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Education Policy Brief

Emotional and Behavioral Disorders: Promoting Prevention and Positive Interventions in School Settings

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INTRODUCTION

The 1997 Individuals with Disabilities Education Act (IDEA) called for educators to create a new paradigm in school environments through the addition of positive behavior interventions and supports (PBIS). Specifically, IDEA encourages schools to create and foster positive supports and prevent disruptive and violent student behaviors. To date, PBIS has been implemented in over 13,000 schools across 49 states (Illinois PBIS Network, 2010). Maryland and Illinois are examples of states with a strong commitment to PBIS. Since the introduction of Maryland's statewide PBIS initiative in 1998, approximately one third of Maryland's schools have received PBIS training (Barrett, Bradshaw, & Lewis-Palmer, 2008). Likewise, since 1999, over 1,300, or one third of Illinois' schools, are implementing PBIS (Illinois PBIS Network, 2010).

In Indiana, PBIS is not coordinated by a statewide initiative. However, since 1999, Indiana University's Center for Education and Lifelong Learning at Indiana Institute on Disability and Community has provided training in PBIS to over 55 schools and 15 school corporations in Indiana. A total of 17 additional schools are receiving training this school year (2011-12) (Cassandra Cole, personal communication, September 22, 2011). The number of PBIS schools in Indiana and elsewhere indicate a growing movement toward adopting proactive and positive behavioral plans for students with disabilities.

Proactive and positive behavioral plans for students with disabilities focus on externalizing and disruptive student behaviors. However, these plans fail to adequately address the needs of students who struggle from internalizing disorders such as anxiety and depression. Left unattended, internal struggles sometimes evolve into externalizing behaviors like bullying and physical violence. For example, in 1999 two teenagers killed 13 people and themselves at Columbine High School in Colorado. Both adolescents were subsequently found to have suffered from depression and suicidal thoughts (Toppo, 2009). Major tragedies such as the Columbine massacre underscore the importance of identifying students with internalizing behaviors so appropriate early interventions can be provided. The 2004 reauthorization of the IDEA in its use of response to intervention (RTI) language presents a possibility for providing early intervention for such disorders.

This Education Policy Brief provides an update on the PBIS efforts in Indiana by showcasing an Indianapolis school district's endeavors in the implementation of PBIS; explores strategies for schools to expand efforts to identify children and adolescents with internalizing disorders and to develop and implement interventions within school settings; examines the national debate and Indiana's policies on the use of physical restraints and seclusion in the context of school settings for dangerous and disruptive students generally and with students with disabilities in particular; and discusses implications and recommendations for educational policy.

POSITIVE BEHAVIOR INTERVENTIONS AND SUPPORTS

Four years have passed since the Center for Evaluation & Education Policy (CEEP) published a policy brief addressing the concept of PBIS and describing Indiana's disciplinary practices and outcomes (Washburn, Stowe, Cole, & Robinson, 2007). The previous brief called for a shift in disciplinary approaches from reactive to proactive by delineating those components that would allow PBIS to be effective and sustainable. Such components include: 1) long-term commitment across district and school personnel, 2) evidence-based practices, 3) systematic external support, and 4) the formation of leadership teams to coordinate implementation and sustain the program. These recommendations are consistent with those of Sugai and Horner (2006). They describe PBIS as a system of preventive and proactive measures and actions designed by the schools to provide appropriate levels of support and interventions to their students.

According to the Director, the majority of teachers, staff, and principals at MSDLT were very enthusiastic about this program and believed that PBIS was the right system to have in MSDLT's elementary schools.

The first level of support is applied school-wide. Support at this level includes reinforcing positive student behaviors and explicitly teaching prosocial behaviors that conform to school rules and behavioral expectations. The second level applies to a subset of students who do not positively respond to the support provided at the first level. More intense and highly individualized interventions are available at the third level for a small percentage of students with greater needs. At this level, an individualized behavior support plan is created which may include the delivery of specialized services (e.g., mental health) and/or the initiation of more structured programs such as Systems of Care. PBIS relies on data to help schools continuously evaluate the program and guide decisions. In this section, we discuss an Indianapolis school district's accomplishments and challenges in its efforts to implement PBIS across all of its elementary schools.

Call for District-wide Change

The Metropolitan School District of Lawrence Township (MSDLT) is located in northeast Indianapolis. MSDLT is one of 11 school districts that serve students in the city of Indianapolis. According to the Indiana Department of Education (IDOE), in the 2010-11 school year, MSDLT served close to students, of whom 39 percent were White, 39 percent were African American, 7 percent multiracial, 14 percent were Hispanic, and 1 percent other (IDOE, 2011). Additionally, 50 percent of the students qualified for free and reduced lunch. We sought to ascertain MSDLT's efforts to implement PBIS and conducted two phone interviews with the Director of Elementary Education, Dr. Denna M. Renbarger (here forth referred to as Director).

