with other people.

National View: How Other States and the Federal Government Regulate Seclusion and Restraint

Action at both the national and local levels about regulating the appropriate use of seclusion and restraint with children is uneven, but there is proof of progress. A variety of federal and state laws, introduced over the past 10 years, stress efforts to guard the interests of children with disabilities and protect their safety. Not all these laws or policies address seclusion and restraint use directly. As a group, however, they help put Wisconsin's deficient approach into perspective.

We begin by looking at federal and state regulation of seclusion and restraint and positive behavioral interventions in schools.

Federal Law Affecting Schools

The Individuals with Disabilities Education Act (IDEA) governs the education of students with disabilities and entitles them to a free and appropriate public education. IDEA requires that each child receiving special education services has an Individualized Education Program (IEP) developed by a team consisting of school personnel, the family and, if possible, the child.

The law directs the IEP team to consider use of Positive Behavioral Interventions and Supports in developing the plan, along with other strategies to address the child's behavior. If the IEP does not address a child's behavior adequately and the team changes his or her placement to an Interim Alternative Educational Setting, the child has a right to receive a functional behavioral assessment, behavior intervention services and changes in the IEP to address the problem behaviors.

While IDEA emphasizes Positive Behavioral Interventions and Supports, it does not restrict the use of negative measures such as seclusion and restraint. That means the use of these techniques is essentially unregulated by federal law.

State Laws in School Settings

States have recognized the dangers of seclusion and restraint by enacting laws that mandate a focus on positive behavior interventions in schools and/or place restrictions on applying the stricter measures. At least 20 states currently have statutes or administrative regulations in place that govern the use of seclusion and physical restraint.⁶⁷ See Table 1 on pages 36-39 for information on these state laws and regulations.

While IDEA emphasizes Positive Behavioral Interventions and Supports, it does not restrict the use of negative measures such as seclusion and restraint. That means the use of these techniques is essentially unregulated by federal law.

TABLE 1
State Laws and Regulations

	AR	CA ¹	CO	CT ²
	AR Dept. of Ed. Reg. § 20.01 et seq.	5 Cal. Code of Regs §§ 3001, 3062	1 Colo. Code Regs. § 301-45	Conn. Gen. Stat. § 46A-150 et seq.
Emphasis on Positive Behavior Intervention	X	X	X	
Seclusion Requirements	X	X	X	
Door Locking Requirements	X	X		
Structural Requirements of the Room	X			
Student Monitoring	X	X	X	
Duration Restrictions	X			
Physical Restraint Requirements		X	X	
Special provisions for students who need to use hands or equipment to communicate				
Student Monitoring		X	X	
Duration Restrictions			X	
Mechanical Restraint Procedures or Restrictions		X		
Seclusion and/or Restraint to Be Used Only in Emergency and/or When Other Less Restrictive Measures Have Been Unsuccessful	X	X	X	X
Training Requirements for Teachers	X	X	X	
Parental Consent (C) or Notification (N) Required		C & N	N	N
Reporting/Reevaluation Required	X	X	X	X
Require a policy		X		
When Law Became Effective	2008	2007	2000	2007

¹ This report does not consider California to have statewide laws restricting restraint or seclusion in schools because California does not use or define the terms “restraint” or “seclusion.” Instead, California uses the term “emergency interventions,” which are undefined, and permits their use only to “control unpredictable, spontaneous behavior which poses clear and present danger of serious physical harm to the individual or others and which can-

IA 281 Iowa Adm. Code § 103.1 et seq.	IL 23 Ill. Adm. Code §1.285	ME Code of Maine Reg. § 05-071-033	MD COMAR § 13A.08.04.01 et seq.	MA 603 Code of Mass. Reg. § 46.01 et seq.	MN Minn. R. § 3525.2900
			X		X
X	X	X	X		X
X	X	X	X		
X	X	X	X		X
X	X	X	X		X
X	X	X	X	X	
X	X	X	X	X	X
X	X				X
		X		X	
	X	X		X	
X	X	X	X		
X	X	X	X	X	X
X	X	X (R only)	X	X	
N	N		C & N		C & N
X	X	X	X	X	X
		X	X	X (R only)	X
2008	2002	2001	2003	2001	1999

not be immediately prevented by a response less restrictive than the temporary application of a technique used to contain behavior.”

² The State of Connecticut Board of Education is in the process of issuing regulations for schools for the use of physical restraints and seclusion, pursuant to Conn. Gen. Stat. § 10-76B.

TABLE 1

	MT	NV	NY	NC
State Laws and Regulations Appendix	Mont. Admin. R. 10.16.3346	Nev. Rev. Stat. § 388.5265 et seq.	8 NYCRR §§ 19.5, 200.1, 200.22	N.C.G. S.A. § 115C-391.I
Emphasis on Positive Behavior Intervention	X		X	X
Seclusion Requirements	X		X	X
Door Locking Requirements	X		X	
Structural Requirements of the Room			X	X
Student Monitoring	X		X	X
Duration Restrictions	X		X	
Physical Restraint Requirements	X	X	X	X
Special provisions for students who need to use hands or equipment to communicate				
Student Monitoring		X		
Duration Restrictions	X	X	X	
Mechanical Restraint Procedures or Restrictions	X	X	X	X
Seclusion or Restraint to Be Used Only in Emergency or When Other Less Restrictive Measures Have Been Unsuccessful	X	X	X	
Training Requirements for Teachers	X	X	X	
Parental Consent (C) or Notification (N) Required	C ³ & N	N	C & N	N
Reporting/Reevaluation Required		X	X	X
Require a policy		X	X	?
When Law Became Effective	2001	1999	2007	2006

³ A parent's failure to consent to aversive treatment within the student's IEP is subject to due process proceedings under Mont. Adm. R. 10.15.3507 et seq.

⁴ Wash. Admin. Code § 392-182A-03135 requires that all of the factors identified in the table with a "?" be addressed in the student's individualized education program but does not mandate any specific requirements.

