ABSTRACT: The current emphasis on educating children in the least restrictive environment has resulted in the use of physical restraint procedures across all educational placement settings, including public schools. Since its initial use, restraint has been controversial. Professionals who use physical restraint claim that it is necessary to safely manage dangerous behaviors. Child advocates, however, argue that far too many children suffer injury and death from the very staff charged with helping them. The authors review research literature, legislation, and court decisions on topics related to the use of restraint in schools and identify position statements and recommended practices from nationally recognized professional organizations and advocacy groups. Recommendations are given for research, policy, and procedures for the use of physical restraint in schools.

Definition

As a professional term, restraint is defined as any physical method of restricting an individual's freedom of movement, physical activity, or normal access to his or her body (International Society of Psychiatric and Mental Health Nurses, 1999). The term is sometimes used to address three different types of restraint procedures: mechanical, ambulatory, and chemical. Mechanical restraint entails the use of any device or object (e.g., tape, tiedowns, calming blanket, body carrier) to limit an individual's body movement to prevent or manage out-of-control behavior. Ambulatory restraint is also known as manual restraint or "therapeutic holding" (American Academy of Pediatrics Committee on Pediatric Emergency Medicine, 1997). It involves one or more people using their bodies to restrict another individual's body movement as a means for reestablishing behavioral control and establishing and maintaining safety for the out-of-control client, other clients, and staff (American Academy of Child and Adolescent Psychiatry, 2000).
Finally, chemical restraint uses medication to control behavior or restrict a patient’s freedom of movement. This type of restraint is typically used only in institutional or hospital programs; it has evolved only in the past 40 years as a result of developments in psychotropic medications.

Today, physical restraint is used in numerous professional settings including medical and psychiatric facilities, law enforcement and correctional facilities, and schools. These different types of restraint can be used with both adults and children in the event of emergency situations stemming from aggressive, violent, or dangerous behavior or as a precaution against such behavior.

The primary focus of this article is on the use of ambulatory or manual restraint as an intervention by educators in schools. There are numerous instances in which mechanical restraint has been used in educational settings, but its use will be addressed only in the context of some court decisions and policies that relate to physical restraint. While some might include confinement, such as that which occurs in time-out rooms, as a form of mechanical restraint, it is beyond our scope to address that controversial issue here. Since chemical restraint is not typically used in schools, it is not addressed here.

**History**

The use of physical restraint originated in the psychiatric hospitals of France during the late 18th century. Restraint procedures were developed by Philippe Pinel and his assistant Jean Baptiste Pussin for the same intent it is used today, as a means of preventing patients from injuring themselves or others (American Academy of Child and Adolescent Psychiatry, 2000; Fisher, 1994; Weiner, 1992). From their initial usage, mechanical and manual restraint have been controversial procedures. Almost immediately after the procedures became popular, a nonrestraint movement was started in England in an attempt to prevent physical and often brutally aversive mechanical restraint from being used on psychiatric patients in hospitals (Jones, 1972; Masters et al., 2002; Scull, 1979). In response, a Lunacy Commission was established in 1854 to monitor and regulate the use of seclusion and restraint in asylums. In contrast to England’s decreased use of restraint during this time frame, the United States viewed physical restraint as a form of therapeutic treatment and adopted it as an accepted practice for dealing with violent patients (Masters et al., 2002; Tomes, 1988).

For many years, law enforcement and correctional agencies have employed physical restraint and related conflict deescalation procedures as tools in apprehending and managing prisoners. Physical restraint also has a long history in hospitals and psychiatric institutions, particularly in the clinical treatment of violent persons (Romoff, 1985). The use of physical restraint has been applied to children with emotional disturbance since the 1950s, and it was included in a list of “techniques for the antiseptic manipulation of surface behavior” compiled by Redl and Wineman (1952). Redl and Wineman stated explicitly that physical restraint should not be used as, nor should it be associated with, physical punishment. They stated that a child’s loss of control should be viewed as an emergency situation in which the educator or clinician should either remove the child from the scene or prevent the child from doing physical damage to himself or herself or others. The person performing the restraint should remain calm, friendly, and affectionate while attempting to maintain a positive relationship with the child, thereby providing the opportunity for therapeutic progress once the child’s crisis subsides.

