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CCBD's Position Summary on the Use of Physical Restraint Procedures in Educational Settings

Council for Children with Behavioral Disorders

Abstract

This document provides policy recommendations of the Council for Children with Behavioral Disorders (CCBD) regarding the use of physical restraint procedures in educational settings. It includes (a) an introduction with definitions of terminology; (b) a discussion of the problems with the use of physical restraint, policy on this topic, and the lack of research; (c) a Declaration of Principles; and (d) Recommendations Regarding the Use of Physical Restraint in educational settings. Although the policy recommendations in this document pertain to the United States, we believe the principles and nonpolicy recommendations are equally applicable to other countries.

Keywords

restraint, crisis, policy issues, school, mental health

Introduction

What Is Restraint?

The Children's Health Act of 2000 defined three categories of restraint: *physical restraint*, *chemical restraint*, and *mechanical restraint*. Each of these is defined below.

Physical restraint is defined, according to the Office for Civil Rights's (OCR, 2012) Civil Rights Data Collection, as "a personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort." Physical escorts include "the temporary touching or holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a resident who is acting out to walk to a safe location." Despite the OCR definition, most crisis intervention training programs and professionals consider physical escorts to also be physical restraints.

Chemical restraint is defined as a drug or medication used on a student to control behavior or restrict freedom of movement that is not (a) prescribed by a licensed physician for the standard treatment of a student's medical or psychiatric condition and (b) administered as prescribed by the licensed physician. The use of medications to manage behavioral symptoms has proliferated, with widespread application in children (including preschool age) with the purpose, at least in part, to control behavioral symptoms such as hyperactivity and inattention (Blum et al., 2018). Educators have been criticized for urging (or in some cases requiring) parents to seek medications to control the behavior of their child at school. The Individuals with Disabilities Education Act (IDEA) of 2004 prevents schools from requiring the use of medication before receiving special education services, and some states or school districts have policies that regulate the involvement of educators in making any decisions or recommendations to parents regarding medications. While educators can provide data and input to assist physicians and parents in the titration and ongoing monitoring of medications, educators should not be in a position where they determine whether or how much medications students receive. That should be left to medical professionals. When medications are under the direct supervision of a health care professional, this is not

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considered chemical restraint. Chemical restraint occurs when the use of medications that are prescribed by physicians to be used "as needed" or "PRN" (i.e., *pro re nata* in Latin) at the discretion of school personnel.

Mechanical restraint includes "the use of devices as a means of restricting a student's freedom of movement." This entails the use of any device or object (e.g., tape, ropes) that limits an individual's body movement to prevent or manage problem behavior. Mechanical restraints such as handcuffs are universally used in law enforcement, and restraints such as straightjackets and straps have historically been used in medical and mental health facilities. However, mechanical restraints such as tape, straps, tie downs, weighted blankets or vests, or other devices have also been used by educators to control student behavior (U.S. Government Accountability Office, 2019b). These situations represent mechanical restraint by educators and are not appropriate.

Mechanical restraints to limit behavior should be distinguished from medically prescribed devices that serve the purpose of compensating for orthopedic weaknesses (e.g., to protect a student from falling, or to permit the student to participate in activities at school). For example, mechanical devices have been employed in school settings in situations where students with physical disabilities, such as cerebral palsy, are placed in standing tables or chairs with restraints that permit them to participate in educational activities where their muscles or bones would not otherwise permit their participation.

Weighted blankets and a variety of other devices also have been used with students with autism spectrum disorder (ASD) and attention-deficit/hyperactivity disorder for therapeutic purposes (e.g., to address sensory issues). The degree of restriction of these devices varies, and they are not themselves teaching strategies although the ostensible objective is to increase the opportunity for the student to learn, or to address a student's sensory issues. None of these devices should be employed in schools unless specifically recommended by an occupational or physical therapist, physician, or school nurse with specific guidelines for length of time and circumstances for their use. When used by either trained school personnel or by a student for the specific and approved therapeutic or safety purposes for which the device was designed, it is not considered mechanical restraint. However, when applied contingent on problem behavior and used in an effort to calm a student or reduce hyperactivity or other problem behavior, these same devices should be considered mechanical restraints.