OR OAR § 581-021-0062	PA 22 Pa. Adm. Code § 14.133	RI RI Code R. § 08-010-013	TN Tenn. Code Ann. § 49-10-1302 et seq.	TX 19 Tex. ADC § 89.1053	WA Wash. Admin. Code § 392-172A-03120 et seq.
	X	X		X	
X	X	X	X	X	X
	X		X	X	X
X					
X	X	X		X	X
					?
X	X	X	X	X	X
					X
X		X	X		X
X				X	?
	X	X	X		
X	X	X	X	X	X
X	X	X		X	?
N	C & N	N	N	N	? ⁴
X	X	X	X	X	X
X	X	X		X	
2006	2001 <i>amended 2008</i>	2006	2009	2002	2007

⁵ N.C.G.S.A. § 115C-391.1(j)(1) requires that local boards of education provide copies of the State law and all local board policies to school personnel and parents, but the statute does not require that the local board of education develop policies.

Hospitals receiving
Medicaid or Medicare
funds must comply with
extensive federal regulations
on the use of seclusion
and restraint, including
chemical restraints.

In almost every case, these laws require that seclusion or restraint use is limited to preventing individuals from putting themselves or others in danger, or when less-restrictive interventions prove unsuccessful. The majority also require training to prepare teachers to use these interventions.

Many of the states define seclusion procedures in their statutes and regulations. Seclusion or time-out regulations typically include student monitoring standards and room design requirements—like unlocked doors, wall height, windows and furnishings. Some states mandate a maximum amount of time a student may spend in seclusion.

Regarding the use of physical restraints, some states prohibit mechanical restraints or prone restraints. They often set time limits for the use of physical restraints. Limits may be time specific or require release as soon as staff members determine the student is no longer in imminent danger of causing physical harm to self or others. A few states require that children who need their hands free to communicate be exempt from restraints or restrained in a way that allows them to continue communicating.

Most of the statutes with procedural requirements for the use of restraints also require training in the safe use of restraints on children for all staff members authorized to do so.

Some states emphasize the importance of ongoing parental consent. This translates into notifying parents of state laws regarding the use of restraint and seclusion during development of a child's IEP and/or each time the school uses one of these measures on the child.

Positive behavioral interventions also figure in existing state statutes and regulations. They call for emphasizing these constructive measures in a student's IEP in stronger language than the IDEA, which says positive behavioral interventions be "considered" but not required until a child is placed in an Interim Alternative Educational Setting (IAES).

Review of the IEP or BIP and reevaluation of the child is another frequent component of state laws and regulations. Similar to the IDEA requirement that a child's BIP be reevaluated after an IAES placement, the laws oblige schools to focus on actively developing a student's skills rather than allowing behavior that leads to crisis intervention.

Federal Laws in Mental Health Treatment Facilities

We continue our examination of laws governing seclusion and restraint use by looking at the situation in mental health facilities. Federal laws apply to Medicaid/Medicare-funded inpatient facilities, non-hospital residential treatment facilities for persons under age 21 and non-medical community based facilities for children and youth that receive certain federal funding.

Inpatient Facilities

Hospitals receiving Medicaid or Medicare funds must comply with extensive federal regulations on the use of seclusion and restraint, including chemical restraints.⁶⁸ The regulations allow use of these measures only when needed to

ensure the physical safety of the individual or others, and when less-restrictive interventions are determined to be ineffective. These interventions must end at the earliest possible time. Only a physician or independent licensed practitioner can order the use of seclusion or restraint, and the physician, independent practitioner or a registered nurse must conduct a face-to-face evaluation of the patient within one hour of the initiation of seclusion or restraint. Orders may last up to four hours for adults, two hours for children age 9 to 17 years, and one hour for children under age 9. Medical or support staff must document each episode in detail. Regulations also require that staff members be trained in the proper application and monitoring of seclusion and restraint, nonphysical intervention skills, and identification of events or circumstances that can trigger a patient's dangerous behavior.

Non-Hospital Residential Treatment Facilities for Persons Under Age 21

Medicaid-funded residential treatment facilities also must comply with extensive federal regulations that largely parallel those for hospitals. However, the regulations set a stricter standard for use of seclusion and restraint. They allow the practices only if the resident exhibits unanticipated behavior that places the resident or others at serious threat of violence or injury, and in cases when the situation clearly calls for immediate intervention. Facility staff cannot use seclusion and restraint simultaneously. Staff debriefings are required after each incident, as are debriefings that involve the resident, parents/guardians and staff members. The facility must notify parents/guardians as soon as possible after initiating seclusion or restraint. Currently, there are no facilities in Wisconsin covered by these regulations, but these rules do provide guidance about appropriate use and monitoring of seclusion and restraint.

Non-Medical Community-Based Facilities for Children

Community mental health programs serving children that receive funding under the Public Health Service Act, including Mental Health Block Grant funds, must comply with the requirements of the Children's Health Act of 2000.⁷⁰ This law prohibits the use of mechanical restraints and chemical restraints and requires continuous face-to-face monitoring of children in seclusion. It states that facilities can use seclusion or physical restraints only in emergency situations to ensure the immediate physical safety of the child or others, and after less-restrictive interventions prove ineffective. The Act also anticipates requiring extensive staff training once there are federal regulations in place. Unfortunately, the federal government has not yet developed these regulations.

State Laws in Mental Health Treatment Facilities

Practically all states have laws and regulations that govern the use of seclusion and restraint, especially for inpatient facilities. Programs certified by the Joint Commission also have to meet extensive requirements regarding seclusion and restraint use. Recently, a number of states revised their statutes and regulations to better regulate and hopefully reduce the use of seclusion and restraint. We review three of these state laws here.

Massachusetts's regulations, effective in 2006, require that all facilities licensed by the state and authorized to use seclusion or restraint must develop a plan to reduce and, if possible, eliminate the use of seclusion and restraint.