The Director reported an increase in disciplinary issues in MSDLT in the last several years. The alarming number of discipline issues became a catalyst in the decision for MSDLT to implement PBIS in its 11 elementary schools in 2002. During the summer of 2002, a team of individuals with extensive knowledge of PBIS provided training to all MSDLT elementary principals. In turn, principals trained their teachers and staff. According to the Director, the majority of teachers, staff, and principals at MSDLT were very enthusiastic about this program and believed that PBIS was the right system to have in MSDLT's elementary schools. The district allocated funding and resources for ongoing professional development.

Encouraging Signs

PBIS encourages shared responsibility through greater teamwork and collaboration across all school personnel. During training, MSDLT personnel were informed of the positive results experienced by other schools utilizing PBIS. Encouraged by the success of other schools, MSDLT personnel worked under a common mission to build a positive environment that would benefit everyone. Prior to the implementation of PBIS, some teachers in the MSDLT's schools viewed their singular role as teaching academics and they routinely deferred students' behavioral problems to administrators.

Principals, teachers, and staff now realize they must all share responsibility for helping students with problematic behaviors in order to provide consistency. Monthly professional development meetings on PBIS were often charged with energy and enthusiasm as various personnel came to learn and embrace new important roles under PBIS. Another reported area of accomplishment was realized when principals fully embraced the components of PBIS. The dedication and leadership of these principals permeated throughout their respective schools to help the process of reforming a system that was punitive-based into one that is strength-based, proactive, and preventative. According to the Director, the principals' strong leadership was also instrumental in establishing the environment of shared responsibilities.

Challenges

Despite efforts at MSDLT schools, there were also challenges during PBIS implementation. The Director noted that one significant challenge was instituting appropriate fidelity of implementation both at the school-level and the teacher-

level. At the school-level, some elementary schools in MSDLT did not follow specified guidelines in developing and maintaining a consistent behavioral system. For example, some schools utilized rules with negative language (e.g., "No yelling in halls" vs. "Talk quietly in halls") in contravention of PBIS tenets. At the teacher-level, unilateral decisions were sometimes made to respond to student behavior in a manner not consistent with PBIS protocol. For example, some teachers ordered misbehaving students out of the classroom and into the hallway or office despite the PBIS guideline to keep misbehaving students in the classroom. Thus, despite a shift in written school procedures, in practice, punitive disciplinary measures continued to be used bin some situations. Schools that struggled to maintain fidelity of implementation continued to see increases in the number of suspensions. Although other explanations are possible, the Director indicated that the elementary schools that consistently countered the principles of PBIS were also the ones that appeared to have a higher number of office referrals and suspensions.

One recommendation is to use those elementary schools that have achieved some success as exemplars to the other schools.

Data collection was another area of difficulty. Data were often inconsistently collected by principals and teachers. According to the Director, teachers did not always report how they handled certain disciplinary actions. In the Director's opinion, this was mainly attributable to a lack of communication between school personnel. In addition, although funding and resources were available to schools to offset the financial costs of implementing PBIS programs, these monies were often left untapped. Taken together, implementation fidelity was affected by conflicting school practices, inconsistencies in data collection, and a failure to maximize the use of available resources.

Despite the challenges MSDLT has faced in PBIS implementation, the Director remains optimistic that PBIS will be established in all schools. Changing a culture of punitive systems is difficult and requires time — in some cases up to five years, according to Bradshaw, Reinke, Brown, Bevans, and Leaf (2008).

The Future of PBIS in MSDLT

Considering the accomplishments and challenges faced by MSDLT in implementing PBIS, we offer several recommendations drawn from the work of McIntosh, Filter, Bennett, Ryan, and Sugai (2010). One recommendation is to use those elementary schools that have achieved some success as exemplars to the other schools. Several of MSDLT's elementary schools showed signs of accomplishments in the implementation of PBIS. These exemplars suggest that high-quality implementation can occur in MSDLT's other elementary schools.

Another recommendation is to provide ongoing coaching and evaluation from knowledgeable district- or state-level experts in order to help and sustain high-fidelity implementation. One avenue through which schools and districts can seek support is the PBIS Indiana Resource Center, which is a part of the Indiana Resource Network. PBIS-Indiana could also help the district better manage their data collection efforts. McIntosh and colleagues underscore the importance of data collection and analysis in ensuring sustainability of PBIS. They argue that school districts should require consistent and ongoing data procedures from all the schools in order to help guide, evaluate, and adapt the components of PBIS.