Vehicle restraints or harnesses such as seat belts, which are routinely required to promote student transportation safety, should not be considered mechanical restraints when employed according to local, state, and federal transportation policies. However, belts or harnesses and other equipment used specifically to reduce problem behavior (e.g., keep students in their seat, prevent aggression) should be considered mechanical restraint. Similarly, law enforcement officers using mechanical restraints in accord with appropriate and widely accepted police procedures for use with youth in school settings should not be considered mechanical restraints.

How Often Is Physical Restraint Employed in School Settings?

Unfortunately, there are no reliable national data on the use of physical restraint in schools. The only federal agency that gathers data on the use of physical restraint in schools is the U.S. Office of Civil Rights through its revised Civil Rights Data Collection. Data are gathered directly from school districts. Although gathered and tabulated for several years, these data have been shown to be unreliable. Reports of unreliable data have appeared since 2014 (Whipond, 2014), and a 2019 U.S. Government Accountability Office (2019a) highlighted inaccuracies, mostly underreporting of the use of physical restraint in schools. Underreporting may be due to lack of training regarding definitions or data requiring reporting, lack of clear data gathering procedures within school systems, lack of supervision for data gathering, as well as to possible efforts to minimize potential controversy regarding these procedures by hiding their use. Contributing to the problem of data accuracy is the absence of an enforcement or oversight mechanism for providing data regarding the use of restraint (Knackstedt, 2017). As a result, it is not possible at the present time to accurately estimate the frequency of restraint use in schools.

What Are the Problems With the Use of Physical Restraints?

Injury and death. The use of physical restraint has caused both deaths and injuries to students. Injuries to adults who initiate physical restraints also appear common. A precise or scientific way to measure the number or extent of the injuries to children or staff as a result of the use of physical restraint has not yet been developed and there is no way to accurately estimate these deaths or injuries. No agency is designated to gather or record this type of information. However, each year child deaths as a result of physical restraint are documented. A recent report that scanned media reports indicated there were 28 deaths of children and youth between 2003 and 2017 as a result of physical restraint procedures, with seven deaths between 2013 and 2017 (Holden & Nunno, 2019). This is generally consistent with an estimate of the Child Welfare League of America (2000) of about eight to 10 deaths each year from use of restraint. Injuries to both students and staff certainly occur much more frequently and are even more difficult to document. Such injuries vary in their severity, but can be severe (Kentucky Protection and Advocacy, 2016; Nex-

star Media Wire, 2020).

In addition to death and physical injury, there are strong beliefs that psychological injury also occurs, particularly for those children who have experienced prior abuse by adults. There also has been attention to the psychological effects on those conducing restraints. These effects, for both children and adults, may range from short-term, such as fear and an adrenaline rush of physical confrontation, to long-term, such as post-traumatic stress disorder. Although there are little research data to verify this hypothesis specifically for physical restraint, it is both plausible and supported by numerous anecdotal reports from those who have been restrained or engaged in restraint. In other contexts, no one questions such effects in connection with circumstances such as medical emergencies, physical assaults, or muggings.

Misuse and overuse. Most educational facilities purport to employ physical restraint as an emergency procedure to prevent injury to the student or others when a student is in crisis. There is evidence, however, that it is frequently used for various other purposes including to address disruptive (not dangerous) behavior and to increase student compliance to adult commands (Ryan & Peterson, 2004; Simonsen et al., 2014). Other than anecdotal reports, very little is known about the circumstances under which physical restraints are used to control student behavior in school settings. There is ample evidence to indicate that restraints are being used inappropriately or abusively in some school settings to control student behavior (Kentucky Protection and Advocacy, 2016; National Disability Rights Network, 2012; Pillsbury & Disability Rights Legal Center 2018; Zirkel, 2016).