**Standards and Guidelines for Using Restraint**

In most medical, psychiatric, and law enforcement applications, strict guidelines govern the use of physical restraint. Often these standards include accreditation requirements from governing bodies such as the Joint Commission on Accreditation of Healthcare Organizations or other agencies such as the National Association of Psychiatric Treatment Centers for Children (Cribari, 1996) and the American Academy of Pediatrics (1997). These requirements have resulted in widespread training and certification for staff in these programs.

Unfortunately, there has been no such accreditation requirement for schools or many other child care agencies. The lack of these commonly accepted guidelines or accreditation standards in schools makes those who use physical restraint more susceptible to misunderstanding and abuse, let alone improper implementation. To make matters worse, school staff may lack training in effective
behavioral interventions necessary for the prevention of emotional outbursts that are typically associated with children who have severe behavioral problems (Moses, 2000). Such interventions are critical in preventing student behavior from escalating to potentially dangerous levels, where restraint may be needed.

Use of Restraint in Education

Once thought of as an exclusive tool of psychiatric institutions, physical restraint has been thrust into the mainstream of public education. This is, in part, due to the Individuals with Disabilities Education Act (IDEA), which established the principle of serving children with special needs in the least restrictive environment. Many students with emotional or behavioral problems, regardless of disability label, are now being included in public school environments, frequently in general education schools and classes. The physical restraint procedures have moved with the students to more typical school and classroom settings. In addition, because of high-profile media attention, schools are now challenged to demonstrate practices that prevent or contain challenging and sometimes violent behaviors. Physical restraint may be one element of these practices (Skiba & Peterson, 2002).

Professional Training Programs

Currently, most training in physical restraint for schools and other child care agencies is done by a handful of organizations that specialize in this type of training, usually in conjunction with other strategies for conflict deescalation and problem solving. (See Table 1 for a list of representative organizations and contact information.) It is beyond our scope here to describe the similarities or differences in these programs, but most include procedures for conflict deescalation as well as holds and procedures for physical restraint.

Most of these programs evolved from training programs for staff at residential treatment and psychiatric facilities or from psychiatric hospitals, but these organizations now offer their extensive training programs to various agencies, including schools. After the initial training, they provide recurrent training, sometimes through a local person certified in that particular program.

Research on Restraint

We conducted an extensive search to identify articles related to physical restraint. We searched computer databases of the Education Resources Information Center (ERIC), LEGALTRAC, psychINFO, and FindArticles for relevant articles. Keywords used in the computer search included restraint, physical restraint, therapeutic holding, ambulatory restraint, and mechanical restraint. In addition, we conducted a hand search of studies published between 1970 and 2002 from the following journals: Journal of Psychosocial Nursing, Journal of Special Education, Journal of Emotional and Behavioral Disorders, Behavioral Disorders, and Exceptional Children. Finally, we performed an ancestral search by checking the citations from relevant studies to determine whether any of the articles cited would qualify for inclusion in this review. Literature related to restraint in the field of geriatrics was not reviewed.

After conducting an extensive search, we identified 26 articles. These included three articles that reviewed the legal aspects of restraint (Coffin, 1999; Kennedy & Mohr, 2001; Lohmann-O’Rourke & Zirkel, 1998) and five articles reviewing the use of physical restraint (Day, 2002; Fisher, 1994; Soloff, Gutheil, & Wexler, 1985; Wright, 1999). While there were 15 experimental research studies investigating the use of restraint with children, only 3 were conducted in school settings (Grace, Kahng, & Fisher, 1994; Magee & Ellis, 2001; Ruhl & Hughes, 1985). The majority of studies were conducted in either a psychiatric facility or a hospital (Barlow, 1989; Hunter, 1989; Jones & Timbers, 2003; Miller, Walker, & Friedman, 1989; Persi & Pasquali, 1999; Petti, Mohr, Somers, & Sims, 2001; Swett, Michaels, & Cole, 1989).