PBIS implementation at MSDLT may also be improved by the formation of a leadership team. The central role of the PBIS leadership team is to coordinate training, coaching, and evaluation while securing funding, visibility, and political support (Sugai & Horner, 2006). Members of this team should include representatives from the community, special and general educators, mental health service providers, family members, and school administrators. At the school level, a leadership team that includes the school, principal, counselor, teachers, and staff is also crucial to the success of PBIS by managing and providing more immediate day-to-day decisions.

Several recent events hold promise in helping MSDLT achieve its goals with PBIS. One of these undertakings is the successful implementation of a district-wide anti-bullying curriculum. This program, which emphasizes prevention, empathy, and pro-social behavior, is complementary to the PBIS framework. Another recent occurrence is the renewed focus from the schools that did not appropriately implement PBIS during the first 8-year period to recommit themselves to implementing some components of PBIS in their schools. For example, these schools are beginning to once again focus on and reward positive behaviors. Currently, the goal of MSDLT is that these features will eventually become part of the fabric in the schools' culture and will serve as a basis for any future plans to implement PBIS. Calls for more teacher accountability also mean that data collection and analysis will soon be common practices in the classroom. This will certainly help with efforts to appropriately implement and sustain PBIS in MSDLT for the long term.

We also recommend other critical elements needed to ensure implementation fidelity and sustainability of PBIS at MSDLT. These include: developing and conducting surveys to better assess the effectiveness of training and the attitudes of school personnel toward PBIS, collecting data on the school's disciplinary practices and analyzing how the data relate to the fidelity of implementation, and examining the data on student demographics and the resulting impact on the number of disciplinary issues.

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Policy Perspective

RESTRAINT AND SECLUSION PRACTICES IN SCHOOLS CAN BE SAFE AND SHOULD BE INCLUDED IN IEPS

Sarah Montminy

As a special education teacher working with students with high support needs in Illinois and Indiana, I have encountered many students who engage in dangerous behaviors. Over the course of nine years, I have been part of hundreds of restraints involving students with disabilities. I have often been concerned with the lack of federal and state oversight in the use of physical restraints and seclusion practices in schools and have worked diligently with the administrators in the schools where I have worked to ensure that policies and documentation in my school corporation examine all aspects of physical restraint and seclusion procedures in order to ensure that safety for all students remains our central focus in crisis situations.

In our school corporation, a Safe Crisis Management (SCM) team consisting of 5-20 people, depending on the size of the student body and number of students with high-support needs, are trained by JKM, Inc. to respond to situations where physical risk of harm to the student or others is apparent. The SCM team includes principals, assistant principals, special education teachers, general education teachers, and paraprofessionals. This team takes part in a two-day initial training that focuses on prevention, promoting positive behaviors and supports, and strategies in addressing dangerous behaviors. Once certified, members of the SCM team are required to be recertified annually.

The policy of our corporation is to use physical restraint and seclusion only when absolutely necessary. The frequency of use depends on the intensity of harmful behaviors exhibited by the current student population. In my current class of 16 students, the majority has never been restrained, despite the fact that they do engage in physical aggression, because systems are in place such that the physical aggression does not escalate nor is it persistent to the point of needing seclusion or restraints. A few of my students routinely engage in behaviors that can escalate in intensity until a physical restraint is necessitated. I have had students who were restrained daily, sometimes multiple times a day, because their behaviors were so intense in nature. In my career I have only used seclusion in one case that involved repeated nudity. If an incident arises where a physical restraint becomes necessary, trained staff from the SCM team are notified to respond and assist the staff already engaged in the restraint. Per corporation policy and SCM best practice procedures, the process begins with the least restrictive hold necessary. Additional positions and increased staff may be employed, if needed. Moreover, the process requires a staff member to document the student's vital signs at 5-minute intervals and to write notes on verbalizations and behaviors during the physical restraint. Following the restraint, the staff involved meets to debrief, assess the function of the behavior, and reevaluate the effectiveness of current accommodations and modifications, positive behavior supports, and visual supports.

When trained staff are vigilant and cautious with students who are in crisis, seclusion and physical restraint are safe options for keeping potentially dangerous students in their least restrictive environment. Any legislation that might strip educators of their ability to intervene through the use of physical restraint and seclusion with special education students who are prone to aggressive and/or dangerous behaviors may mean that these students will no longer be able to be included in public education. I fear that the progress made toward inclusion of students with high-support needs may be lost.

If a student on my caseload has a behavior intervention plan that includes physical acts of harm toward self or peers, I include the procedures for restraints and seclusion in their IEP (individualized education program). Professionally, I feel strongly that parents who are informed of the options we have for keeping their child safe are more likely to ask questions and voice concerns proactively. In cases where communication with parents is minimal, using the student's annual case review as an opportunity to discuss options for ensuring the safety of their child and his or her classmates is important. I want my students' parents to understand the interventions that may be used and that they are never employed as a punishment.