Disproportionate use. Available data consistently indicate the disproportional use of restraint with students with disabilities. Survey data (e.g., Barnard-Brak et al., 2014) reported that students with disabilities were far more likely to be restrained than students without disabilities. In addition, review of court proceedings suggests that restraint is more frequently applied with particular disability groups, with students with ASD the most frequent recipients of restraint (Freeman & Sugai, 2013; Zirkel, 2016). Overrepresentation of students with disabilities is problematic when physical restraint is used inappropriately for a disciplinary consequence, in the absence of a behavioral crisis, or with inadequate preventive and de-escalation interventions.

There may also be disproportionate use with students in poverty, or those who are of minority status (Gagnon et al., 2017). This finding may overlap with the overrepresentation of students with a disability, as students in poverty or those who are minorities are overrepresented in students identified with a disability. As with disability status, where overuse and abuse of physical restraint procedures occur, then disproportionate use becomes problematic.

Cost. There are considerable costs associated with the use of restraint. Aside from the obvious costs of medical care of students and adults injured as a result of use of physical restraint (Chan et al., 2012), there are a variety of systemic, organization, and consumer costs (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010, 2011). These include costs of school liability insurance, purchase of crisis intervention training, damage to school facilities and materials, lawsuits and legal liability, and more. By preventing or limiting the use of these practices to situations where they are clearly needed to prevent serious injury, educational settings can provide better quality education with increased staff satisfaction and decreased staff turnover, resulting in significant cost savings (SAMHSA, 2010).

Absence of standards. In most medical, psychiatric, and law enforcement applications, strict standards govern the use of physical restraint and seclusion. Hospitals and treatment centers that receive federal funds in the United States are governed by federal legislation regulating their use of restraint. Often accreditation requirements from governing bodies, such as the Joint Commission on Accreditation of Healthcare Organizations or other agencies, address the use of restraints. These requirements have resulted in widespread training and certification of staff in medical and psychiatric programs that employ physical restraints, and many of these types of programs have attempted to drastically reduce their use of these procedures as a result of the injuries and deaths.

In Great Britain, a self-standing professional organization accredits all training related to physical restraint and crisis intervention, and its standards are specifically intended to "reduce the use of restrictive physical interventions" through preventive intervention and high-quality training (British Institute of Learning Disabilities [BILD], 2014). Virtually all agencies that engage in physical restraint are required to seek accreditation, which includes independent outside site visitors monitoring the content and quality of training to ensure compliance with safety standards and the goal of reducing restrictive interventions.

In contrast, in the United States, there has been no such accreditation requirement from national professional organizations in education for the use of restraint in educational settings. Teacher preparation programs do not include training related to physical restraint. Rather, most schools purchase "crisis intervention" training that includes instruction on various physical restraint holds provided by private and mostly profit-making vendors (Couvillon et al., 2010, 2018). As the curriculum of these training programs is proprietary, there is no opportunity

for consumers to make decisions regarding the topics addressed, quality of training, or safety features. The lack of accepted written standards and oversight by an independent agency is a significant gap in the use of physical restraint in educational settings.

Ethical and human rights issues. Although discussed last, ethical and human rights issues may be the most important consideration regarding the use of physical restraint. Physical restraint is an intervention which can lead to death or injury and which has no educational value. Furthermore, there is no research whatsoever indicating that restraint functions as a therapeutic procedure (Day, 2002; Simonsen et al., 2014; Trader et al., 2017).

Injuries and deaths along with the widespread accessibility of phone cameras have increasingly documented instances of misuse of restraint in educational settings that have come to the attention of the public. This has evoked concern that these procedures are in violation of basic human rights. As a result of the increased awareness of the misuse and abuse of these procedures, there has been increased action by protection and advocacy organizations and by parents. The action includes cases that have been brought to court making claims of violations of basic civil and human rights under the U.S. Constitution, the 14th amendment, and Section 1983 of civil rights law, not just violations of treatment under the IDEA.

Physical restraint may be a safety procedure when used appropriately, but should only be used when the risks of serious injury of not employing these procedures are greater than the risks of serious injury in employing them. Many educators may not be aware of these ethical and civil rights concerns (Scheuermann et al., 2015).

