

**Report of the New York State Psychological Association
Task Force on Aversive Controls with Children**

August 22, 2006

Historical and Legal Framework

Since the mid-1970's, parallel to the movement to de-institutionalize persons with mental illnesses and/or developmental disabilities, federal laws were first enacted that protected the rights of children with disabilities to receive a public education. Since that time, there has been an increasing mandate to educate ("include") more and more children and youth with severe disabilities in mainstream or regular education settings. One of the consequences of this shift to providing education in the least restrictive environment, however, is that regular and special education personnel, both in regular public schools and publicly operated special education schools, now find themselves facing more diverse and complex behavior challenges in the classroom.

The severity of some students' symptoms often necessitates both reasonable accommodations under Section 504 of the Rehabilitation Act of 1973, and an Individualized Education Program (IEP) for those children classified as eligible for special education under the Individuals with Disabilities Education Act (I.D.E.A.). If a student's behavior is significantly interfering with his or her ability to benefit from the placement and program or is significantly interfering with the rights of other students to benefit from their placement and program, IDEA requires that the student's Committee on Special Education (CSE, or CPSE for preschool children) arrange for a multidisciplinary Functional Behavioral Assessment (FBA) that will lead to a Behavioral Intervention Plan (BIP). Students who are classified as eligible for special education constitute approximately 11% of the student population nationwide at this time, although not all students classified for special education require BIPs.

In response to the growing need for effective school-based techniques to manage challenging behaviors, the federal government has supported research on the use of positive behavioral supports and has increasingly called upon schools to use the wide range of such research-validated methods currently available. At the same time, prohibitions on the use of techniques that essentially punish disabled students for symptoms of their disability have been promulgated by a variety of federal agencies and professional organizations.

Pertinent to this discussion, there has also been a history of litigation and legislation stemming from abuses of aversive behavior modification therapies. In response to such abuses at facilities like Willowbrook and Opendate in NYS, and a permanent injunction that resolved the Willowbrook litigation, the right of disabled NYS residents to be free from aversive techniques was strengthened.

The need to protect disabled individuals from abusive aversive behavior modification techniques also led to federal legislation, such as 42 USC 290jj, which restricts the use of restraint and seclusion:

A public or private non-medical, community-based facility for children and youth (as defined in regulations to be promulgated by the Secretary) that receives support in any form from any program supported in whole or in part with funds appropriated under this Act shall protect and promote the rights of each resident of the facility, including the right

to be free from physical or mental abuse, corporal punishment, and any restraints or involuntary seclusions imposed for purposes of discipline or convenience.

... the restraints or seclusion are imposed only by an individual trained and certified, by a State-recognized body (as defined in regulation promulgated by the Secretary) and pursuant to a process determined appropriate by the State and approved by the Secretary, in the prevention and use of physical restraint and seclusion, including the needs and behaviors of the population served, relationship building, alternatives to restraint and seclusion, de-escalation methods, avoiding power struggles, thresholds for restraints and seclusion, the physiological and psychological impact of restraint and seclusion, monitoring physical signs of distress and obtaining medical assistance, legal issues, position asphyxia, escape and evasion techniques, time limits, the process for obtaining approval for continued restraints, procedures to address problematic restraints, documentation, processing with children, and follow-up with staff, and investigation of injuries and complaints.

The Willowbrook case was also part of Congress's deliberations in deciding to pass the "Developmental Disabilities Assistance and Bill of Rights Act" of 2000 (Public Law 106-402). Of particular note, 42 U.S.C. § 15009 states, in part:

(a) In general

Congress makes the following findings respecting the rights of individuals with developmental disabilities:

- (1) Individuals with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities, consistent with section 15001 (c) of this title.*
- (2) The treatment, services, and habilitation for an individual with developmental disabilities should be designed to maximize the potential of the individual and should be provided in the setting that is least restrictive of the individual's personal liberty.*
- (3) The Federal Government and the States both have an obligation to ensure that public funds are provided only to institutional programs, residential programs, and other community programs, including educational programs in which individuals with developmental disabilities participate, that—*
 - (A) provide treatment, services, and habilitation that are appropriate to the needs of such individuals; and*
 - (B) meet minimum standards relating to—*
 - (i) provision of care that is free of abuse, neglect, sexual and financial exploitation, and violations of legal and human rights and that subjects individuals with developmental disabilities to no greater risk of harm than others in the general population;*
 - (ii) provision to such individuals of appropriate and sufficient medical and dental services;*
 - (iii) prohibition of the use of physical restraint and seclusion for such an individual unless absolutely necessary to ensure the immediate physical safety of the individual or others, and prohibition of the use of such restraint and seclusion as a punishment or as a substitute for a habilitation program;*
 - (iv) prohibition of the excessive use of chemical restraints on such individuals and the use of such restraints as punishment or as a substitute for a habilitation program or in quantities that interfere with services, treatment, or habilitation for such individuals; and*

(v) provision for close relatives or guardians of such individuals to visit the individuals without prior notice.

....

(b) Clarification

The rights of individuals with developmental disabilities described in findings made in this section shall be considered to be in addition to any constitutional or other rights otherwise afforded to all individuals.

Thus, not only does 42 U.S.C. § 15009 specifically bar educational programs serving developmentally disabled students from non-emergency use of restraint and seclusion, it also prohibits exposing developmentally disabled students to any greater risk of harm than that to which students in the general population are subjected.

Over the past decade, a number of federal agencies and commissions have stressed the need to strictly limit or eliminate the use of force, restraint, and seclusion on disabled individuals. The President's New Freedom Commission on Mental Health issued its final report in 2003. Among its conclusions are these statements:

Seclusion and restraint will be used only as safety interventions of last resort, not as treatment interventions. Only licensed practitioners who are specially trained and qualified to assess and monitor consumers' safety and the significant medical and behavioral risks inherent in using seclusion and restraint will be able to order these interventions." (p. 9)

Similarly, in "A Roadmap to Seclusion and Restraint Free Mental Health Services for Persons of All Ages" training manual, the US Department of Health & Human Services' Substance Abuse and Mental Health Services Administration (SAMSHA, 2006) wrote:

In 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) set forth a bold vision to reduce and ultimately eliminate the use of seclusion and restraint in behavioral healthcare settings.

These practices are detrimental to the recovery of persons with mental illnesses. Too often, the use of seclusion and restraint results in trauma, injury, and even death. We can and must do better to protect the lives and well-being of those whom we serve. SAMHSA has established seclusion and restraint as a priority area and has developed a National Action Plan to reach our vision of seclusion and restraint free mental health services.

Because I.D.E.A. is often the first federal law that state education departments and schools look to for guidance as to what is legal and necessary in provision of services and safeguards for disabled students, it is important to note that although I.D.E.A. stresses the use of positive behavior supports, it is silent on the use of aversive techniques to modify behaviors that may be symptoms of a child's disability. The fact that I.D.E.A. does not specifically prohibit aversive techniques, however, does not make them legal, inasmuch as the protections of 42 USC § 15009 apply to non-institutional educational programs. Furthermore, in discussing the use of Positive Behavior Interventions and Supports (PBIS), the U.S. Department of Education Office of Special Education Programs (OSEP) Technical Assistance Center explains:

PBIS was initially developed as an alternative to aversive interventions used with students with severe disabilities and has been broadened to include a wider range of individuals. PBIS states that the interventions need to be those that would be considered acceptable if used in community and school environments. Interventions that result in humiliation, isolation, injury and/or pain would not be considered appropriate¹.