Sarah Montminy is a special education teacher in Spencer-Owen Community School Corporation

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In sum, despite PBIS training, administrator and staff buy-in, and some level of accomplishment in the initiative, MSDLT has experienced difficulties in maintaining fidelity in its implementation of PBIS. The previous CEEP Education Policy Brief called for statewide initiatives in PBIS to better ensure fidelity of implementation (Washburn et al., 2007). Barrett, Bradshaw, and Lewis-Palmer (2008) emphasize the importance of long-term commitment to statewide coordination of evaluation, training, and coaching in order to achieve high levels of fidelity in implementation. Bradshaw et al. (2008) found that schools that provide PBIS training for educators are more likely to implement PBIS with high fidelity within one or two years. However, schools should expect a 3-to-5-year window before program changes translate to changes in student behaviors.

Although a statewide model is not yet available in Indiana, schools may still take advantage of other PBIS training opportunities. For example, in the summer of 2011, PBIS Indiana began providing training and technical support to Indiana schools. Even without formal PBIS training, schools may begin to immediately implement components of PBIS such as teaching and reinforcing positive student behaviors and moving away from punitive disciplinary models through the adoption of preventative practices sensitive to cultural, social, and linguistic differences.

INTERNALIZING BEHAVIOR DISORDERS

As noted previously, the perpetrators of violent acts in Columbine High School suffered from significant emotional distress; but, unfortunately, awareness of the link between this distress and the potential for violent actions occurred too late. Therefore, we advocate for early intervention and encourage schools to expand the scope of PBIS to target students who suffer from internalizing disorders which, if untreated, can develop into externalized aggression against self and others. Depression affects almost eight percent of school-aged children and is closely related to violent acts (Fröjd et al., 2008; Zayfert, Becker, & Gillock, 2002).

The National Institute of Mental Health (NIMH), reports that violence against self (e.g., suicide) is the third-leading cause of death for children, youth, and young adults between 10 and 24 years of age (NIMH, 2002). Also, data from the National Survey on Drug Use and Health (Johnston, Bachman, & Schulenberg, 2006) indicate that approximately 900,000 youth between the ages of 12 and 17 considered suicide during episodes of depression. In practical terms, these data show how likely it is for a typical high school classroom to have three students with internalizing behavioral disorders who have attempted suicide.

The National Institute of Mental Health (NIMH), reports that violence against self (e.g., suicide) is the third-leading cause of death for children, youth, and young adults between 10 and 24 years of age (2006).

Research also shows that students with internalizing behavior disorders experience a number of negative outcomes in their academic and personal lives. Social withdrawal, diminished self-esteem, and poor physical health are often reported in students who suffer from anxiety, social phobia, and depression (Maag, 2002; Zayfert et al., 2002). According to Kauffman (2005), anxiety is the most common type of internalizing disorder affecting students, as about 20 to 30 percent of children and adolescents referred to health clinics for behavioral disorders are referred for anxiety (Merry, McDowell, Wild, Bir, & Cunliffe, 2004).

In January 2011, Indiana's House of Representatives took note of the high rate of school-age students suffering from depression and other internalizing behavioral disorders and also pointed to the limited level of teacher awareness of the nature of the disorder. As a result, House Bill 1019 was introduced as an attempt to ameliorate teachers' lack of knowledge about internalizing disorders such as depression.

This bill would have required the state's Division of Mental Health and Addiction to work with the IDOE to develop a basic in-service course on the prevention of student suicide that aims to prepare and train teachers to recognize the warning signs of a student considering suicide. While passing in the House by a 97-1 vote, this bill did not receive a hearing in the Senate Committee on Health and Provider Services. Efforts like those proposed under House Bill 1019 to increase the knowledge teachers have about internalizing disorders and provide suggestions on the role schools can play in addressing students' mental health needs are encouraged.

School-based Mental Health Interventions

Services for internalizing disorders are available to students primarily within schools or through clinics. However, research indicates that many students with depression do not receive effective services due to lack of access or because of a desire to avoid the social stigma that often accompanies treatment for internalizing disorders (Weisz, McCarty, & Valeri, 2006). In cases in which students are identified by schools as being at risk for depression, substance abuse, and/or suicide, these students may participate in counseling programs both within the school setting and through out-of-school mental health services; however, there is typically little to no communication and/or interaction between schools and the service providers, possibly resulting in minimal intervention benefits. Clearly it is important to promote communication between community-based service pro-

viders and the mental health services provided by schools.

Generally, school-based psychotherapy interventions include cognitive behavior therapy (CBT) and interpersonal psychotherapy (Michael & Crowley, 2002; Michael, Huelsman, & Crowley, 2005). Interventions following the cognitive behavior therapy model focus on two general areas: behavior and cognition (Maag & Swearer, 2005). Components include training on self-instruction, problem-solving, and cognitive re-structuring of reality through the use of strategies such as modeling, role-playing, and positive reinforcement (Maag, 1988). The aim of CBT is to help students who present depressive symptoms elevate their moods and facilitate their emotional, social, and behavioral growth by teaching them self-management skills (Hughes & Adera, 2006).