Laws and Policy Regarding Use of Physical Restraint in School Settings

While there is no federal law or regulation related to the use of physical restraint in schools, over the past 10 years, bills have been regularly introduced in Congress to regulate these procedures in schools. In the absence of federal law, the U.S. Department of Education (2012) created a list of "principles" to provide guidance for educators in the use of physical restraint in schools. The principles stated that the use of physical restraint should only occur when there is an imminent risk of serious bodily injury to someone as a result of the student behavior. This detailed recommendation reflects a widespread consensus about when restraint procedures could appropriately be used with children in school. Any use of physical restraint other than to prevent immanent serious bodily injury is inappropriate. These U.S. Department of Education guidelines represent the only federal policy on this topic at the present time.

Due to concerns about the use of restraint, many states have adopted legislation that regulate use; however, they vary greatly in substance and protection. For example, Butler (2019) reviewed and classified the existence of state laws in December 2019 and rated their quality depending on who the restraint laws and regulations protected (e.g., students with disabilities only) and how restraint can be used (e.g., for emergencies only). According to her classification,

> To provide meaningful protection, a state must fall into one of two categories. One, it provides multiple protections against restraint and seclusion for students. Two, it has few protections but strictly limits the technique to emergency threats of physical harm. States that protect only against one practice are not regarded as having meaningful protections. (Butler, 2019, p. 11)

According to this criterion, 29 states had meaningful legislation for all students, 38 states had meaningful legislation for students with disabilities, three states had some protection that did not fall in the meaningful category, and nine had extremely weak or no meaningful legislation. In sum, 21 states failed to have meaningful legislation protecting *all* students and delineating the circumstances under which it can be employed. Unfortunately, there is no research indicating that having a state law or regulation in place has significantly affected or reduced the use of physical restraint. In addition, while having a "legally binding" law in place may be useful, if there is no enforcement or data monitoring, such a law may not be meaningful in practice.

There is almost no knowledge of local school district policies on physical restraint and seclusion even though many believe that local policies and procedures may have a greater impact than district, state, or federal policies (e.g., Gagnon et al., 2017). Thus, attention needs to be paid to local policies and procedures, in addition to state and federal. For example, one recent study showed significant variation of local school district policies within one state (Van Acker et al., 2019).

Lack of Research on the Use of Physical Restraint Procedures

To date, there are virtually no experimental data or rigorous research pertaining to the use of physical restraint procedures in public school settings. As noted earlier, there is little knowledge about how often these procedures are employed, or under what circumstances (Barnard-Brak et al., 2014). As discussed earlier, we do not have any data on the extent or nature of student deaths or student or staff injuries occurring from physical restraint. We have limited data about the type of restraints that are employed and

little research-based information about the relative safety of specific restraint procedures (supine vs. prone, etc.). Furthermore, we have no documentation about the nature and extent of training received by educators who actually employ physical restraint. This dearth of information about nature, use, and outcomes of restraint is of great concern, particularly given the U.S. mandates of No Child Left Behind and IDEA 2004 legislating that all educators are to rely on evidence-based practices that are supported by scientific research. This lack of data should be addressed through a national research initiative led by the U.S. Department of Education.

Declaration of Principles

In light of the aforementioned concerns with the use of restraint in school settings, the Council for Children with Behavioral Disorders (CCBD) supports a set of guiding principles which, if fully implemented, are intended to significantly diminish its use in educational settings. These principles are adapted in part from the Declaration of Principles by the Council of Parent Attorneys and Advocates (COPAA, 2011). The principles provide a preface to the CCBD's recommendations regarding physical restraint. CCBD also endorses the list of principles in the U.S. Department of Education's (2012) Resource Document.