As has already been noted, research-validated methods for implementing positive behavioral support, that could help teachers, CSEs, and school personnel effectively address disabled children's problematic behaviors have been widely available for many years. Unfortunately, there has been too little emphasis in NYS on ensuring that educators receive the professional training and supports that they need to do that. Teachers frequently report that they have not been sufficiently trained in either understanding the causes of behaviors exhibited by children in their charge or research-validated classroom management techniques to effectively handle them. Educational surveys indicate that teachers would welcome and use such training. As an example, Hershell (1999) wrote:

In a survey of 126 teachers, 75% reported feeling that their educational training insufficiently prepared them to manage children with special needs and 72% reported feeling insufficiently prepared to manage even a typical classroom (Merrett & Wheldall, 1993). Further, almost half (45%) of teachers reported that in-service training is not helpful (Peter D. Hart Research Associates, 1995). This lack of adequate training in classroom management is particularly distressing considering that 86% of teachers indicate that they could improve their teaching with proper training (Merrett & Wheldall, 1993).

Against this historical backdrop, the New York State Education Department (NYSED) recently found itself grappling with the complex issue of addressing severe behavioral issues of disabled students aged 3-21 while providing them with a free appropriate public education in the least restrictive environment. In June 2006, the Board of Regents approved amendments concerning the use of aversive behavioral interventions, corporal punishment, and time out rooms.

In July 2006, the New York State Psychological Association (NYSPA) created a task force (the "Task Force") charged with both evaluating the regulations about the protection of children with disabilities from the use of aversive or noxious controls, and making recommendations in regard to these regulations to the honorable members of the NYS Board of Regents. The Task Force specifically reviewed the following aspects of these amendments: use of aversive behavioral interventions, corporal punishment exceptions, restraint, and time out room provisions.

"Aversive Behavioral Interventions"

According to the newly enacted amendments, aversive behavioral interventions consist of the following:

- (i) application of noxious, painful, intrusive stimuli or activities intended to induce pain such as electric skin shock, ice applications, hitting, slapping, pinching, kicking, hurling, strangling, shoving, deep muscle squeezes or other similar stimuli;
- (ii) any form of noxious, painful or intrusive spray, inhalant or tastes
- (iii) withholding sleep, shelter, bedding, bathroom facilities or clothing

¹ OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, www.pbis.org/english/About_the_Center.htm

- (iv) contingent food programs that include withholding meals or limiting essential nutrition or hydration or intentionally altering staple food or drink in order to make it distasteful
- (v) movement limitation used as a punishment, including but not limited to helmets and mechanical restraint devices
- (vi) the placement of a child unsupervised or unobserved in a room from which the student cannot exit without assistance; or
- (vii) other stimuli or actions similar to the interventions described in subparagraphs (i) through (vi) of this paragraph.

While the document contains a clear prohibition of the use of aversive behavioral interventions in a broad range of public and private schools and other educational settings in and out of New York State, the amendments also stipulate a “child-specific” exemption. Our review of the terms of the provisions and the exemption procedures raise troubling questions. Some of the issues are as follows:

Lack of compliance with federal and state laws. A primary question the Task Force faced was the legality of aversive behavioral intervention use in educational programs. After reviewing the federal laws cited in the introduction to this report, the Task Force concluded that the use of some of the aversive techniques listed in the regulations categorically violates federal protections for developmentally disabled students; others would be violative if they infringed upon protections against risk of harm, humiliation, isolation, or injury.² In addition, the Task Force has noted that at least in some cases, aversive techniques may violate the NYS penal code, an interpretation supported by a New York Civil Liberties Union review.³

The Task Force found instances reported in the media in which individuals engaging in some of these practices have been charged criminally. In a recent case in New Jersey, a special education tutor was sentenced to one year in jail under the terms of a plea bargain for hitting, kneeling, and shaking a severely disabled child. Similarly, in Florida, a man used a mild electric current to try to teach a boy in his care not to urinate into wall sockets. His stated motivation, similar to that employed by those currently advocating the use of aversive stimuli or consequences, was to teach the child not to do something potentially self-injurious. The man has been charged with aggravated child abuse and the child removed from his care.

The Task Force is unaware of any authority of NYSED to legalize techniques that are prohibited by the penal code, child abuse laws, and child neglect provisions

Disturbingly, some of the “techniques” listed in this section of the amendments sound eerily similar to recent reports about methods for interrogation of suspected terrorists that have been labeled as “torture” and widely condemned by human rights organizations.

² In June 2006, in *State of CT Office of Protection & Advocacy v. Hartford Bd. of Ed.*, the United States Department of Justice filed an amicus brief on behalf of the US Department of Health & Human Services and US Department of Education which took the position that 42 USC §15009 applied to public schools operated by school districts such as the Hartford Public Schools. Counsel at both at the United States Departments of Justice and the Office of Counsel of the United States Department of Health & Human Services have reportedly told at least one special education attorney that in their view, 42 §15009 applies to both day and residential schools.

³ Testimony of Beth Haroules for the NYCLU at public hearings in NYC, August 14, 2006, http://www.nyclu.org/nysed_specialed_behaviour_rules_tstmny_081406.html

If NYSED did not intend to convey that all of the interventions listed in the general prohibition are possible with a child-specific waiver, it should have indicated in the amendments specifically indicate which of the listed aversive behavioral interventions could never be permitted under any circumstances. In its communications with other mental health organizations, advocacy groups, and civil rights organizations, there has been a shared confusion as to why NYSED would list “strangling” as an aversive behavioral intervention and not make clear that it would never be permissible under any circumstances.

Aversive procedures that the amendment proposes to authorize for disabled students would constitute corporal punishment if employed as interventions for non-disabled students. Under the corporal punishment prohibitions, teachers and school personnel may not hit, kick, punch, hurl, or strangle a non-disabled child as punishment for behavior but it appears that, under the regulations, the prohibition against these procedures for disabled students would effectually be lifted by calling the technique an “aversive behavioral intervention” and obtaining a waiver. The implications of regulations that selectively permit the use of corporal punishment with disabled youth but not nondisabled youth are both obvious and disturbing, regardless of whether one calls it “corporal punishment” or “aversive behavioral intervention.”

Absence of evidence-based research. Even if such techniques were legal to use in schools, the Task Force found a lack of data from controlled and replicated research in school settings demonstrating a connection between use of many of the adverse behavioral interventions listed in these amendments and effective, safe modification of stipulated problem behaviors. In fact, in the introduction to its own proposal, NYSED acknowledges a lack of empirical support for the very interventions its amendments now permit by waiver. Although NYSPA’s Task Force did find some published studies demonstrating significant reductions of severely self-injurious behaviors in selected cases employing the use of certain aversive procedures such as electric skin shock (cf, Jacob-Timm, 1996), and a few studies employing aversive techniques that were conducted in school settings, most of the studies on aversive controls are based on use in clinical or residential settings, do not provide long-term follow-up data, and do not warrant any firm conclusion that any positive effects would be obtained or replicated in public school settings. Furthermore, other studies and reports failed to verify efficacy of some of these interventions at all and, in some cases, reported exacerbation of problem behaviors following administration of these “techniques.” Other clinical studies, as well as reports from protection and advocacy organizations and professional mental health associations, have discussed the risk of psychological trauma, marginalization, or alienation related to use of punitive or aversive measures on disabled youth.

For all of the reasons previously described, the Task Force recommends that aversive behavior interventions be prohibited, without exception, as part of a behavior intervention plan. This would not preclude use of particular techniques or treatments if they are medically necessary to protect the child from serious self-injurious behavior or other-injurious behavior. The Task Force recognizes that there may be some extreme cases requiring treatment approaches incorporating aversive components, but we think that those should be viewed as treatment plans, not behavior intervention plans.