Minnesota Law Limits Use in Community-Based Programs for Children

Minnesota recently passed a law that governs the use of restrictive measures, including physical holds and seclusion, in a number of community-based treatment programs for children.⁷¹ The law limits use of physical holds or seclusion to emergency situations as a response to imminent serious risk of physical harm to the child or others, and when less-restrictive interventions do not work. Other provisions of the law state that programs cannot use these measures except under the supervision of a mental health professional. Staff members must constantly and directly observe the child and suspend the use of the restrictive measure when the threat of harm ends. The law requires extensive documentation, administrative reporting and review, and staff training. Programs must obtain parental consent for use of seclusion or restraint when the child enters the program and notify parents the same day any restrictive measure is used.

Florida Laws Establish Restrictions and Align with Federal Requirements

A 2006 Florida law states it is the intent of the Legislature "to achieve an ongoing reduction in the use of restraint and seclusion in programs and facilities serving persons with mental illness."⁷² The law restricts use to situations that pose an imminent danger to the client or others. Regulations promulgated in 2008 recognize the possible effect of these measures on persons with trauma histories. The extensive provisions explicitly prohibit use of prone restraint or other measures that impair respiration, and simultaneous use of seclusion and restraint for minors. The 2008 law requires programs to develop safety plans for each patient, comply with parental notification for minors, conduct extensive staff training, and develop and follow policies for documenting, debriefing and reporting on all instances of seclusion or restraint—generally incorporating the requirements of federal law.

Massachusetts Emphasizes Prevention and Training

Massachusetts's regulations, effective in 2006, require that all facilities licensed by the state and authorized to use seclusion or restraint must develop a plan to reduce and, if possible, eliminate the use of seclusion and restraint. Facilities must train all staff members in the prevention and minimal use of seclusion and restraint. The training should include information about the harmful effects of these measures, the impact on persons with trauma histories, and crisis prevention and de-escalation strategies. The program must have a crisis-prevention plan for each patient that identifies individual triggers and helpful strategies to reduce agitation or distress. They must conduct a thorough staff debriefing after each episode and an additional debriefing with the patient. Senior administrators must review all restraint and seclusion episodes. The law restricts use of restraints or seclusion to circumstances where there is a substantial imminent risk of, or the presence of, serious self-destructive behavior or physical assault. The regulations also contain specific requirements regarding orders for seclusion or restraint, duration, monitoring and documentation.

Recommendations for Immediate Action on Behalf of Wisconsin's Children

Out of Darkness...Into the Light presents powerful stories that describe the harm to our children caused by seclusion and restraint which parents report being used in Wisconsin's education and treatment settings. It also highlights respected professional studies and reports that authenticate effective models of intervention offering a proven alternative. In light of this information and our own experiences, Disability Rights Wisconsin, Wisconsin Family Ties and Wisconsin FACETS strongly urge the federal government and the State of Wisconsin to take the recommendations we summarize in this chapter as a call to action for significantly reducing the use of seclusion and restraint on children.

Action Needed at All Levels

Change in how society uses this critical method of care and control begins at the federal level. We ask lawmakers and decision makers in **federal government** to act on several fronts.

- Pass legislation regulating the use of seclusion and restraint in schools.
- Promulgate rules to implement the requirements of the Children's Health Act of 2000.

What happens in Wisconsin to reform this issue depends on what happens in the **Wisconsin legislature**. State lawmakers must act now to introduce and revise laws that bring Wisconsin into the light.

- Pass legislation regulating the use of seclusion and restraint in schools.
- Revise the existing statute on seclusion and restraint in treatment programs and facilities, Sec. 51.61, Wis. Stats.

State agencies that monitor and regulate programs serving children with disabilities throughout Wisconsin can make a big difference for those children by being proactive on seclusion and restraint. We call on the Wisconsin Departments of Public Instruction, Health Services, and Children and Families to take steps immediately on several key initiatives.

- Develop regulations to implement federal and state statutes and the will to en-

State agencies that monitor and regulate programs serving children with disabilities throughout Wisconsin can make a big difference for those children by being proactive on seclusion and restraint.

force these regulations.

- Provide evidence-based systematic training for schools, service providers, and parents.

Key stakeholder groups that support families or individuals associated with schools and treatment facilities serving children with disabilities throughout Wisconsin also can make a big difference for those children by being proactive on seclusion and restraint. Disability Rights Wisconsin, Wisconsin Family Ties and Wisconsin FACETS calls on these groups to collaborate with us on the issue of reducing seclusion and restraint use on Wisconsin children.

Principles Form the Framework of New or Revised Laws

Better laws regulating the use of seclusion and restraint with children require a framework of guiding principles to ensure they are effective and enforceable. The authors of this report recommend that the statutes, regulations for implementing the laws and essential training requirements incorporate these precepts.

Emphasize Positive Behavioral Interventions and Supports and Trauma-Informed and Sensitive Care

- Require development of a Positive Behavioral Interventions and Supports (PBIS) program on both an individual and facility basis, or similar intervention, to avoid use of seclusion or restraint.
- Require the use of Functional Behavioral Assessments to guide the use of behavioral interventions, including seclusion and restraint.
- Require a review of programs to encourage the implementation of trauma-informed and sensitive care principles.
- Require participation by all personnel who may be involved in using restraint or seclusion in an evidence-based training program that covers positive behavioral interventions and crisis management, and principles of trauma-informed and sensitive care.

Identify What Circumstances Justify the Use of Seclusion and/or Restraint

- Allow use only during an emergency when there is an imminent risk to the physical safety of the child or others.
- Prohibit use as part of a treatment plan, for punishment, the convenience of staff or due to lack of sufficient on-site staff resources.
- Allow use only after staff members have tried less-restrictive interventions without success.
- In school settings, if staff members contemplate using the measures in an emergency situation as part of a behavior intervention plan (BIP) for students with disabilities, they must detail their intentions in the plan and include the same information in the child's IEP, 504 plan or other child-centered planning tool. The BIP also must include less-restrictive positive behavior interventions that staff members utilize prior to the use of seclusion or restraint.