Principles

- Behavioral interventions for children must promote the right of all children to be treated with dignity.
- Educational settings should adopt a comprehensive approach that assures all children are screened and receive necessary educational and mental health supports and programming in a safe and least restrictive environment.
- Positive and preventive educational interventions, as well as mental health supports, should be provided routinely to all children who need them, school staff should be trained to employ these techniques, and the level of staffing should be adequate to provide such supports in an effective manner.
- Staff working with students with behavioral or mental health needs, and particularly students with emotional or behavioral disorders and autism, should have mandatory training in the use of positive behavior supports, trauma-informed care, and/or other effective strategies for understanding, preventing, and addressing student behavior challenges.
- All children whose pattern of behavior impedes their learning or the learning of others should receive appropriate educational assessment, including functional behavioral assessments accompanied by behavioral intervention plans that incorporate appropriate positive behavioral interventions (e.g., instruction in appropriate behavior and strategies to de-escalate their behavior).
- All educational settings should use federal guidelines specifying behavior that constitutes a crisis and staff working with students with emotional and behavioral problems should be trained to recognize and invoke crisis procedures only when the child presents an immediate imminent danger to him/herself or others.
- All parents of school age children have the right to be informed about school, district, and state policies pertaining to the use of crisis procedures, as well as a right to be informed of each and every instance that these procedures are used with their children.
- All staff in schools should have mandatory conflict de-escalation training, and conflict de-escalation techniques should be employed by all school staff to avoid and defuse crisis and conflict situations.

For restraint to be used judiciously, it is essential that behavioral and mental health interventions are in place that largely prevent the need for restraint. Included among these should be a variety of positive behavioral and emotional supports implemented in a tiered fashion with intensity matched to severity of student problem behavior. These include preventive and instructive procedures, such as establishing and teaching behavioral expectations (acknowledging that for many students, this may require deliberate targeted instruction in what the behavioral expectations mean as being able to repeat the expectations does not necessarily guarantee the student understands them), recognizing and reinforcing positive behavior, providing mental health services and interventions, and relying on functional behavioral assessment and related intervention support plans for any student whose behavior indicates a need for more intensive intervention. Lack of resources to provide appropriate kinds of services should never be an excuse to employ restraint procedures.

Conflict de-escalation is crucial to prevent the use of restraint as well as useful generally to prevent and defuse behavior problems for students with emotional or behavioral disorders and for all students who may engage in power struggles or escalate emotional crises. As a result, this is an area of training that should be provided to all educators and school staff members, not just those in special education, and should be a part of school curriculum for students.

Recommendations Regarding Restraint in School Settings

Restraints should be used in educational settings only when the physical safety of the student or others is in immediate

danger. Because restraint is employed in educational settings with some students who are not in special education, regulations and procedures should apply to all students, not just those with special education labels. The following are CCBD recommendations related to the use of restraints when employed in educational settings.

Recommendations

1. Restraint used to control behavior should be used only under the following emergency circumstances and only if all four of these elements exist:
   - The student's actions pose a clear, present, and imminent physical danger to him or her or to others;
   - Less restrictive measures have not effectively de-escalated the risk of injury;
   - The restraint should last only as long as necessary to resolve the actual risk of danger or harm;
   - The degree of force applied may not exceed what is necessary to protect the student or other persons from imminent bodily injury.

These four components define the circumstances and limits of the use of restraint. Restraint should never be used as a punishment, to force compliance, or as a substitute for appropriate educational support.