Should NYSED decide not to enforce a total prohibition and to consider such interventions within a treatment plan approach, more safeguards and protections are required as part of the BIP process and child-specific waiver, as described below.

As outlined, the amendments provide insufficient safeguards against inadequate, inappropriate and potentially harmful use of aversive procedures. Given the severe nature of what these provisions may permit by a child-specific waiver, the establishment of stringent, unambiguous safeguards to consider any application for exception would seem of utmost importance. In our view, however, the amendments do not provide required and medically necessary levels of protection.

Authority of the Commissioner's Panel. The regulations specify a review procedure by "an independent panel of experts appointed by the commissioner", but lack any stipulation that these recommendations to the child's CSE or CPSE are in any way binding. The regulations require the CSE or CPSE to consider the panel's finding and then to notify the commissioner if it then grants itself a waiver to use these techniques. In our view, this reduces the role of the "expert panel" to an advisory function, opening the door for a unitary CSE to amend or reject recommendations by licensed physicians, psychologists and others about critical treatment decisions for which they have required expertise. The commissioner's panel must have the authority to deny a waiver if the State is serious about protecting the safety of students.

Physician and Psychologist Consultations. Without stipulating that aversive techniques are legally permissible or that they are adequately validated and ethical, the Task Force notes that at the very least, the regulations should require consultation with a licensed physician and a licensed psychologist or certified school psychologist with expertise in the student's disabilities to examine or assess the student and to advise the CSE or CPSE whether there are any medical or psychiatric/psychological complications or contraindications to the use of an aversive behavioral intervention for that particular child.

As NYSED's report on one state-approved school suggests, if schools are considering using aversive interventions on children with psychiatric histories such as Post-Traumatic Stress Disorder (PTSD), a higher level of monitoring for adverse effects is required (at the very least). Including professionals with high levels of competence and expertise on the child's disorders is necessary to insure the development of a plan that includes adequate monitoring of potential adverse effects. Inclusion and active participation of these professionals will also address another concern raised by NYSED's site monitors, who expressed concern that a program did not differentiate between the treatment of students with psychiatric disorders and those with developmental disabilities. We concur with the site monitors' concern. What is safe, effective, appropriate, and legal for one population may not be safe, effective, appropriate, or legal for another population.

Behavior Analyst Consultation and Involvement. In its evaluation report on one state-approved placement, NYSED site monitors raised concerns about the level of training and competence of those who were designing behavioral interventions. We concur with their concern that those developing plans must have high levels of competence in behavior analysis, and we recommend that in addition to consultation with a physician and psychologist, a CSE considering an aversive behavioral intervention for a specific student should also consult with a certified behavior analyst or a psychologist with a high level of competence in behavior analysis.

Availability of Appropriately Qualified Personnel. In considering whether to apply for child-specific waiver, the student's CSE/CPSE must also consider whether it has appropriately trained and qualified personnel to implement, supervise, and monitor the aversive behavioral intervention. Under no circumstances should a school implement an aversive behavioral intervention if it does not have appropriately trained and qualified medical and clinical personnel and cannot make arrangements to have appropriately trained and qualified medical and clinical

personnel present in the child's school building at all times that the student would be exposed to the aversive behavioral intervention. The Task Force concurs with concerns raised by NYSED site monitors that the use of aversive controls requires more than just monitoring to see if a treatment is being implemented as planned; it requires assessment and monitoring for adverse physical and emotional sequelae of any aversive intervention and such assessment must be performed by those with the necessary clinical skills.

For those reasons, and although it would not be practical for NYSED to adopt all of the federal regulations that protect disabled youth in restraint or seclusion, the Task Force was unanimous that simply assigning "staff" to monitor students in involuntary time out rooms was inadequate to protect the health and safety of students. Specific recommendations for necessary safeguards are provided later in this report.

Summary. NYSPA's Task Force believes that at least two of the aversive behavioral interventions identified in the regulations are flatly illegal as behavior interventions for developmentally disabled students if they are not confined to emergency situations only, and other interventions may be illegal under NYS law for all disabled students, especially since they appear to permit corporal punishment of disabled – but not nondisabled – students. Most of the interventions are not supported by adequately controlled research for use in school settings even if they are legal.

The recommended safeguards are not meant to imply that NYSPA endorses the use of aversive behavioral interventions in schools. The Task Force recognizes that there may be situations in which a student has a serious self-injurious symptom or behavior that may not respond to positive supports in schools, despite the best efforts of school personnel. Under such circumstances, the Task Force views this as a treatment issue, not an educational issue. We do not believe that NYSED is the appropriate state agency to deal with serious health and treatment issues or that a CSE is the appropriate forum for making treatment decisions. That said, if it is legal to use such techniques, and if the State permits CSEs to make such decisions, then the student's CSE should consult with at least one physician who has examined the child and who can address any medical concerns or complications, one psychologist who has assessed the child and who can address any psychiatric or psychological concerns, and one certified behavior analyst or psychologist with expert knowledge of behavior analysis and program development. Any proposed plan should conform to treatment standards and treatment protections found in federal laws and regulations, including the need for assessment and screening for adverse psychological consequences of an aversive intervention.

“Corporal Punishment”

Corporal punishment, defined as “any act of physical force upon a pupil for the purpose of punishing that pupil” was previously prohibited under the Rules of the Regents. The new amendments weakened the prohibitions by permitting physical force, if no other alternatives can be reasonably employed:

- [(1)] (i) to protect oneself from physical injury;
- [(2)] (ii) to protect another pupil or teacher or any person from physical injury;
- [(3)] (iii) to protect the property of the school, school district or others; or

[(4)] (iv) to restrain or remove a pupil whose behavior is interfering with the orderly exercise and performance of school or school district functions, powers and duties, if that pupil has refused to comply with a request to refrain from further disruptive acts.

The Task Force concurs that the use of force may be necessary to protect oneself from injury or to protect another person from injury if the child is assaulting someone or there is an imminent threat of serious physical injury. The Task Force has significant concerns about the last two approved uses of physical force, however, even if other methods have failed or could not be reasonably employed.

As worded, the new regulations give far too much room for individual interpretation of behaviors warranting the use of physical force for restraining or removing a student. Language such as “A pupil whose behavior is interfering with the orderly exercise and performance of school district functions” is far too general and ambiguous, opening the door for actions that may not actually be warranted and risking unnecessary harm to the individual student, other students and school personnel. The Task Force also notes that it is not physical force, but rather, restraint, that may be indicated (see Restraint section for recommendations).

There is also the risk that misinterpretation or misunderstanding about the behavioral manifestations of a particular student’s disability could lead to more excessive action in handling the student than is necessary or warranted.

Part of the problem that Task Force members noted with the new exceptions is that they do not adequately distinguish between corporal punishment and physical force/restraint. Physical force or restraint may be perceived by the student as punishment, even if it is not intended as such. Therefore, although the regulations prohibit the use of corporal punishment, by not adequately defining and restricting “restraint” and “the use of physical force,” some students may feel that they are subject to corporal punishment and indeed, some school personnel may use force that is essentially corporal punishment even if they do not intend it as corporal punishment.

The Task Force also expressed significant concerns that the new regulations effectually permit corporal punishment of disabled (but not nondisabled students) via a waiver process, as discussed in the section on “aversive behavioral interventions.”