Better laws regulating the use of seclusion and restraint with children require a framework of guiding principles to ensure they are effective and enforceable.

Establish Training Requirements for Educators and Treatment Staff

- Require evidence-based training of all staff members in the practices of de-escalation, Positive Behavioral Interventions and Support programs, relationship building, effects of seclusion and restraint, effects of trauma, and policies and regulations regarding use of seclusion or restraint.
- Allow only well-trained staff to order, monitor or administer seclusion or restraint.
- Require that training programs be certified by appropriate state agencies.

Establish Standards of Parental Consent and Notification

- Require that parents/guardians are notified at the time of a child's admission about the possible use of seclusion or restraint in a school or program and the rules governing such use; also require parental consent for including seclusion or restraint use in an IEP.
- Require that parents receive written and verbal notification after each episode of seclusion or restraint use; also document notification.
- Require that parental notification includes information about the method of seclusion or restraint used, the location where seclusion or restraint took place, the length of time the episode lasted, beginning and ending times of each episode, what behavior preceded use of seclusion or restraint, which less-restrictive measures school or facility staff members used or attempted prior to initiation of seclusion or restraint, identification of personnel who authorized and administered seclusion or restraint, and the reaction of the child to the measures taken.

Codify Process of Documentation, Reporting and Review

- Require detailed documentation and reporting of each episode to administrative/supervisory personnel. A report should include information about the behavior that preceded use of seclusion or restraint, any less-restrictive alternatives utilized prior to seclusion or restraint, or reasons why the staff member judged a situation warranted bypassing the less-restrictive methods, names of personnel who authorized and applied seclusion or restraint, the method used, the location where seclusion or restraint took place, the times the measures began and ended, the length of time for each episode, and the reaction of the child to the use of seclusion or restraint.
- Require administrative review of each episode to determine if there needs to be changes in staffing, training, and/or the child's program.
- Require periodic reporting to state oversight agencies.
- Require review of treatment plans, IEPs, behavioral intervention plans and other similar plans to determine if there are opportunities to address the behavior leading to use of seclusion or restraint.

Set Requirements for the Use of Physical Restraints or Seclusion

- Develop clear and consistent definitions of seclusion, isolation, restraint, time out and related terms.
- Allow use only for the shortest time necessary until the crisis subsides; set strict time frames governing use of these measures.

Principles for Creating or Revising Laws

- Emphasize Positive Behavioral Interventions and Supports and Trauma-Informed and Sensitive Care
- Identify What Circumstances Justify the Use of Seclusion and/or Restraint
- Establish Training Requirements for Educators and Treatment Staff
- Establish Standards of Parental Consent and Notification
- Codify Process of Documentation, Reporting and Review
- Set Requirements for the Use of Physical Restraints or Seclusion
- Establish Special Provisions Relating to the Use of Seclusion
- Create Special Provisions Relating to the Use of Physical Restraint
- Develop Policy Covering All Intervention Activities
- Establish Clear State Oversight

- Allow only qualified, trained, identified staff members to order, monitor and terminate use of seclusion or restraint.
- Allow only well-trained staff members to administer seclusion or restraint.
- Require that any order for seclusion or restraint takes into account the child's developmental stage, trauma history and clinical situation.
- Require close monitoring of any use of seclusion or restraint, and prohibit leaving a child alone while these measures are in use.
- Require that a trained person conduct a face-to-face assessment of the emotional and physical impact of restraint or seclusion use on the child immediately after each episode.
- Require debriefing following each episode with staff members, child and parents.

Establish Special Provisions Relating to the Use of Seclusion

- Prohibit use of locked doors in non-institutional settings.
- Mandate structural requirements of any seclusion room or space to ensure it is a safe and humane environment; this may vary depending on the child's sensory needs.

Create Special Provisions Relating to the Use of Physical Restraint

- Require that the degree of force applied not exceed what is necessary to protect the individual or others from imminent injury.
- Prohibit the use of mechanical restraints in non-institutional settings.
- Include special provisions for people who use their hands to communicate (i.e., people who use sign language) that prevent staff members from restraining the individual's hands or arms in a way that restricts his or her ability to communicate.
- Prohibit any maneuver or technique that does not give adequate attention and care to the head, that places pressure or weight on the chest, lungs, sternum, diaphragm, back or abdomen, causes chest compression, obstructs circulation or breathing, or utilizes pain to obtain compliance or control.

Develop Policy Covering All Intervention Activities

- Require that each facility/program/school district using seclusion or restraint develop and implement a comprehensive policy regarding positive behavioral interventions, crisis management, and use of seclusion or restraint.
- Include the concept of minimizing seclusion and restraint use in the policy and incorporate the standards contained in these recommendations.

Establish Clear State Oversight

- Require state-level oversight of seclusion or restraint use in schools and all residential and treatment programs serving children.
- Give state agencies effective enforcement authority for violations of state law.

Act Now for Our Children's Future

The time is now for moving the issue of seclusion and restraint use on Wisconsin children out of the darkness and into the light. It is time to develop and implement approaches that primarily address the needs of children who have “challenging behaviors” with *positive* rather than *negative* methods.

All concerned—decision makers and administrators at all levels, treatment providers, educators, parents and disability advocates—must commit to decreasing the use of seclusion and restraint of children by supporting and passing legislation that strictly regulates the use of these measures. The steps we take now to create change are the best hope we have to end stories of harm like those recorded here.

Are Existing Laws Sufficient?

Some individuals and groups involved in discussions among special education stakeholders about better regulation of seclusion and restraint use in schools question whether additional legislation is the answer. They claim existing law covers the practice. However, that argument is false. Facts in this report make clear both federal and state special education laws are silent regarding the use of seclusion and restraint.

Some argue the state's corporal punishment law is sufficient to cover the use of seclusion and restraint in schools. This law (Sec. 118.31, Wis. Stats.) prevents school officials, employees and agents of school boards from using corporal punishment, defined as the “intentional infliction of physical pain which is used as a means of discipline.” It excludes actions consistent with a student's IEP from the definition.