2. U.S. states and school districts should have specific regulations for the use of physical restraints within educational settings.
   - States and school districts that do not have specific regulations should create them to ensure that both educators and policy makers are informed about and receive training on the use of these procedures and their potential for misuse, and the liability that might result.
     - Guidelines or technical assistance documents are not adequate to regulate the use of restraint procedures and generally do not contain mechanisms for providing oversight or correction of abuses.
   - Regulations:
     - Should apply to all students, not just students eligible for special education.
     - Should apply to all educational settings, not just public schools.
     - Should operationally define actions that fall within and outside of the definition of physical restraint.
     - Should prohibit dangerous types of physical restraint.
     - Should define crisis situations and include measures to assure it is used only in situations of imminent risk of serious physical harm to self or others.
     - Should specifically identify how the use of crisis procedures will be monitored at the state or district level (e.g., inclusion in accreditation procedures and monitoring in each educational facility) to include reporting of accurate incident data to an outside agency on a regular basis, identifying responsibility for assessing the accuracy of data provided by schools, and analysis of data and oversight along with intervention when data indicate overuse or potential abuse of restraint.
3. The type of restraints schools are permitted to use should be regulated by policy.
   - Prone restraints (with the student face down on his or her stomach) or supine restraints (with the student face up on the back) or any maneuver that places pressure or weight on the chest, lungs, sternum, diaphragm, back, neck, or throat are the most dangerous and should be used with extreme caution. No restraint should be administered in such a manner that prevents a student from breathing or speaking. Training programs should specifically train how and why they must be avoided.
   - Mechanical restraints should never be used in school settings when their purpose is to manage or address student behavior, with the following two exceptions:
     - Vehicle safety restraints should be used according to local, state, provincial, and federal regulations as needed for student safety when in vehicles.
     - Mechanical restraints employed by law enforcement officers in school settings should be used in accord with their policies and acceptable professional standards.
4. Positive and preventive procedures should be in place to reduce the reliance on reactive procedures.
   - All school personnel should be trained on how to implement positive behavior supports.
   - Data should be collected to verify implementation of positive supports and procedures.
   - Mental health supports should be available to students with a process to identify students in need.
5. Restraints should only be conducted by persons who are trained in the use of such procedures. Professional learning and ethical practice standards should be developed by each educational accreditation agency/organization.
   - Training must be relevant to the particular setting. For example, training designed for mental

health agencies may not translate well into educational settings. Likewise, procedures designed for self-defense may be inappropriate in educational settings.
- Training should result in some form of certification or credential for each individual staff member and overall certification or credential for the school district, agency, or school.
- Training should be recurrent with annual updates at a minimum and should be appropriate to the type of school setting and to the age and developmental level of students.
- Training should include content and skills on the use of positive, instructional, preventive methods for addressing student behavior.
- Because restraints have a history of being used as punishment, staff training must include procedures to correct the perception that it is acceptable to use in this manner.
- Training should include content and skill development on conflict prevention, de-escalation, conflict management, and evaluation of risks of challenging behavior.
- Training should include potential psychological harm that the use of these procedures may have on children who have experienced trauma related to previous abuse.
- Training should include information about how medications or health problems and might affect the physical well-being of the student during restraint procedures.
- Training should include multiple methods for monitoring a student's well-being during a restraint.
- Given death and injury associated with restraint, training should minimally include certification in First Aid and cardiopulmonary resuscitation (CPR) in the event of an emergency related to restraint.
- A pulse oximeter and a portable automatic electronic defibrillator, and related training for staff on their use, should be available and readily accessible in any school where the use of physical restraint is used.

6. Each incident of restraint should be immediately documented, including the student behavior that resulted in the restraint, de-escalation procedures used prior to the restraint, the type and length of the restraint.
   - A copy of this documentation should be placed in the student's permanent record.
   - Parents or guardians should be informed as soon as possible after each and every incident of restraint and should be provided a copy of all documentation as soon as it is created.
   - The program supervisor or building administrator should be informed as soon as possible after each use of restraint. In addition, data should be provided to district- and state-level staff, as required, and federal agencies for documentation and planning.
   - Due to the risk of injury, shock, and potential delayed effects, the physical well-being of the student should be monitored for the remainder of the school day. Similarly, the physical well-being of the person(s) who conducted the restraints should be monitored.
   - A staff debriefing should occur as soon as possible after every incident of the use of restraint but no later than 48 hours after the incident.
     - This debriefing should include all of the participants in a restraint situation, an administrator, and at least one other staff member who has expertise in the use of behavioral techniques and who was not involved in the restraint procedure. For students with behavior support plans, team members should also attend to discuss revisions to the plan.
     - Parents or guardians should be invited to participate in this debriefing.
     - The student should also be invited to participate. If not, a special debriefing with the student should occur separately.
     - The debriefing should focus on antecedent conditions that preceded the behavior of concern, alternate interventions that were used and why they were unsuccessful in de-escalating the behavior, how this situation could have been handled in such a way to prevent the need for the use of restraint, and how a similar event could be avoided in the future.
     - A report of the finding of this debriefing should be included in the student's file with a copy provided to all of the student's teachers and sent to the parents or guardians.
7. Schoolwide safety coupled with plans to avoid/reduce/eliminate use of restraint should be developed for every district/school.
   - Research indicates that state policies appear to have little correlation with frequency of restraint rates and despite an increase in the number of states adopting policies, state trends in use remain similar across school years