Interpersonal Psychotherapy (IPT) is a short-term therapy based on the theory that interpersonal conflicts or transitions maintain depression (Curry, 2001). Unlike CBT, IPT is less concerned with teaching cognitive restructuring behaviors to students who suffer from maladaptive internalizing behaviors. Instead, IPT's emphasis is on the importance of a therapeutic relationship between the educator/therapist, the students, and their families.

The focus of IPT is on assisting students in overcoming interpersonal conflicts; handling peer pressure, social isolation, self-image; and dealing with feelings of grief, loss, or death. IPT offers support so that students can adapt to changes in life situations and improve their social functioning (Ruffolo & Fischer, 2009). Despite differences in principles and foci, both CBT and IPT can be delivered by mental health professionals, school psychologists, or special educators (Curry, 2001; Mufson, Dorta, Olfson, Weissman, & Hoagwood, 2010; Rufollo & Fischer, 2009).

Even with the long-term acknowledgment that school-based psychosocial interventions can be the answer for students whose emotional struggles impede learning and academic performance, school-based mental health services are marginalized as auxiliary to learning (Maag, 2002). That is, school personnel tend to see any activity not directly related to instruction as a deviation from educators' primary role of knowledge transmission. Concerns are also raised when school resources and instructional time are consumed by issues perceived to be the sole responsibilities of mental health and social services (Maag, 2002). Although opportunities are available for psychosocial services in schools, available professionals are often insufficiently trained to appropriately deliver psychosocial interventions.

In order for schools to work effectively with mental health services and to address the psychosocial needs of their students, greater efforts must be made for comprehensive and integrated intervention approaches.

Taken together, limitations in training and time constraints often prevent schools from successfully implementing psychosocial interventions, and this may consequently result in fragmented, isolated, or inadequate interventions for students struggling with internalizing behavioral disorders (Adelman & Taylor, 2000).

In order for schools to work effectively with mental health services and to address the psychosocial needs of their students, greater efforts must be made for comprehensive and integrated intervention approaches. According to Adelman and Taylor (1999), initiatives for mental health provisions need to be developed and integrated within each school's policy to address the needs of students with internalizing disorders. Special programs and services need to be structured to enable students to benefit as much as possible from instructional time. Also, schools need to collaborate with mental health services and community clinics in order to foster and emphasize the integrated treatment of students who experience acute and/or chronic internalizing behavioral disorders.

We believe that the school setting represents a suitable environment for providing mental health services in two important ways. First, educators can be highly involved in the design and implementation of effective psychosocial interventions intended to support students struggling with internalizing behavioral disorders. For example, teachers can incorporate cognitive-behavioral techniques and psychosocial strategies during the time spent with students either in the classroom or during extracurricular activities.

Furthermore, special educators can design school activities that encourage self-expression and offer a creative emotional outlet to all students and especially to those who suffer from anxiety, depression, and suicidal ideas. Finally, for students with internalizing behavioral disorders, intervention techniques such as social skills training, self-management training, and cognitive and behavioral approaches can also be implemented by general and special educators to address a variety of challenging behaviors of students in the classroom (Maag, 2005).

A second and important way school settings may be suitable for providing mental health services is that schools can provide mental health services to students who do not access clinic-based services. Mental health professionals can collaborate with educators within the school setting either with students who present symptoms of internalizing disorders but whose depression does not reach clinical levels or for students who, for various reasons (e.g., stigma), do not go to community-based intervention settings.

We encourage school and community programs to become integrated by expanding existing school resources and

creating opportunities for interaction, communication, and exchange of information between mental health agencies and school personnel. Some means of integrating community and school programs include: classroom-based activities that enhance learning and socialization, parent involvement in schooling, and consistency in the psychosocial services offered. By developing coordinated intervention methods, the fragmented and isolated mental health services can become part of a comprehensive educational approach that may succeed in breaking down the barriers to student learning and emotional growth.

The preparation of school personnel is an important factor in the integration of psychosocial support within the school context. Based on their extensive, daily interaction with students, teachers can be an invaluable source of information and important allies to the mental health professionals, the students, and the students' families. Although teachers are not mental health providers, they can be the first to note emotional imbalances, such as anxiety and depression, based on their everyday interaction with students. Moreover, teachers can discuss with the students and their families the challenging emotional behaviors they have observed and the impact of the emotional struggles on the academic growth of their students. Thus, educators can support students' interaction with mental health professionals and encourage family involvement in the process of mental health services because of the existing trusting relationship that can be established in the school setting.