The law permits school officials to use “reasonable and necessary force” for a variety of purposes, including quelling a disturbance, preventing an act that threatens physical injury, removing a disruptive pupil from a school or school sponsored activity, and protecting the safety of others. To determine whether a response equals “reasonable and necessary force,” the statute says, “deference shall be given to reasonable, good faith judgments” made by school personnel.

There are obstacles to overcome for this law to apply to seclusion and restraint in schools. Its use would have to involve the intentional inflicting of pain, it would have to be used as discipline, it could not be written into an IEP and the force used would have to meet the test of being unreasonable and unnecessary. Few cases

It is time to develop and implement approaches that primarily address the needs of children who have “challenging behaviors” with *positive* rather than *negative* methods.



Experience with seclusion and restraint in two different schools left Deven, who has significant mental health problems, with a profound fear of adults in school settings.

meet these criteria. In addition, the law says nothing about who may authorize seclusion or restraint, under what circumstances, for how long, provisions for monitoring and parental notification, and other key elements involved in the regulation of seclusion and restraint.

Are Existing Guidelines Sufficient?

There are guidelines in place regarding the use of seclusion and restraint in schools, titled *Directives for the Appropriate Use of Seclusion and Physical Restraint in Special Education Programs*, developed by the Wisconsin Department of Public Instruction (DPI). But it is misleading to suggest schools widely implement these guidelines because there is no requirement for school districts to document or report how they adhere to the directives.

This is a severe limitation. The guidelines may offer direction for implementing seclusion and restraint techniques in school settings. But lack of a clear mandate to follow the directives means the people who administer seclusion and physical restraint to students with disabilities may not feel obligated to abide by the DPI guidelines.

Additionally, by not requiring school districts to adhere to the directives, Wisconsin denies parents and guardians the right to know about the seclusion and restraint interventions their children experience. When schools keep parents and guardians in the dark about seclusion and restraint use, they prevent them from playing an important decision-making role in their child's education.

How Much and What Kind of Training is Enough?

Training is a key to engendering change in the use of seclusion and restraint. School and human service providers need to learn positive methods for addressing the needs of children with "challenging behaviors." They need evidence-based training that covers Positive Behavioral Interventions and Supports, de-escalation, and crisis intervention and prevention—all critical to changing a culture that fosters the use of seclusion and restraint.

Parents also need training to understand the rights of their children and how to apply these positive approaches. Such knowledge gives them power, but it also makes them better partners with the professionals who teach or care for their children.

Training cannot do it all. It is most effective when coupled with enforceable standards. Among other things, standards make it clear what seclusion and restraint practices involve, when to use them, how to monitor each practice, and how and when to notify parents about their use.

The Child Welfare League of America emphasizes the need for family involvement, leadership, organizational change and continuous quality improvement, in addition to training. Reform efforts in other states succeeded thanks to a combination of training, leadership for organizational culture change, and the introduction of clear, enforceable regulatory standards.

Several professional organizations in Wisconsin dedicated to special education

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developed a training presentation for teachers and school personnel based in part on the DPI directives on the use of seclusion and restraint. The presentation echoes DPI's emphasis on (1) the importance of the dignity and safety of children and school staff, (2) using seclusion and restraint only as a last resort, (3) and incorporating language about the use of seclusion and restraint into a student's IEP.

However, the training does not address DPI's strong emphasis on positive and proactive behavioral interventions to regulate student behavior before it escalates to the point that seclusion or physical restraint becomes necessary. DPI states that it is "important to teach behavior just as [teachers] teach academics." This training does not provide school personnel with the knowledge to undertake this important task. Also, there is no legal requirement that every Wisconsin school or treatment facility conducts and documents the training regularly for all staff members. It is far from sufficient to effect the fundamental change we need.

What About Common Sense?

One of the oft-heard arguments against legislation to define and regulate the use of seclusion and physical restraint is that "common sense" is sufficient as a guide when employing these methods with children. Sadly, there are far too many documented cases of children experiencing physical and emotional harm, even at the hands of trained professionals, to justify this notion. In fact, a *lack* of commonality among the individual behaviors, situations and personalities of the children themselves reinforces the argument for imposing serious, enforceable limits *beyond individual interpretation* to ensure the safety and well being of every child. We must act now for their future.

Training cannot do it all. It is most effective when coupled with enforceable standards.

Footnotes

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⁵⁸ Sec. 51.61(1), Wis. Stats.

⁵⁹ Isolation is defined as "any process by which a person is physically or socially set apart by staff from others but does not include separation for the purpose of controlling contagious disease." HFS 94.02(26), Wis. Admin. Code. Seclusion is defined as "that form of isolation in which a person is physically set apart by staff from others through the use of locked doors." HFS 94.02(40), Wis. Admin. Code. Physical restraint is defined as "any physical hold or apparatus, excluding a medical restraint or mechanical support, that interferes with the free movement of a person's limbs and body." HFS 94.02(34), Wis. Admin. Code.

⁶⁰ While the Wisconsin law, which was written in the mid-1970s, appears to allow for the use of restraint or isolation as part of a treatment program, professional opinion and public policy now recognize these measures are not "treatment." Instead they are recognized as safety measures used only as a last resort. National Association of State Mental Health Program Directors, (1999) *Position Statement on Seclusion and Restraint*; SAMHSA, *Roadmap to Seclusion and Restraint Free Mental Health Services*.

⁶¹ See Sec. 51.61(5) and (7), Wis. Stats.

⁶² HFS 56.09(5)(h), HFS 57.27(1)(c) and (3)(b) 4., and HFS 59.05(5)(e) and (g), Wis. Admin. Code.

⁶³ HFS 59.27(3)(b) 4., Wis. Admin. Code.

⁶⁴ HFS 52.42(5)(a) 1., Wis. Admin. Code.

⁶⁵ DHFS, DDES Info Memo 2005-04.