(Gagnon et al., 2017); therefore, additional reductive plans are needed.
- Regular, team-based reviews of policies should be conducted with school emergency plans updated and revised as indicated by crisis response data and other relevant information (e.g., changes in relevant legislation, other behavior data).
- Repeated use of physical restraints for any one student or multiple physical restraints across different students should be viewed as the failure of educational programming and indicate the need to modify supports, educational methodologies, and other interventions.

8. Restraint should not be included in individualized safety or emergency plans.
   - For students with disabilities, the use of restraint is an emergency procedure and should not be incorporated into the student's Individual Educational Program (IEP) or Behavior Intervention Plan (BIP) and should not be considered a behavior change strategy. IEPs and BIPs reflect plans for educational programming. Physical restraint is regarded as an emergency procedure that should be a part of an emergency or safety plan, not routine programming. CCBD asserts that it is the obligation of educational staff to be fully apprised of medical needs and the health status of all students and the implications for use of restraint. Furthermore, employment of restraint outside indicates the need for comprehensive staff training to assure restraint is never unnecessarily, prematurely, or inappropriately used. More generally, inclusion in an IEP or BIP might legitimize physical restraint as part of educational programming, imply that it could be used routinely by educators, and may be interpreted by staff members (though wrongfully) that the parent or guardian has provided consent or support for its use by signing the IEP.
9. The U.S. Department of Education and its Institute of Education Sciences (IES) should develop and fund a series of studies to address the current lack of research on all aspects of physical restraint. Research should be conducted regarding the use of restraint with students across all settings, with the goal of reduction and/or elimination. Areas for future research include but are not limited to
   - How often restraints are employed in various settings;
   - Which specific types of restraint are used;
   - The nature of the antecedents or behavior that precipitates restraint;
   - The *Diagnostic and Statistical Manual* diagnoses (American Psychiatric Association, 2013), special education category (if applicable), or other characteristics of students who receive restraint;
   - The intended purposes or goals of restraint;
     - The efficacy/lack of efficacy of restraint procedures in achieving these goals;
   - The potential outcomes or side effects including injuries and fatalities to student or staff as a result of the use of restraint in schools as well as other long-term psychological, emotional, behavioral, and other effects on students or staff;
   - The training level and certification of each staff members involved with the incident where restraint is employed;
   - The degree to which procedures for de-escalation of student behavior and positive behavior supports are used before, during, and after restraint;
   - The existence or lack thereof of policies and procedures related to restraint.
10. CEC, CCBD, and other divisions should collaborate with other appropriate professional organizations to create content and training standards, quality indicators, and accreditation procedures for crisis intervention training which includes physical restraint. This effort can be informed by the BILD model in Great Britain.

Summary

CCBD believes federal law is vitally important to provide consistent guidance in regulating the use of restraint and preventing its misuse. CCBD also recommends that educational settings have behavioral and mental health supports and conflict de-escalation interventions to prevent the need for restraint. When developing local and state policies and procedures, each local education agency (LEA) and state education agency (SEA) must define the methods of and criteria for use, as well as the implementation process. Each year staff must receive training on the policies and procedures adopted by the LEAs and SEAs. Each incident requiring the use of restraint must be fully documented to support data-based decision-making and should be reviewed at least annually by LEAs and SEAs. CCBD cautions against the abuse and misuse of restraint and supports its use only to resolve imminent risk of danger or harm.

Author's Note

The Executive Committee of CCBD recognizes Reece Peterson, Lee Kern, Sarup R. Mathur, and Susan Albrecht for primary authorship of this position paper.

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