Response to Intervention (RTI) is a three-tier model that can provide students who experience internalizing behavioral disorders with timely and gradually intensified access to mental health support. RTI is designed to support students by using the expertise of different professionals and combining emotional strategies with learning interventions and objectives. The RTI model in schools can serve to guide delivery of a continuum of services between school personnel and their counterparts in community-based agencies. According to RTI, teachers integrate classroom-based interventions of various intensity and duration in order to support learning and inclusion for all students. Given the educational reform efforts to intervene early and reduce the number of students identified for special education services, RTI reflects the current focus on early intervention.

More specifically, primary prevention (or Tier 1) in the school setting can foster opportunities for positive development and wellness of all students. During this tier of RTI, educators can consult with school mental health specialists to discuss concerns about the initial signs of internalizing behavioral disorders. Students who fail to respond to the early intervention efforts in Tier 1 are identified as at-risk and are provided with more intense interventions that can be delivered by special education teachers who may already possess the required skills. The aim of early school-targeting interventions in Tier 2 can focus on support and guidance to ameliorate behavioral problems and school adjustment issues for the students who need additional support. Tier 3 can ensure that students with severe and chronic emotional and behavioral problems are referred and receive psychological services as well as guidance and assistance to experience academic success.

In essence, the success of school-based mental health services depends on the effective collaboration between school personnel and community mental health services. Collaboration between community resources and the school can enhance early intervention approaches, and can intensify care and individual support to respond to the needs of students with severe internalizing behavioral disorders.

PHYSICAL RESTRAINTS AND SECLUSION PRACTICES

Despite school-wide efforts to create and maintain a safe learning environment for all students through the development and implementation of PBIS programs in schools around the country generally and Indiana in particular, some students continue to engage in disruptive behaviors. Many schools around the country use procedures known as restraints and seclusion in response to students who pose a threat to others or to themselves. According to the Council for Children with Behavioral Disorders (CCBD), restraints refer to anything that limits, restricts, or keeps an individual in control and prevents him or her from demonstrating or expressing harmful or hostile behavior (CCBD, 2009b). Seclusion is the involuntary confinement of an individual alone in a room or in an area from which the individual is physically prevented from leaving (CCBD, 2009a).

However, the use of restraints and seclusion has come under criticism by child and adolescent advocates in consort with parent organizations who urge policymakers to entirely ban the use of these practices in schools (Diament, 2010). Critics of restraints and seclusion argue that these practices are not only lacking in effectiveness but, more importantly, they are traumatic at best, and deadly at worst (Diament, 2010).

The national debate surrounding restraints and seclusion procedures has forced educators, parents, advocacy groups, and professional organizations on both sides to weigh in on this concern. The issues associated with the use of restraints and seclusion practices in schools are divided along two lines. First, some argue that these practices should be completely banned without any exceptions. Others argue that the use of restraints and seclusion in schools should be restricted and used only under limited circumstances and with regulatory procedures in place. Critics charge that these practices are barbaric, while advocates of seclusion and restraints argue that without access to these tools, schools are defenseless against students who display dangerous behaviors.

Federal and State Laws on Restraints and Seclusion

Fueled in large measure by allegations and findings of gross misconduct in the treatment of troubled teens in residential facilities, the Committee on Education and Labor and the House of Representatives charged the Government Accountability Office (GAO) with conducting a close examination of school settings to determine the extent to which children and adolescents are exposed to physical restraints and seclusion practices (U.S. GAO, 2009). In May of 2009, the GAO released a report of selected cases of death and abuse involving both public and private schools in which it found hundreds of allegations of schools harming and causing the death of children under their care. Furthermore, the GAO found that there is widespread use of restraints and seclusion practices in schools across the country but no federal laws to regulate their use. In this section we highlight the absence of federal policy regulating the use of seclusion and restraints and conclude by noting Indiana's effort to adopt policies guiding school personnel in the use of these practices with students in general and for students with disabilities specifically.

In May of 2009, the GAO released a report of selected cases of death and abuse involving both public and private schools in which it found hundreds of allegations of schools harming and causing the death of children under their care.

The GAO investigation noted that the use of restraints and seclusion practices is common. For example, in Texas 4,202 students were secluded or restrained a total of 18,741 times over a period of one school year, from September 2007 to June 2008. The GAO investigation also found hundreds of allegations of abuse and death related to the use of restraints and seclusion over a 2-year period in schools across the country. Notably, a 7-year-old died after being held facedown for hours by school staff, and a 13-year old hanged himself in a seclusion room after prolonged confinement. In other cases that were non-fatal but similarly egregious, a 5-year-old reportedly suffered broken arms and a bloody nose as a result of being tied to a chair with bungee cords and duct tape by a teacher (U.S. GAO, 2009).