⁶⁶ Wisconsin Department of Health Services and Department of Children and Families (March 13, 2009), *Prohibited Practices in the Application of Emergency Safety Interventions with Children and Adolescents in Community Based Programs and Facilities*.

⁶⁷ An additional eleven states have developed Guidelines to govern use of seclusion and/or restraint.

⁶⁸ 42 CFR 482.13(e), (f), and (g).

⁶⁹ 42 CFR 483.350 - 483.376.

⁷⁰ 42 U. S. Code Sec. 290jj.

⁷¹ Minn. Stat. 245.8261.

⁷² Sec. 394.453, Florida Statutes.

⁷³ Florida Administrative Code 65 E-5.180(7).

⁷⁴ 104 Code Mass. Regs. 27.12.

Glossary of Terms

Behavioral Intervention Plan (BIP) A plan to address a student's behavior that is based on a Functional Behavioral Assessment (FBA). It should include descriptions of typical routines and most difficult problem situations for the student; monitoring and evaluation plan; identification of case manager to be responsible for coordination of the plan; and identification of individual responsibilities for specific interventions described in the plan, data collection and reporting. *Addressing the Needs of Students with Disabilities*, Bulletin No. 07.01, WI Dept of Public Instruction, Feb. 2007.

Chemical restraint A drug or medication when it is used as a restriction to manage an individual's behavior or restrict an individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Taken from CMS definition of restraint; see 42 CFR 482.13(e)(1)(i)(B).

Community treatment facilities For purposes of this report, day treatment programs, crisis intervention programs and other outpatient programs for children with disabilities.

504 Plan A school's plan for accommodating the disability of a student who needs accommodations, but does not qualify for special education and does not have an IEP (Individualized Education Program).

Functional Behavioral Assessment (FBA) A continuous process for identifying: (1) the purpose or function of the behavior, (2) the variables that influence the behavior, and (3) components of an effective behavioral intervention plan (BIP). *Addressing the Needs of Students with Disabilities*, Bulletin 07.01, WI Dept of Public Instruction, Feb. 2007.

IAES Refers to Interim Alternative Educational Setting, an out-of-school placement where a school district can provide authorized special education supports and services to a child after he or she receives a suspension for bringing a weapon or drugs to school, or seriously injuring another student or staff member.

IDEA Individuals with Disabilities Education Act, a federal law that governs how states and public agencies provide early intervention, special education and related services to eligible infants, toddlers, children and youth with disabilities.

Individualized Education Program (IEP) An education plan designed to meet the specific needs of a child with a disability or disabilities. A team that includes the family, the child if possible, and school personnel develop the plan together.

Isolation Any process where a person is physically or socially set apart by staff

from others but does not include separation for the purpose of controlling contagious disease. HFS 94.02(26), Wis. Admin. Code.

Mechanical restraint The use of devices as a means of restricting a resident's freedom of movement. 42 U.S.C. Sec. 290jj(d)(1).

Mechanical support An apparatus used to properly align a patient's body or help a patient maintain his or her balance. HFS 94.02(28), Wis. Admin. Code.

Medical restraint An apparatus or procedure that restricts the free movement of a patient during a medical or surgical procedure or prior to or subsequent to such a procedure to prevent further harm to the patient or to aid in the patient's recovery, or to protect a patient during the time a medical condition exists. HFS 94.02(29), Wis. Admin. Code.

Physical restraint Any physical hold or apparatus, excluding medical restraint or mechanical support, that interferes with the free movement of a person's limbs and body. HFS 94.02(34), Wis. Admin. Code.

Positive Behavioral Interventions and Supports (PBIS) Approach based on a functional behavioral assessment that attempts to understand the purpose of a problem behavior so the behavior is replaced with new and more appropriate behaviors that achieve the same purpose. Positive approaches are developmentally, chronologically, cognitively and functionally appropriate for the student/individual and focus on two areas: (1) modifying the environment to try to prevent challenging behaviors; and/or (2) addressing behavior programmatically by teaching replacement behaviors and skills. *Addressing the Needs of Students with Disabilities*, Bulletin 07.01, WI Dept of Public Instruction, Feb. 2007.

Prone restraint A physical restraint where an individual holds a person's face on the floor while pressing down on the person's back.

Residential treatment facilities For purposes of this report, term includes inpatient treatment facilities, residential care centers, and group and individual foster homes.

Restraint This term has multiple definitions. For Wisconsin law, see definition of physical restraint above. At the federal level:

- The Children's Health Act of 2000 defines "physical restraint" as:

A personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs or head freely. Such a term does not include a physical escort. 42 U.S.C. Sec. 290jj(d)(3). [Physical escort is the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a resident who is acting out to walk to a safe location. 42 U.S.C. 290jj(d)(2).]

- Centers for Medicare and Medicaid Services (CMS) define *restraint* as:
 - (A) Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely;
 - (B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition;
 - (C) A restraint **does not** include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). 42 C.F.R. Sec. 482.13(e)(1)(i).

Seclusion This term has multiple definitions.

- Wisconsin law defines it as that form of isolation in which a person is physically set apart by staff from others through the use of locked doors. HFS 94.02(40), Wis. Admin. Code.
- The federal Children's Health Act of 2000 defines *seclusion* as any behavior-control technique that involves locked isolation. The term does not include *time out*. 42 U.S.C. Sec. 290jj(d)(4).
- The federal CMS defines it as the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. 42 C.F.R. Sec. 482.13(e)(1)(ii).

Time Out A behavior-management technique that is part of an approved treatment program and may involve separating the individual from the group, in a non-locked setting for the purpose of calming. 42 U.S.C. Sec.290jj(d)(5).

Trauma-Informed Care Care or services based on the assessment and potential modification of an organization, management and service-delivery system to include a basic understanding of the impact trauma has on the life of an individual seeking services. Trauma-informed organizations, programs and services emphasize understanding the vulnerabilities or triggers of trauma survivors that traditional service-delivery approaches may exacerbate, so that services and programs are more supportive and avoid retraumatization. National Center for Trauma Informed Care, <http://mentalhealth.samhsa.gov/nctic>.