The Task Force therefore recommends that *exceptions [(3)] (iii) and [(4)] (iv) in the corporal punishment provisions be revoked*; Additionally:

Under conditions where a child is behaviorally out of control, provisions concerning the emergency use of restraint or holding should apply.

Restraint

Public Debate and Policies

In 1998, the Hartford Courant published an investigative report by Eric Weiss and others that dealt with deaths due to restraint or seclusion. Their report identified 142 such cases during the previous 10 years and started a public and professional discussion that led to further investigations on the safety of restraint and seclusion. The GAO subsequently conducted its own study, focusing on populations receiving services for mental illness or mental retardation in residential facilities receiving public funding. Their report, published in 1999, also noted significant risks of harm, trauma, or death associated with restraint and seclusion. The GAO

report formed the basis, in part, for subsequent federal regulations prohibiting the use of non-emergency restraint and seclusion on mentally ill youth. As noted previously, the President's New Freedom Commission on Mental Health also concluded that "... it is inappropriate to use seclusion and restraint for the purposes of discipline, coercion, or staff convenience."

Most medical, psychiatric, and law enforcement agencies have strict guidelines regarding the use of physical restraint that prohibit the use of restraint and seclusion for developmentally disabled or mentally ill youth for anything other than an immediate emergency where there is imminent risk of significant injury to the child or others. Accreditation requirements are needed from organizations such as the Joint Commission on Accreditation of Healthcare Organizations, the National Association of Psychiatric Treatment Centers for Children, and the American Academy of Pediatrics. There have been no accreditation requirements for schools or various child care agencies, however (Ryan & Peterson, 2004). This results in the possibility for more abuses of the use of restraints, a lack of training, and inaccurate and punitive implementation.

Research on Restraint

In a review of the literature on restraint and seclusion, Day (2000) noted that:

In general, children's reactions as reported in the literature were by and large negative. Common emotional reactions, for example, included neglect, fear, a loss of control, vulnerability, and of being punished (Angold, 1989; Martinez et al., 1999). Myriad other such reactions have been reported, such as feelings of anger, anxiety, boredom, confusion, embarrassment, depression, humiliation, abandonment, loneliness, sadness, loss of dignity, powerlessness, helplessness, despair, and being delusional (Angold, 1989; Appelstein, 1993; Plutchik et al., 1978; Singh et al., 1999; Walsh & Randall, 1995; Wherry, 1986). Raychaba (1992) found that the improper use of seclusion and restraints may lead to feelings that one is "bad" and "sick" and needs to be locked up. The experience may be particularly problematic for children who have been victims of violence or abuse (Earle & Forquor, 1995; Raychaba, 1992).

An extensive review of the literature indicated no research existed concerning how extensive restraint in schools has become. Day (2002) found that restraint in residential settings is common with 34% of staff using these procedures more than twice a week (Hunter, 1989). Day (2002) concluded that there was little empirical support for therapeutic benefits to children receiving restraint, although others conclude that restraint in inpatient settings is necessary, safe, and effective (cf, Ziegler, 2004 for a discussion of these issues).

Ryan and Peterson (2004) provide a helpful review of the research and issues relating to the use of restraint in school settings. In addition to one survey of teachers reporting on use of various techniques to address aggressive or disruptive behaviors (Ruhl & Hughes, 1985), Ryan and Peterson found only two studies that experimentally investigated physical restraint in schools settings. In one single-case study that appears to have been conducted in a special education school, Grace, Kahng, and Fisher (1994) reported positive effects of a 3-minute basket hold technique for seriously destructive and somewhat lesser destructive behaviors in a nonverbal 11 year-old with severe mental retardation. In contrast, Magee and Ellis (2001) reported negative effects of physical restraint in two developmentally disabled children when the function of the targeted behavior had not been clearly established; in those cases, restraint positively reinforced problematic behavior or was ineffective in decreasing problematic behavior.

Because there is very little controlled research on the use of restraint in school settings, the Task Force searched the clinical literature for safety issues or risks that might be applicable to school settings. In addition to the emotional sequelae noted earlier, Day (2000) provides a clear warning:

Fourth, restraints and seclusion should never be used with children who present with certain psychological or medical characteristics or under certain circumstances... Contraindications for the use of seclusion and restraints with children include a history of sexual abuse, physical abuse, or neglect and abandonment (Cotton, 1989; Masters, 2000; Mayton, 1991), the availability of only male or only female staff to perform the restraint (Sourander et al., 1996; Vander Ven 1988), risk of psychosis (Vander Ven, 1988; Kupfersmid, Mazzarins, & Benjamin, 1988), risk of excited delirium, usually as a result of drug intoxication (Chan, Vilke, Neuman, & Clausen, 1997), or if the intrusive measure is positively reinforcing the behaviour (Fisher, 1994; Mayton, 1991; Masters & Devany, 1995). For example, some adolescent males may find being physically restrained by female staff as sexually stimulating (Vander Ven, 1988).

The possibility that restraint might positively reinforce the undesirable behavior was confirmed by the Magee and Ellis (2001) report in schools. In the absence of comparable research in school settings for the other identified risk factors, prudence would dictate that the same contraindications be applied, but the amendments contain no such exclusions or contraindications to the use of physical restraints.

As noted in the section on “aversive behavioral interventions,” apart from any psychological or health reasons for recommending a restriction on the use of restraint, 42 USC § 15009 flatly prohibits the use of restraint with developmentally disabled youth for anything other than emergency safety situation. Even when restraint would be permissible – to protect the health and safety of the child or others from imminent and serious physical injury -- NYSED’s regulations contain no provision for psychological assessment of the child immediately following use of restraint, and do not require frequent and periodic review of the child’s overall psychological functioning once a plan has been implemented. Mohr (2002), testifying to the Centers For Medicare And Medicaid Services, discussed the importance of debriefings, noting how in her study of the debriefing process following restraint of seriously emotionally disturbed youngsters, the children often did not know why they had been restrained; the reasons they perceived differed from the staff member’s report. Restraint, then, may not decrease the likelihood of future episodes if there is no adequate debriefing so that the student can make the connection between the behavior and the restraint.⁴ Assessment of a child in restraint and the need for prompt debriefing have been universally recommended by all major mental health associations, but such protections were not included in NYSED’s regulations.

On the basis of the above, the Task Force finds that NYSED’s new regulations fail to incorporate sufficient safety standards and fail to protect the rights of developmentally disabled students. The regulations also fail to address issues such as economic and minority status factors that may lead to selective and discriminatory use of restraint and fail to insure that all

⁴ Mohr’s statement represented the position of Advocates Coalition for the Appropriate Use of Restraints; the coalition’s organizations include The Arc of the United States, the Bazelon Center for Mental Health Law, The National Association of Protection and Advocacy Systems, The National Alliance for the Mentally Ill, The Federation of Families for Children’s Mental Health, Children and Adults with Attention Deficit/Hyperactivity Disorder, The International Association of Psychosocial Rehabilitation Services and The National Mental Health Association.

school personnel are fully trained and certified in crisis de-escalation and research-validated restraint methods before they first restrain a child.