Although these numbers represent a relatively small percentage of the overall school population, the fact that children are at risk for serious physical harm or can die in schools as a result of disciplinary procedures warrants immediate attention from policymakers. Furthermore, given that few states (California, Kansas, Pennsylvania, Rhode Island, and Texas) collect data on the use of restraints and seclusion practices, it is possible that the number of restraint and seclusion cases resulting in serious bodily harm or death is higher than reported in the GAO investigation. The GAO investigation also states that very young children and children with disabilities are being restrained and secluded in schools (U.S. GAO, 2009).

The Children's Health Act of 2000 amended Title V of the Public Health Service Act regulates the use of restraints and seclusion on residents of certain hospitals and healthcare facilities, as well as residential, non-medical, community-based facilities that receive any type of federal funds, but these regulations do not apply to school settings. The GAO investigation found state-level policies regarding the use of restraints and seclusion varies widely.

The GAO reported:

- 19 states have no laws or regulations related to the use of restraints or seclusion practices in schools: Arizona, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, New Jersey, North Dakota, Oklahoma, South Carolina, South Dakota, Vermont, Wisconsin, and Wyoming;
- 7 states have some restrictions on the restraints but have no regulations on seclusion: Alaska, Colorado, Hawaii, Michigan, Ohio, Utah, and Virginia;
- 8 states specifically prohibit the use of prone restraints that impede a child's ability to breathe: Colorado, Connecticut, Iowa, Massachusetts, Pennsylvania, Rhode Island, Tennessee, and Washington;
- 17 states require that selected staff receive training before being permitted to restrain children: California, Colorado, Connecticut, Illinois, Iowa, Maine, Maryland, Massachusetts, Nevada, New Hampshire, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Texas, and Virginia;
- 13 states require that schools obtain parental consent before using restraints: Colorado, Delaware, Maryland, Massachusetts, Montana, New Hampshire, New York, North Carolina, Oregon, Pennsylvania, Tennessee, Virginia, and Washington;
- 19 states require parents to be notified after their child has been restrained: California, Colorado, Connecticut, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, and Virginia; and
- 2 states require annual reporting on the use of restraints: California and Connecticut.

The only federal law indirectly dealing with the use of restraints or seclusion practices in school settings applies to students with disabilities. The IDEA mandates that schools develop and implement an individualized education

program (IEP) that explains the educational goals for the student and the types of services to be provided. If the student has behavioral goals that may include the use of restraints or seclusion practices, then procedures for their implementation must be noted in the student's IEP.

As a step toward developing federal policy on the use of restraints and seclusion in schools, in March of 2010, the U.S. House of Representatives passed a measure limiting the use of these practices to cases in which there is imminent danger and prohibiting the practices from being included in the IEP if a student has a disability.

At the Senate level, however, a bill was introduced at the close of the 2010 congressional session that would allow the use of restraints and seclusion to be included in the IEP of students with disabilities. Critics of the use of restraints and seclusion argue that the new measure "legitimizes" practices that the Alliance to Prevent Restraint, Aversive Interventions and Seclusion (APRAIS) seeks to prevent. It remains to be seen whether the Senate bill allowing educators to include the use of restraints and seclusion procedures in IEPs will gain enough congressional support to pass.

Indiana's Guidelines and District-level Policies on Restraints and Seclusion Practices

Following the GAO report, U.S. Secretary of Education Arne Duncan sent a letter to the states urging them to develop, review, and, if necessary, revise policies and guidelines on the use of restraints and seclusion practices to ensure that children in all schools across the country are safe from being unnecessarily or inappropriately restrained or secluded (U.S.DOE, 2010). At the time of this policy brief, Indiana does not have a state-level policy on the use of restraints or seclusion; instead it provides guidance for the use of these practices (see IDOE, 2009). Despite the absence of a state-level policy, some districts across the state have been revising or developing district-level policies since the GAO report in 2009. As an example, the Northwest Indiana Special Education Cooperative (NISEC) Board of Managers developed and adopted policies outlining the conditions under which physical restraints and seclusion practices are to be used in school settings.

NISEC limits the use of restraints to emergency situations in which staff members believe the student may cause harm to self or others. The NISEC regulations clearly indicate restraints are not to be used as a form of punishment for minor infractions such as a verbal threat, a refusal to comply with an issued request, or the use of profanity. Restraints under the NISEC model must also ensure student blood flow and respiration are not inhibited and must consider medical contraindications.

NISEC restraints must also be administered and supervised by school personnel trained in approved restraint techniques. In cases where the restraint involves a student with a disability, the restraint policies require the method of restraint to be consistent with the student's IEP. NISEC requires written documentation (i.e., an incident report) no later than one day after the restraint was used, with copies of the documentation forwarded to the director of special education; the parents; and, if the student has a disability, the IEP team (NISEC, 2010).