The last five studies were conducted with children and adolescents suffering from severe autism or mental retardation and focused on attempting to reduce the use of mechanical restraint for the prevention of self-injurious behaviors (SIB; Favell, McGimsey & Jones, 1978; Fisher, Piazza, Bowman, Hanley, & Adelinis, 1997; Luiselli & Waldstein, 1994; Milliken, 1998; Wallace, Zouh & Gaff, 1999). Finally, we found eight position papers offering guidelines for the proper use of restraint with children (Cribari, 1996; Luiselli, & Waldstein, 1994; Milliken, 1998; Mohr & Anderson, 2001; Ross, 2001; Schloss & Smith, 1987;
Prevalence of the Use of Physical Restraint

After an extensive search, we were unable to identify any research indicating how widespread the use of restraint in schools has become. Anecdotal information based on court cases and legislation seems to indicate that it has become common at least for larger school systems to have some staff performing physical restraint in public school settings.

While studies regarding the prevalence of physical restraint procedures in more restrictive settings were also limited, Day (2002) asserted that the use of these procedures in residential settings has become commonplace. A survey of frontline child care workers from psychiatric facilities found that restraint was used frequently, with 34% of staff reporting to have used these procedures more than twice per week (Hunter, 1989). Currently the accreditation of psychiatric hospital programs...
requires written procedures and training on these topics, presumably meaning that these procedures are commonplace in these settings as well. An early study conducted within an adolescent psychiatric unit found that 23% of the population experienced at least one restraint during an 18-month period. Additional findings of interest included higher occurrences of restraint on Mondays and Fridays due to what the authors called “weekend anxiety.” Researchers also reported that restraint was more common among younger children, perhaps because they possess fewer mechanisms for coping with frustration. Male staff members were more likely to initiate restraint than females (Miller et al., 1989).

One study performed by Persi and Pasquali (1999) tracked the frequency of physical restraint used among 281 children ages 4 to 17 who were placed in four different types of segregated settings: psychiatric inpatient unit, residential group home, day treatment program, and day treatment program located in community schools. The study found that 107 restraints were performed throughout the year. The incidence of restraint varied among settings, with the group home and day treatment programs using the procedure more frequently than either the community day treatment program or inpatient unit. The study also found that males were slightly more likely to be restrained than females, and there was a mild significant relationship between age and restraint. Researchers did not find a linear relationship with age but noted that the onset of adolescence brought about an abrupt increase in the level of restraint administered. Surprisingly, in direct contrast to earlier findings, the study found that female staff initiated a larger number of restraints than their male counterparts. When comparing the use of restraint among placement settings, the study concluded that the pattern of physical restraint in actual settings is highly variable and difficult to explain, requiring additional studies.

Physical restraint has not been researched as an educational intervention (Selekman & Snyder, 1997). A review of literature found several journals that had published articles regarding restraint, but most articles focused on addressing the controversial nature of the procedure. One of the first studies on reducing restraint was performed by Swett, Michaels, and Cole (1989), who investigated whether the passage of a Massachusetts state law addressing restraint effectively reduced the number of chemical restraints and seclusionary procedures used in a juvenile psychiatric facility. The researchers found that while the number of chemical restraints had decreased significantly, the number of physical restraints had actually increased. A later study, by Berrios and Jacobowitz (1998), was conducted in a psychiatric inpatient unit with children ranging in age from 5 to 12 years being restrained with therapeutic holds (e.g., ambulatory restraints). The study claimed that therapeutic holding reduced the duration of a child’s behavioral episode only slightly but was effective in reducing the number of other restraints performed by 15.9%.

**Situations or Behaviors That Prompt Use of Restraint**

We identified only one study (Petti et al., 2001) that examined the circumstances when physical restraint was employed. Researchers debriefed both staff and clients following 81 incidents of restraint in a psychiatric hospital setting. Findings of interest included staff reporting that 65% of restraints were initiated due to a perceived safety threat, while 19% were the direct result of patient noncompliance. An interesting finding from patient interviews was that a staff member threatening time-outs was a causal factor for escalated levels of aggressive behavior. This may suggest that patients perceive time-outs as a coercive intervention.