In its report on restraint-related deaths, Protection & Advocacy, Inc. (2002) described a number of cases where death was due to positional asphyxiation from restraint. In a number of cases, death due to restraint occurred after only a few minutes of restraint. A review of the cases and the published literature suggest a number of factors that may contribute to restraint-related deaths:

- position during restraint, particularly the prone position;
- agitated delirium syndrome;
- obesity;
- prolonged struggle or physical exertion;
- drug and/or alcohol intoxication, in particular cocaine and methamphetamine intoxication or cocaine-induced psychosis;
- mania;³
- respiratory syndromes, including asthma and bronchitis;
- exposure to pepper spray (capsicum); and
- pre-existing heart disease, including an enlarged heart (hypertrophic cardiomyopathy) and other cardiovascular disorders

³ *Persons with mental disorders, especially drug-induced or psychotic illness-induced agitated delirious states, seem to be at greater risk.*

Some of the factors the P & A noted would also apply to students, who are more likely to struggle wildly if restrained, who may be manicky due to Bipolar Disorder, or who may have asthma. Recent reports on NYC students indicate that special education students in NYC schools have a rate of asthma that is twice as high as the general population of students. If restraining a student with asthma is particularly risky, NYSED and the NYC DOE need to take steps to disseminate this information to schools and to insure that the children's safety is protected. We also note that students with Down Syndrome are more likely to have cardiac conditions and that the use of emergency restraint techniques or compression on the chest might lead to serious injury or death.

The P & A report also noted that even when patients were being monitored while in restraint, staff might misinterpret the behavior. For example, the staff, seeing the patient stop struggling, might conclude that the patient had now calmed himself, when in fact, the patient had gone into respiratory arrest. If trained staff working in specialty units and facilities can make such mistakes, it is inadequate to merely specify that a "staff" member must monitor the situation.

Despite the fact that restraint can lead to death, NYSED's regulations contain no provisions about careful physical examination and review of a student's health history to determine if restraint might be fatal. Nor do the regulations require periodic monitoring and medical/clinical assessment to assure the child's safety as well as a clinical psychological assessment following restraint.

.The Task Force therefore recommends that:

- *NYSED should restrict the use of restraint to safety emergencies involving imminent risk of serious physical injury to the child or others;*

- *For classified students who might need emergency restraint, the student should be examined by a physician who can determine whether restraint is permissible at all, and if so, what kind -- or if it must be barred for the student due to other health factors;*
- *For classified students who might need emergency restraint, the student should be examined by a licensed psychologist or a certified school psychologist with expertise in the student's disabilities who can determine whether the student has a psychiatric or social history that might preclude restraint or that might necessitate only using a particular type of restraint by a particular type of staff;*
- *NYSED should require that all personnel who might need to employ emergency restraints first obtain training and certification in a research-validated method of crisis de-escalation and safe restraint (such as SCIP-R);*
- *NYSED should require schools to record and report all instances of emergency restraint and all injuries resulting from restraint,*
- *NYSED should require that parents be notified in writing of each and every instance of emergency restraint;*
- *NYSED should require that all injuries associated with the use of restraint be immediately reported to the child's parents verbally and then in writing;*
- *NYSED should adopt, by regulation, essential safety precautions such as the use of medically trained personnel to monitor students in emergency restraint, the use of appropriately qualified clinical personnel to assess the child's emotional status following emergency restraint, and the use of debriefing following any instance of emergency restraint. This information should also be recorded and reported to the State.*

Time Out Rooms

Time Out vs. Time Out Rooms

Time out from positive reinforcement is a research-validated and effective behavior management technique if used properly. The use of time out rooms in schools as opposed to time-out procedures used in the classroom or in close proximity to the classroom has not been as well researched, however. In reviewing the new amendments, the Task Force found that although NYSED's new regulations addressed some issues related to time out rooms, it failed to restrict their use in ways that would be consistent with available research, federal law, federal regulations designed to protect the health, safety, and rights of developmentally disabled or mentally ill youth, and the ethical treatment of disabled youth.

Definitions and Levels of Time Out

There are two basic classes of time out procedures: student-directed or student-initiated time out and teacher-directed time out.

A student-directed or student-initiated time out is often a useful technique when a child is experiencing a sense impending personal deregulation. The child, by prior arrangement with, and signal to the teacher, may elect to just step out of the room for a few minutes to take a walk for a few minutes, or to engage in an activity that allows the child to restore him- or herself to calm. No adult intervention or support may be necessary; the child simply needs time to "re-group." Such student-initiated time outs can often prevent inappropriate or disruptive behavior in the classroom and should generally be encouraged. Teachers can support the student's efforts to self-manage by insuring that the student does not miss any important notes or work while the student is out of the classroom. If students repeatedly take self-initiated time outs, however, the student's team should consider whether the time out is not a neutral time out but

rather an escape from academic work or if there is any other secondary gain that needs to be addressed. School personnel also need to insure that the positive reinforcement associated with time-in activities is rich compared to time-out.

Teacher-directed time-outs include a variety of interventions that vary in their intensity and in the isolation of the student from the usual setting:

- Non-punitive “take a break or time-out” procedures where the teacher suggests or permits the student to take a break from a frustrating task that might lead to deregulation or loss of control;
- “Sit and watch” or observational techniques where a child does not earn positive reinforcers during the specified period but still learns and remains in the classroom;
- Procedures such as “the Good Choice Chair” or “Time to Yourself Chair,” where the child physically moves to another location in the classroom and can neither observe the activity nor earn positive reinforcers;
- Situations in which the child is sent to a nearby classroom and is under that teacher’s observation for the specified time (“exclusionary time out”);
- Situations in which the child is sent to the principal’s office or a counselor’s office to just sit for a specified amount of time without interacting with anyone;
- Situations in which the child is sent to the counselor’s office to seek help in restoring her- or himself to calm;
- “Seclusionary time out” (considered “exclusionary” time out by some sources) where the child is removed or sent to a room in isolation and is not permitted to leave the room at will. In one study, students in a separate special education facility were found to have spent, on average, 23 hours in isolation time out rooms over a single school year (Costenbader & Reading-Brown, 1995).

The issue of whether time out rooms are wholly equivalent to “seclusion” as used in clinical settings is beyond the scope of this report, but Day (2002) provides a clear statement of some of the issues:

Time-out will be most effective when: (a) the environment is pleasurable for the child; (b) removal from that environment is seen as a negative consequence for misbehavior; (c) the procedure is implemented consistently by staff; and (d) the procedure is perceived by staff and children as fair, that is, not punishment, and everyone knows and agrees on or consents to the rules up front. Time-out will *not* be effective if it is implemented by staff, and perceived by the child, as punishment and if it becomes too aversive, for example, with lengthy periods of isolation in a negative location. Indeed, opponents of the use of seclusion assert that seclusion is sufficiently different from time-out and, as a result, is removed from the context of these fundamental theoretical principles. In this regard, as Angold (1989) and Atkins and Ricciuti (1992) have observed, the theoretical basis for seclusion is likely punishment. As well, some writers have clearly distinguished between seclusion and time-out (e.g., Atkins & Ricciuti, 1992; Smith, 1991), whereas others have not, instead conceptualizing a number of procedures under the general rubric of seclusion (e.g., Endres & Goke, 1973; Miller, 1986).

If schools are using time out rooms for purposes of seclusionary or exclusionary time out – where the child is not allowed to leave the room -- even if there is no lock on the door -- then the reason for the seclusion is an issue that must be addressed in the regulations. Both clinical and school-based literature suggest that seclusion may be necessary and helpful at times for children who are severely deregulated and who need a place and time to regain control or

calmness, and some reports suggest that although children and adolescents may initially feel anger and humiliation as a consequence of such techniques, some youth eventually develop neutral or even positive perspectives on their experiences (e.g., Lowenstein (1998) in Day, 2000). But federal law is clear that seclusion of developmentally disabled youth can only be used for emergency situations where there is risk of imminent harm to the student or others; Seclusion may not be used for punishment, discipline, or coercion purposes.