NISEC's policy also specifically outlines the use of mechanical restraints. Mechanical restraints are only allowed if authorized by a treating physician. Moreover, the physician must conduct an examination of the student following each restraint as soon as possible. While in a mechanical restraint, students must be given an opportunity to move freely and exercise use of any body part that is restrained. The supervising staff member is required to loosen the mechanical restraint every 10 minutes to determine if the restraint is still necessary and to ensure the restraint is not harming the student (NISEC, 2010).

With regard to seclusion, NISEC's regulations require that any enclosure or room used to seclude a student be similar to other rooms in the school with respect to materials, construction, height of ceilings, lighting, ventilation, and temperature. NISEC prohibits any labeling of the room which may cause a stigma and further prohibits the use of external locks on seclusion room doors. The room must also allow for both visibility of the student and communication with the student at all times. In cases where two or more students are concurrently placed in the same room, the staff supervising the seclusion room must ensure students are not close enough to injure each other. Seclusion of any student must end as soon as the student is calm.

The regulations prohibit the seclusion of any student 30 minutes after the student stops the specific behavior for which seclusion was imposed. Moreover, if the student secluded has a disability, the duration of the seclusion must be consistent with the student's IEP (NISEC, 2010).

In sum, schools within the NISEC region of Indiana have responded to U.S. Secretary of Education Duncan's charge since the GAO 2009 report to review, develop, and, where necessary, revise state policies on the use of restraints and seclusion in schools by adopting policies to guide these practices in schools. It should be noted that NISEC's newly adopted policy regarding students with disabilities is in line with the U.S. Senate's bill, which would allow restraint and seclusion procedures to be included in the student's IEP.

CONCLUSIONS AND RECOMMENDATIONS

We have highlighted Indiana's progress in implementing PBIS in Lawrence Township schools by describing its accomplishments, challenges, and continued efforts to promote positive behavioral interventions in the manner in which schools approach school-wide discipline. In addition, we have noted that the school setting can ensure accessibility as well as timely, appropriate interventions for students who exhibit maladaptive externalizing and internalizing behaviors. Effective collaboration with community services can intensify these efforts so that the students in need and their families can experience consistency in the delivery of the interventions.

Indiana continues to strive to be proactive and positive in its disciplinary school policies, which include efforts to prevent and treat anxiety and depression. In cases where students' behavior needs are extreme and emergency procedures are required to prevent or diminish risk of physical harm, some school districts in Indiana have established guidelines for the use of restraints and seclusion practices when warranted.

In closing:

- Based on the initial success of PBIS when it is implemented in schools, we recommend that funding remains available to schools to allow them to promote the use of non-punitive responses to misbehavior. We especially encourage school principals to determine why funds available to implement PBIS remain untapped, since it is unlikely that funding will continue to be allocated if it is not used.

- Given the current focus on prevention, we recommend schools extend the application of RTI as a framework of multi-tiered service delivery to students with internalizing emotional disorders. We especially promote the collaboration between general and special education teachers and school counselors, social workers, and families to provide early intervention to students who display symptoms of depression and or suicide.

- At the policy level, although we applaud efforts by individual school corporations (e.g., NISEC) to provide guidelines for the use of physical restraints and seclusion practices in schools, we recommend that Indiana adopt a single set of guidelines for the use of these practices in schools and collect data on these practices as a way of monitoring their effectiveness and safety. We also recommend that separate data be gathered to indicate the extent to which children with disabilities are more susceptible to exposure to these extreme disciplinary practices. Most importantly, we strongly endorse the development and adoption of state-level policies to regulate and monitor the use of restraints and seclusion practices in schools.

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WEB RESOURCES

Resource links for Positive Behavioral Intervention and Supports

Office of Special Education Programs Center on Positive Behavioral Interventions and Supports
http://www.pbis.org/

PBIS Indiana Resource Center
http://www.indiana.edu/~pbisin/about/

Resource links for School Based Mental Health services

UCLA Mental Health Project
http://smhp.psych.ucla.edu/

The Center for Health and Health Care in Schools
http://www.healthinschools.org/School-Based-Health-Centers.aspx

Indiana Department of Education: Student Assistance Services
http://www.doe.in.gov/sservices/sas_infolinks.html

Resource links for Restraints and Seclusion Practices

Advocacy News - The Council for Children with Behavioral Disorder website
http://www.ccbd.net/advocacy

Documents from United States Department of Education on Restraints and Seclusion
http://find.ed.govsearch?client=default_frontend&output=xml_no_dtd&proxystylesheet=default_frontend&q=restraints+and+seclusion+policy&sa.x=12&sa.y=8

Indiana Department of Education Policy Guidance for Use of Physical Restraints and Seclusion in Schools
http://www.doe.in.gov/stateboard/docs/seclusion_and_restraint_policy.pdf

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