Seclusion and/or Restraint Information Form
Sponsored by Disability Rights Wisconsin (DRW)
Wisconsin Family Assistance Center for Education, Training, Support (FACETS)
and Wisconsin Family Ties (WFT)

Please call Sarah Mears at DRW if you need help completing this form: 800-928-8778. (Add more pages if needed.) Favor de llamar DRW si Ud. necesita ayuda llenando esta forma: 1-800-928-8778. Un intérprete de español esta disponible.

GENERAL INFORMATION

Child's Name _____ Date of Birth _____

Child's disabilities, if any: _____

Child's Address: _____

Parent(s)/Guardian(s) Name(s): _____

Relationship to Child: _____

Address (if different from Child): _____

Phone: (Home) _____ (Cell): _____ (Alternate): _____

Email _____ I prefer to be reached by: Home Cell Alt Email Any/All

Do you have pictures of the seclusion/restraint situation? ☐ Yes ☐ No

RELEASE OF INFORMATION

Are you willing to release the pictures for use in this campaign? ☐ Yes ☐ No

Are you willing to speak out about your experience with seclusion/restraint? ☐ Yes ☐ No

****It is your decision how we use the information you provide on this form, please check one option:**

____ I agree to allow all of this information to be used publicly.

____ I agree to allow only the following information to be used publicly:

____ No, I do not want any of the information I have provided to be released publicly; the information provided is to remain confidential.

SECLUSION/RESTRAINT DETAILS

Did the seclusion/restraint (physical, mechanical, chemical restraints or seclusion) take place at:

1. School - fill out “**School**” section below
2. Treatment Facility - fill out “**Treatment Facility**” below
3. Both - fill out **both** sections

➔ SCHOOL ➔

School district child attended when seclusion/restraint occurred: _____

School building where seclusion/restraint occurred: _____

School attending presently: _____

When did seclusion/restraint take place: _____ Age of child at the time? _____

Is/Was the use of seclusion/restraint part of your child's IEP or Behavior Intervention Plan? ☐ Yes ☐ No

If yes, what seclusion/restraint interventions did your child's IEP or Behavior Intervention Plan say could be used? _____

Please describe how seclusion and/or restraint was used on your child (what kind of seclusion/restraint was used, how often, how long, staff involved, etc.) _____

Did the school keep any records of the seclusion/restraint interventions used (as, when used, by which staff, in what situations, length of seclusion/restraint)? ☐ Yes ☐ No

Did the school try to measure the impact/lack of impact of the seclusion/restraint? ☐ Yes ☐ No

Did the school have a written policy about seclusion/restraint (as, records to be kept, licensed health care provider approval required, staff training, etc)? ☐ Yes ☐ No ☐ Not sure

How and when were you informed that seclusion/restraint was used? _____

How did you feel when you found out seclusion/restraint was used? _____

How did your child feel when he/she was secluded/restrained (Such as, scared, angry, lost sense of safety, embarrassed, traumatized, lost trust for staff, etc.)? _____

Were any complaints filed? ☐ Yes ☐ No If yes, to whom and what were the responses? (Such as, School, Police, Child Protective Services, etc.)

Was medical attention needed due to the seclusion/restraint, (including admittance to a hospital)?

Was psychological treatment needed due to the seclusion/restraint, (including admittance to a hospital)?

Has your child suffered any long term effects? _____

Any other information you feel we should know?: _____

➔ TREATMENT FACILITY ◀

Treatment Facility child was at when seclusion/restraint occurred: _____

Location of Facility: _____

Is your child currently at the facility? ☐ Yes ☐ No Or another facility? ☐ Yes (_____) ☐ No

When did the seclusion/restraint take place: _____ Age of child at the time? _____

Is/Was seclusion/restraint part of the child's Treatment Plan? ☐ Yes ☐ No

If yes, what seclusion/restraint did your child's Treatment Plan say could be used? _____

Please describe how seclusion and/or restraint was used on your child (what kind of seclusion/restraint was used, how often, how long, staff involved, etc.): _____

Did the Treatment Facility keep any records of seclusion/restraint interventions used (Such as, when used, by which staff, in what situations, length of seclusion/restraint, during which shifts)? ☐ Yes ☐ No

Did anyone measure the impact/lack of impact of the seclusion/restraint used? ☐ Yes ☐ No

Did the Treatment Facility have a written policy about seclusion/restraint (Such as, records to be kept, licensed health care provider approval required, staff training, etc.)? ☐ Yes ☐ No ☐ Not sure

How and when were you informed that seclusion/restraint was used? _____

How did you feel when you found out seclusion/restraint was used? _____

How did your child feel when he/she was secluded/ restrained (Such as, scared, angry, lost sense of safety, embarrassed, traumatized, lost trust for staff, etc.)? _____

Were any complaints filed? ☐ Yes ☐ No If yes, to whom and what were the responses? (Such as, to the School, Police, Child Protective Services, etc.) _____

Was medical attention needed due to the seclusion/restraint, (including admittance to a hospital)? _____

Was psychological treatment needed due to the seclusion/restraint (including admittance to a hospital)? _____

Has the child suffered any long term effects? _____

Any other information you feel we should know?: _____

Please return to:

Disability Rights Wisconsin
131 W Wilson St., Suite 700
Madison, WI 53703

Fax: 608-267-0368
Phone: 800-928-8778 or 608-267-0214

Thank You!