As discussed in the section on Restraint, there are professionally recognized contraindications to the use of seclusion and significant reports of psychological harm or injury associated with seclusion, but the new amendments fail to address these issues adequately. In 2006, the American Psychological Association Zero Tolerance Task Force issued its draft report, "Are Zero Tolerance Policies Effective in the Schools? An Evidentiary Review and Recommendations." That report noted:

To the extent that zero tolerance policies are related to student shame, alienation, rejection, and breaking of healthy adult bonds, there are a number of reasons to be concerned that such policies may create, enhance, or accelerate negative mental health outcomes for youth. Some have suggested that the psychological effects of the coercion and shaming of students are linked to the increase in delinquent behavior. Further, the potential effects of alienation, rejection, and isolation associated with punitive and exclusionary school discipline are well documented, and may distance youth from healthy peer communities, accelerate contact with delinquent peers, reduce the amount of adult supervision they receive, and enhance the likelihood of marginalization.

The inappropriate use of seclusionary time out may also lead to the negative sequelae described above.

Medications, Restraint, and Seclusion/Time Out Rooms

The 1999 GAO report noted that:

Many advocates we spoke with indicated that restraining individuals who are on certain medications can be risky. For example, a commonly prescribed antidepressant may result in metabolic problems when a patient's movement is restricted, which may lead to life-threatening hyperthermia. Clinicians have postulated that potentially fatal cardiac arrhythmia can result from the combination of certain drugs and the adrenaline produced by an individual's agitation and physical struggle while being restrained. (p. 10)

An article by Richard Friedman, M.D., that appeared on June 19, 2006 in the New York Times also describes the increased risks of hyperthermia associated with medications such as Prozac (or other selective serotonin reuptake inhibitors), allergy medications, antihistamines, and psychostimulants such as Dexedrine and Ritalin. More recently, the NYS Commission on Quality of Care and Advocacy for Persons with Disabilities issued an alert to New York State facilities on precisely this issue. Because many children with mental illness - classified as "emotionally disturbed" by NYS CSEs - take many of the medications listed in Dr. Friedman's article and the CQC's alert, the CQC's recommendations are particularly important to consider for safety reasons.

Despite the serious risk to health, safety, and life, NYSED has not disseminated this information to schools and does not include, or refer to, many of those protections in its new regulations.

The Task Force recommends that, in addition to revising the regulations to conform to federal prohibitions, if time out rooms as aversive behavioral interventions are permissible legally, then the regulations should be amended to:

- *Require signed informed consent following an explanation of potential benefits and risks for the use of time out room as part of a behavior plan with the specific behaviors resulting in time out being listed in the written plan;*
- *Require examination by a physician to insure that the child has no medical complications that would preclude the use of time out rooms;*
- *Require assessment by a licensed psychologist or a certified school psychologist with expertise in the student's disabilities, to insure that the child has no psychiatric or social history that would preclude the use of time out rooms;*
- *Require the maximum amount of time a child may be kept in a time out room to be specified in the written plan, and the maximum number of instances per day;*
- *Require that time out seclusion rooms be maintained or cooled to within the thermal comfort zone of 70-74°;*
- *Require schools to insure that staff who monitor a student in seclusionary time out have the necessary medical and clinical skills to determine if a child's physical or emotional health is in danger, and*
- *Require time out rooms to conform to health code regulations.*

While the new regulations state that time out rooms should comply with local safety and fire regulations, no mention is made of compliance with health code regulations or requirements. The Task Force is aware of some cases in which parents have raised serious concerns about the cleanliness of time out rooms. In order to protect against transmission of diseases communicable via body fluids, the regulations should be revised to include a requirement that each room which is, or may be, used for time out/seclusion purposes must meet all applicable health code and be regularly inspected to insure compliance with such code requirements.

In addition:

- *NYSED should prohibit locks on any door of any room that is used for time out/seclusion;*
- *NYSED should immediately disseminate critical health and safety information to all schools, BOCES, and state-approved private schools, state-operated residential schools, and preschools;*
- *All instances of seclusion in time out rooms should be reported to the child's parents in writing and to the State,*
- *All instances of injuries during seclusion must be reported to the child's parents as soon as possible (verbally, and then in writing); and must be reported to the State.*

Misuse and Abuse of Time Out Rooms

The Task Force is aware of numerous complaints of overuse and misuse of time out rooms in NYS, and media reports at least several lawsuits filed this year over time out room misuse and abuse. We urge NYSED to make decreasing time out room abuses and misuse a priority.

In the newly enacted regulations, there appears to be some internal inconsistency relating to the use of time out rooms. Time out rooms are first discussed in the section on "behavioral intervention plans" [at 200.22 (c)]. If the Regents consider the non-emergency use of time out

rooms to be an aversive behavioral intervention only permissible by a child-specific waiver, then the regulations should state so clearly in this section. If that is not their intention, then the regulations need to specify under what conditions a school may use a time out room. The Task Force strongly recommends that the use of involuntary time out rooms be restricted to emergency safety situations and that all other involuntary use be considered an aversive behavioral intervention.

Potential for Discrimination

Reviews of the clinical literature on the use of restraint and seclusion have identified child variables which appear to be correlated with, or predict, increased likelihood for referral for restraint, seclusion, or punitive behavioral interventions. Younger age, nonwhite or minority status, diagnosis of ADHD, Conduct Disorder, or impulsive control disorder, length of stay in facility, and low IQ or neurological impairment are all correlated with increased use of restraints and seclusion (Day, 2000). Hence, in developing regulations that place children at greater risk of injury, harm, or death, it is critical to also consider whether minority students may be at even additional risk.

An issue brief on zero tolerance policies published by the Virginia Department of Education in 2005 noted that:

Racial and gender disproportionality in the use of punitive school discipline has been a highly consistent finding in many studies (Children's Defense Fund, 1975; Glackman et al., 1978; Wu et al., 1982; Taylor and Foster, 1986; McCarthy and Hoge, 1987; Gregory, 1996; Civil Rights Project, 1999; Advancement Project and the Civil Rights Project, 2000). Overrepresentation of students with disabilities has also been found (McFadden et al., 1992; Lietz and Gregory, 1978).

Considering the application of zero tolerance policies as related to economic and minority status, the American Psychological Association Zero Tolerance Task Force noted that:

The right not to be discriminated against on the basis of race, color, or national origin is guaranteed by the Equal Protection Clause of the Fourteenth Amendment and Title VI of the Civil Rights Act of 1964 (Browne, Losen, & Wald, 2002). Yet almost 30 years of research has documented disparities in school discipline due to race and, to a lesser extent disability. Such concerns are magnified if, as suggested above, the intervention to which some students are differentially exposed is itself associated with negative educational outcomes.

In addition to the issue of whether children with disabilities are more likely to be exposed to the application of noxious stimuli as punishment for symptoms of their disabilities, there is also the issue of whether children with disabilities will be more likely to be removed (forcibly or otherwise) from classrooms for symptoms of their disabilities (such as calling out, vocalizations, tics, self-stimulatory behaviors, etc.) The American Psychological Association Zero Tolerance Task Force found that:

Students identified with emotional disturbance (ED) appear to be at higher risk for office referral, suspension or expulsion. Drawing from a nationally representative database, Wagner et al. (2005) found that 47.7 percent of elementary/middle school, and 72.9 percent of high school students with ED reported being suspended or expelled,

percentages significantly higher than students with other disabilities (11.7% at the elementary/middle school level, and 27.6% at the secondary school level).”

Significantly, the APA task force did not find clear evidence that any disciplinary disparities were due to disproportionately higher rates of serious misbehavior by disabled students.

NYSED’s own records show that the vast majority of the children sent to the Judge Rotenberg Center (JRC) are from NYC schools, which is a predominantly minority public school system; that some of these children have diagnoses of autism, Attention Deficit Hyperactivity Disorder, and Obsessive-Compulsive Disorder, and many are abandoned or abused children. The majority of NYS students at JRC are receiving Level III aversives (electric skin shock).

Since NYSED is currently, and has been for some years, working on the problem of over-representation of minority students in special education, the possibility that minority students will also be over-represented in the group of students who are subjected to restraints and/or time out/seclusion cannot be ruled out.

Data provided by NYSED to the federal government also show that children in NYS who are classified as "emotionally disturbed" are currently subjected to long-term suspensions and expulsions 2.5 times as often as are all children with disabilities as a group. It is reasonable to predict that they would also be subject to more of each of the aversive behavioral interventions defined in the new regulations.

Thus, unless the new regulations are withdrawn or amended, it is possible that symptoms of neurological or emotional disorders may be misunderstood as willful misbehavior. These children may be more likely to be: subjected to corporal punishment; sent to time out rooms for non-emergency reasons, or referred for aversive behavioral interventions in those schools and classrooms where there are zero tolerance policies, where there has not been adequate professional training in behavior management or where the teacher and school personnel have not been given adequate training and support to manage the diverse needs of students.

The Task Force notes that these recommendations are not intended to suggest that deregulated or disruptive students may never be sent from the classroom. We believe that providing teachers, CSE members, and other school personnel with greater training and information on research-validated positive behavior supports would obviate the need for many removals. We also believe that insuring that teachers and other school personnel all receive training in crisis de-escalation techniques could reduce the number of instances that may lead to removal, and better protect the safety of students and school personnel. In those instances where positive supports and crisis de-escalation techniques fail, helping the student restore him- or herself to calm should be the immediate goal. Non-punitive time outs with clinical support are more likely to be effective than punishment, which may lead to further deregulation instead of the desired effect.

Summary

The new amendments that incorporate prohibitions and limitations on the use of aversive behavioral interventions, corporal punishment, and time out rooms attempt to protect disabled students, and as such, we commend the Regents for their efforts. As worded and enacted, however, the new regulations violate some federal laws and regulations that concern the rights and treatment of disabled youth. Even if some methods are permissible legally— and we are not sure that they are -- they are generally not considered advisable, and our strong

recommendation is to prohibit them all as planned aversive consequences, without exception, as part of a behavior intervention plan. Should some of the techniques be legally permissible or medically necessary treatments, then NYSED should incorporate the necessary safeguards and protections, including inclusion of more medical and clinical personnel and higher training and certification standards for personnel. The Task Force believes that improving standards for teachers, CSE members, and other school personnel on understanding the diverse needs of students, behavior intervention techniques, and research-validated positive behavior supports might obviate the perceived need for some referrals for aversive interventions. The Task Force also believes that requiring and improving standards and certification for crisis de-escalation techniques and safe restraint methods may also prevent the unnecessary use of physical interventions, thereby improving safety for both students and school personnel.

NYSPA stands ready to share its resources with NYSED and to collaborate with other professionals in planning training that will improve outcomes and safety for our most vulnerable students and school personnel.

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References

42 CFR 483.356-- Subpart G--Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric. Retrieved August 5, 2006 from: <http://www.access.gpo.gov>

42 CFR 483.450-- Subpart H--Condition of participation: Client behavior and facility practices.. Retrieved August 5, 2006 from: <http://www.access.gpo.gov>

42 USC§ 290ii and 42 USC § 290jj Retrieved July 26, 2006 from http://caselaw.lp.findlaw.com/cascode/uscodes/42/chapters/6a/subchapters/iii-a/parts/h/sections/section_290ii.html and http://caselaw.lp.findlaw.com/cascode/uscodes/42/chapters/6a/subchapters/iii-a/parts/i/sections/section_290jj.html

Advancement Project and Civil Rights Project. (2000, June). *Opportunities suspended: The devastating consequences of zero tolerance and school discipline policies*. Cambridge , MA : Harvard University Civil Rights Project.

American Psychological Association Zero Tolerance Task Force. (February, 2006). *Are zero tolerance policies effective in the schools? An evidentiary review and recommendations*. Retrieved July 26, 2006 from http://www.educationnews.org/PR/Zero_Tolerance_Task_Force.htm.

Angold, A. (1989). Seclusion. *British Journal of Psychiatry*, 154, 437-444.

Appelstein, C. D. (1993). Gus II: The restraint. *Residential Treatment for Children and Youth*, 10, 101-110.

Atkins, M. S., & Ricciuti, A. (1992). The disproportionate use of seclusion in a children's psychiatric state hospital. *Residential Treatment for Children and Youth*, 10, 23-33.

Browne, J. A., Losen, D. J., & Wald, J. (2002). Zero tolerance: Unfair, with little recourse. In R. J. Skiba & G. G. Noam (Eds.), *New directions for youth development (no. 92: Zero tolerance: Can suspension and expulsion keep schools safe?)* (pp. 73-99). San Francisco : Jossey-Bass.

Chan, T. C., Vilke, G. M., Neuman, T., & Clausen, J. L. (1997). Restraint position and positional asphyxia. *Annals of Emergency Medicine*, 30, 578-586.

Children's Defense Fund. (1975). *School suspensions: Are they helping children?* Cambridge , MA : Washington Research Project.

Civil Rights Project. (1999, December). *On "zero tolerance" policies: An issue brief*. Testimony submitted to the U.S. Commission on Civil Rights). Cambridge , MA : Harvard University Civil Rights Project.

Costenbader, V., & Reading-Brown, M. (1995). Isolation timeout used with students with emotional disturbance. *Exceptional Children*, 61, 353-363.

Cotton, N. (1989). The developmental-clinical rationale for the use of seclusion in the psychiatric treatment of children. *American Journal of Orthopsychiatry*, 59, 442-450.

Day D. (2000). A Review of the literature on restraints and seclusion with children and youth: Toward the development of a perspective in practice. Retrieved July 26, 2006 from <http://rccp.cornell.edu/pdfs/Day.pdf>.

Day, D.M. (2002). Examining the therapeutic utility of restraint and seclusion with children and youth: The role of theory and research in practice. *American Journal of Orthopsychiatry*, 72, 266-278.

Developmental Disabilities and Assistance Bill of Rights Act, 42 USC § 15009.

Earle, K. A. & Forquer, S. L. (1995). Use of seclusion with children and adolescents in public psychiatric hospitals. *American Journal of Orthopsychiatry*, 65, 238-244.

Endres, V. J., & Goke, D. H. (1973). Time-out rooms in residential treatment centers. *Child Welfare*, 52, 359-366.

Fisher, W. A. (1994). Restraint and seclusion: A review of the literature. *American Journal of Psychiatry*, 151, 1584-1591.

Friedman, R. F. (2006). SUMMER BLUES; One Pill Makes You Hotter and One Pill.... *New York Times*, June 19. Downloaded July 26, 2006 from <http://tinyurl.com/oatyl>.

General Accountability Office (1999). *Improper restraint or seclusion use places people at risk*. Report GAO/HEHS-99-176. Retrieved July 26, 2006 from <http://www.gao.gov/archive/1999/he99176.pdf>

Glackman, T., Martin, R., Hyman, I., McDowell, E., Berv, V., and Spino, P. (1978). Corporal punishment, school suspension, and the civil rights of students: An analysis of Office for Civil Rights school surveys. *Inequality in Education*, 23, 61-65.