APPENDIX B: TABLE 2, SUMMARY OF STORIES

NAME	AGE SECLUDED AND/ OR RESTRAINED	DIAGNOSIS	SETTING	AVERSIVE ACTIVITY
Kyle	5-13	Autism	Elementary and middle schools	Restraint and seclusion
Teag	17	Autism, cognitive disability, seizure disorder	High school	Seclusion
Angellika	7	Post traumatic stress disorder, reactive attachment disorder, bipolar disorder, ADHD, anxiety	Day treatment	Restraint and seclusion
Donovan	7	Bipolar disorder, learning disability, sensory dysregulation, cognitive delays	Elementary school	Seclusion for entire day
Christina	11	Emotional-behavioral disorder	Mental health day treatment facility	Frequent restraint holds
Zachary	3	Autism	Elementary school	Restraint in a Rifton chair
Calvin	6-7	Autism	Elementary school and mental health institute	Restraint
Jenna	16	Bipolar disorder, ADHD, anxiety, depression	Various treatment facilities	Restraint holds
Jacob	6	Anxiety disorder	Elementary school	Restraint
Deven	10-12	Pervasive developmental disorder, bipolar disorder, anxiety disorder, ADHD	Two elementary schools and residential treatment facility	Restraint and seclusion
Niles	11-13	Autism, non-verbal disability, seizure disorder	Middle school	Seclusion
Chelsea	14-17	Mental health, undiagnosed epilepsy	Mental health institute and residential care center	Seclusion and restraint
Frank	7-8	ADHD, bipolar disorder, autism, traumatic brain injury	Elementary school	Seclusion

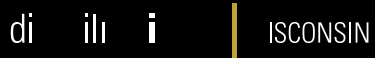
ADVERSE OUTCOMES	PARENTAL NOTIFICATION	MONITORING ACTIVITIES
Increase in anxiety and a decrease in social skills and initiative	Parents notified of seclusion but not restraint	Seclusion records kept as part of IEP/BIP
Self-injurious behavior	None until parental inquiry	Records kept; impact not measured
Death	Periodically	Records kept but impact not measured
Severe psychological effects requiring hospitalization; does not trust school environment	None until parental inquiry	No records kept or impact measured
Trauma and confusion; psychological counseling needed	One phone call to parents	Not sure if records kept; impact not measured
Fear of adults and school staff	Home therapist informed parents	No records kept or impact measured
Bruising of arms and body	Parents had knowledge of restraint but not extended duration	No school records kept or impact measured
Loss of self esteem, emergence of post traumatic stress disorder, and chronic back pain	Parents informed via phone calls	Records kept of the holds
Crying episodes and reluctance to return to school	None until parental inquiry	No records kept or impact measured
Psychological treatment needed; distrust of adults; stigmatized by peers	Informed by one of the schools	Records kept; impact not measured
Increasing aggression and anxiety of small places; loss of interest in certain activities	Daily report sent to parents	Records kept of seclusion
Felt angry and scared	Parents called most of the time when restraint used	Records kept
Dislike of teacher; required counseling	Parents aware of seclusion but not poor conditions of room	No records kept or impact measured

TABLE 2

NAME	AGE SECLUDED AND/ OR RESTRAINED	DIAGNOSIS	SETTING	AVERSIVE ACTIVITY
Justin	16	Autism, speech and language disorders, fine motor skills deficiencies	Middle school	Seclusion and restraint
Adam	11-12	Asperger syndrome, ADHD	Middle school	Seclusion and restraint
Benjamin	11-12	Lennox-Gastaut syndrome, cerebral palsy, autism	Middle school	Restraint in wheelchair for entire day
Sam	14-15	Autism, mitochondrial disease with epileptic encephalopathy	High school	Restraint
Billy	9 & 13	Autism, apraxia, non-verbal disability	Two elementary schools	Seclusion and restraint
Joe	6-10	ADHD, emotional disturbance, and bipolar disorder	Elementary school	Seclusion
Josh	8-12	Asperger syndrome	Elementary and middle schools	Seclusion and restraint
Adam	4	Asperger syndrome	Day care facility	Restraint
Easton	5	Asperger syndrome, sensory integration disorder	Elementary school	Seclusion
Jason	9-10	ADHD, bipolar disorder	Elementary school	Seclusion
Bobby	11-12	ADHD, reactive attachment disorder, developmental disorder	Elementary school	Seclusion and restraint daily
Mark		Down syndrome, esophageal atresia	Elementary school	Seclusion
Alex	10	ADHD	Elementary school	Restraint

ADVERSE OUTCOMES**PARENTAL NOTIFICATION****MONITORING ACTIVITIES**

Broken elbow in multiple places during restraint; continued aggression and apprehension	Informed at IEP meeting	No records kept or impact measured
Scrapes and bruises on his arms; psychological harm	None until police intervention	Seclusion written into IEP but not followed as written
Agitation and attempts to get out of wheelchair	Parents visits to school limited	No records kept or impact measured
Increased aggression both at school and at home; more often seeks consolation and cries; post-traumatic stress and depression	Home-school communication notebook	BIP not implemented despite parental request
Felt scared, angry, unsafe, distrustful of staff, embarrassed, and traumatized by the experience	None until parental inquiry	Seclusion and restraint written into IEP without parental permission
Avoidance of locked rooms and occurrences of nightmares; counseling needed	Parents knew that “time-out” room was used but stark setting not known for four years	Only records were notes of seclusion sent to mother
Back problems; psychological trauma; post traumatic stress syndrome	Parents notified by non-teachers who were concerned	Written into IEP after parental inquiry and against the parents’ wishes
Felt scared, angry, and traumatized	Notification after incident at school	No records kept or impact measured
Loss of safety, embarrassment, and loss of trust in the staff and parents	Notification after incident at school	No records kept or impact measured
Suicidal attempt; admittance to a psychiatric hospital	None until classroom incident	No records kept or impact measured
Increasing anxiety	Daily reports to parents	Written into IEP after three months
Felt angry, scared and embarrassed	Found out by “word of mouth”	Records not kept but impact measured
Increasing agitation; loss of safety	Notification after classroom incident	Restraint written into IEP; no records kept or impact measured



Disability Rights Wisconsin
131 West Wilson, Suite 700
Madison WI 53703
608-267-0214
888-758-6049 TTY
disabilityrightswi.org



Wisconsin Family Ties
16 North Carroll St, Suite 640
Madison WI 53703
800-422-7145



Wisconsin FACETS
2714 North Dr. Martin Luther King Dr
Milwaukee WI 53212
414-374-4645