Grace, N.S., Kahng, S.W., & Fisher, W.W. (1994). Balancing social acceptability with treatment effectiveness of an intrusive procedure: A case report. *Journal of Applied Behavioral Analysis*, 27, 171-172.

Gregory, J.F. (1996). The crime of punishment: Racial and gender disparities in the use of corporal punishment in the U.S. Public Schools. *Journal of Negro Education*, 64, 454-462.

Herschell, A. D. (1999). Managing disruptive behavior in elementary classrooms: Relative contribution of time-out when added to a whole-class token economy. Retrieved from: <http://kitkat.wvu.edu:8080/files/924/Herschell.pdf>

Hunter, D.S. (1989). The use of physical restraint in managing out of control behavior in youth: A frontline perspective. *Child and Youth Care Quarterly*, 18, 141-155.

Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq. (1997).

- Jacob-Timm, S. (1996). Ethical and legal issues associated with the use of aversives in the public schools: The SIBIS controversy. *The School Psychology Review*, 25(2), 184-198.
- Kupfersmid, J., Mazzarins, H., & Benjamin, R. (1988). Programming as a means of assault prevention. *Child and Youth Services*, 10, 49-83.
- Lietz, J. J., & Gregory, M. K. (1978). Pupil race and sex determinants of office and exceptional education referrals. *Educational Research Quarterly*, 3(2), 61-66.
- Lowenstein, L. (1998). The physical restraining of children. *Education Today*, 48, 47-54.
- Magee, S.K., & Ellis, J. (2001). The detrimental effects of physical restraint as a consequence for inappropriate classroom behavior. *Journal of Applied Behavior Analysis*, 34(4), 501-504.
- Martinez, R. J., Grimm, M., & Adamson, M. (1999). From the other side of the door: Patient views of seclusion. *Journal of Psychosocial Nursing*, 37, 13-22.
- Masters, K. (2000). Practice parameters on the prevention and management of aggressive behavior in child and adolescent psychiatric institutions with special reference to seclusion and restraint. Draft manuscript prepared for the Academy of Child and Adolescent Psychiatry.
- Masters, K. & Devany, J. (1995). Practical suggestions for decreasing the use of seclusion and restraint in child and adolescent inpatient and residential facilities. Unpublished paper. Available from Charter Asheville Behavioral Health System, Asheville, NC.
- Mayton, K. & Fontanez, C. (1991). Letter to the editor. *Journal of Psychosocial Nursing*, 29, 33-35.
- McCarthy, J.D. and Hoge, D.R. (1987). The social construction of school punishment: Racial disadvantage out of universalistic process. *Social Forces*, 65, 1101-1120.
- McFadden, A. C, Marsh, G. E, Price, B. J., & Hwang, Y. (1992). A study of race and gender bias in the punishment of school children. *Education & Treatment of Children*. 15, 140-146.
- Merrett, F., & Wheldall, K. (1993). How do teachers learn to manage classroom behaviour? A study of teachers' opinions about their initial training with special reference to classroom behavior management. *Educational Studies*, 19, 91-106.
- Miller, D. E. (1986). The management of misbehavior by seclusion. *Residential Treatment for Children and Youth*, 4, 63-72.
- Mohr, W. K. (2002). Regarding the "One Hour" rule. Retrieved from: <http://www.bazelon.org/issues/restraintandseclusion/morerresources/10-29-02advomments.htm>
- NYS Commission on Quality of Care and Advocacy for Persons with Disabilities. Email alert of July 20, 2006, "Cautionary Notes on Heat-Related Illness."
- NYSED Amendments. Retrieved August 5, 2006 from <http://www.regents.nysed.gov/2006Meetings/June2006/0606emscvesida1.htm>

- Peter Hart Research Associates. (1995). Key findings from a nationwide survey of AFT teaching members. Washington, DC: Author.
- Plutchik, R., Karasu, T. B., Conte, H. R., Siegel, B., & Jerrett, I.. (1978). Toward a rationale for the seclusion process. *The Journal of Nervous and Mental Disease*, 166, 571-579.
- President's New Freedom Commission on Mental Health. (July, 2003). *Achieving the promise: Transforming mental health care in America*. Retrieved July 21, 2006 from <http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf>.
- Protection & Advocacy, Inc. (2002). The lethal hazard of prone restraint: Positional asphyxiation. Oakland, California. Retrieved from: <http://www.pai-ca.org/PUBS/701801.pdf>
- Raychaba, B. (1992). Commentary—"Out of control": A youth perspective on secure treatments and physical restraint. *Journal of Child and Youth Care*, 7, 83-87.
- Rehabilitation Act of 1973, Title 29 U.S.C., § 794 (1973).
- Ruhl, K.L., & Hughes, C.A. (1985). The nature and extent of aggression in special education settings serving behaviorally disordered students. *Behavioral Disorders*, 10(2),. 95-104.
- Ryan, J.B. & Peterson, R. L. (2004). Physical restraint in school. Retrieved August 5, 2006 from <http://www.bridges4kids.org/PBS/articles/RyanPeterson2004.htm>.
- Singh, N. N., Singh, S. D., Davis, C. M., Latham, L. L., & Ayers, J. G. (1999). Reconsidering the use of seclusion and restraints in inpatients child and adult psychiatry. *Journal of Child and Family Studies*, 8, 243-253.
- Smith, P. A. (1991). Time-out and seclusion: Understanding the civil rights and treatment issues. *Residential Treatment for Children and Youth*, 9, 51-59.
- Sourander, A., Aurela, & Piha, J. (1996). Therapeutic holding in child and adolescent psychiatric inpatient treatment. *Nordic Journal of Psychiatry*, 50, 375-379.
- Taylor, M.D. and Foster, G.A. (1986). Bad boys and school suspensions: Public policy implications for black males. *Sociological Inquiry*, 56, 498-506.
- U. S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration. (2005). A Roadmap to Seclusion and Restraint Free Mental Health Services for Persons of All Ages, training manual. Retrieved from: http://www.mentalhealth.samsha.gov/media/ken/pdf./SMA06-4055/Manual_front.pdf.
- Vander Ven, K. (1988). A conceptual overview: Issues in responding to physical assaultiveness. *Children and Youth Services*, 10, 5-27.
- Virginia Department of Education. (2005). Zero tolerance policies: An issue brief. Retrieved July 26, 2006 from http://www.educationnews.org/PR/ZERO_TOLERANCE_POLICIES.htm.
- Wagner, M., Kutash, K., Duchnowski, A.J., Epstein, M.H., & Sumi, W.C. (2005). The children and youth we serve: A national picture of the characteristics of students with emotional

disturbances receiving special education. *Journal of Emotional and Behavioral Disorders*, 13 , 79-96.

Walsh, E. & Randall, B. R. (1995). Seclusion and restraint: What we need to know. *Journal of Child and Adolescent Psychiatric Nursing*, 8, 28-40.

Weiss EM, et al. (1998). Deadly restraint: a Hartford Courant investigative report. *Hartford Courant*, October 11–15.

Wherry, J. N. (1986). The therapeutic use of seclusion with children and adolescents. *Residential Treatment for Children and Youth*, 4, 51-61.

Wu , S.C. , Pink, W.T., Crain, R.L. and Moles, O. (1982). Student suspension: A critical reappraisal. *The Urban Review*, 15, 245-303.

Ziegler, D. & Silver, D. (2004). Considering the literature on restraint and seclusion: Is there support that these interventions are harmful? Retrieved August 5, 2006 from <http://rccp.cornell.edu/pdfs/Zeigler.pdf>.