Unfortunately, no similar studies were performed in a school environment. What is recognized by the professional community is that physical restraint is a widely used protective procedure, often implemented for a variety of reasons including prevention of violence, self-injurious behavior, and injury or property damage due to temper tantrums, as well as a response to noncompliance. However, physical restraint has long been considered to be a behavior management technique appropriate for teachers when crisis behavior occurs (Fagen, 1996; Rizzo & Zabel, 1988), and it may be used for a much wider set of student behaviors such as preventing children from leaving a classroom or school grounds or from destroying private or school property. One study conducted with teachers of students with emotional or behavioral disorders (E/BD) in public schools found that many had used restraint either as part of a planned behavioral intervention or as a spontaneous reaction to
aggressive behavior (Ruhl & Hughes, 1985). The study reported that 71% of these teachers used physical restraint with their students if they displayed aggression toward others, 40% to prevent self-abuse, and 34% to prevent destruction of property.

Efficacy of Restraint Procedures

Despite the belief that physical restraint is a commonly used procedure in schools serving children with E/BD, little is known about its efficacy, due to a lack of research (Persi & Pasquali, 1999). Few of the proponents of physical restraint have claimed that the procedure has any therapeutic value in and of itself. However, proponents of therapeutic holding justify restraint procedures through the attachment theory developed during the early to mid 1970s (Bowlby, 1973; Cline, 1979; Zaslow & Menta, 1975). Day (2002) reviewed these theories and for the most part concluded that there was very little empirical support for therapeutic benefits to children receiving restraint. Most of the studies located were of poor quality and relied upon “unverifiable, and hence questionable, anecdotal evidence and case reports” (Day, 2002, p. 272). There was also no evidence for any potential side effects of restraint. While some might believe that children diagnosed with E/BD who are exposed to restraint on a daily basis could be humiliated by such highly aversive procedures, there is no scientific evidence of psychological damage or harm beyond the clear physical danger of injury or death. Instead, restraint is usually viewed as a physical safety mechanism that may permit continuation of other therapeutic interventions once the restraint is completed. Most educational textbooks dealing with aggressive or violent behavior of students with E/BD suggest that physical restraint might be warranted for purposes of safety despite a lack of empirical research supporting such claims.

Summary of Research

Very little research has been conducted on the prevalence, appropriate applications, or efficacy of physical restraint. Almost no research has been conducted on the use of restraint in school settings. We do not know how widely physical restraint is used in the schools, the extent or nature of injuries occurring when it has been used in the schools, or its effectiveness in achieving the desired outcomes.

Policy Related to Restraint

An extensive search was conducted to identify court or hearing officer decisions, as well as legislation related to physical restraint. To identify cases that have dealt with restraint, we conducted a search of legal databases (i.e., Federal Supplement, which lists all Federal Trial Court decisions; Federal Reporter 3rd Series, listing all Middle Appellate Court decisions; United States Reports, the official publication for all U.S. Supreme Court rulings; LEGALTRAC, a database that indexes law reviews and other legal periodicals; Individuals with Disabilities Education Law Report [IDELR], a specialty law reporter that publishes case law specific to special education, including some hearing officer reports). The results of this search are described in the following sections.

Legislation

The passage of the Children’s Health Act of 2000 established national standards regarding the use of physical restraint with children in psychiatric facilities. Unfortunately, this legislation did not affect schools. Five states—Massachusetts, Colorado, Illinois, Connecticut, and Texas—have passed legislation over the past several years addressing the use of physical restraint with children in the school environment. Texas is the most recent state to do so (Amendments to 19 TAC Chapter 89, 2002), while one additional state, Maryland, has proposed legislation on this topic. Although state guidelines differ, the legislation typically contains many similar elements including (a) definitions of terms common to physical restraint, (b) required procedures and training for staff, (c) conditions when physical restraint can and cannot be used, (d) guidelines for the proper administration of physical restraint, and (e) reporting requirements when restraint is employed.

Court and Hearing Officer Decisions

Over the years, parents and advocacy groups have filed numerous lawsuits and/or grievances against school districts and psychiatric units regarding the use of restraint on children. Plaintiffs have typically argued that restraint violates an individual’s rights under the Eighth Amendment, which prohibits administering cruel or unusual punishment, and the Four-
teenth Amendment, which provides for an individual's liberty interests in freedom of movement and personal security (Kennedy & Mohr, 2001). Cases resulting from these complaints have been lodged through state education agency hearings (e.g., under IDEA or state school disciplinary laws), with the Office for Civil Rights (OCR) in the U.S. Department of Education, and through state and federal court cases.

While the constitutional issues mentioned earlier can be brought directly in federal court, other options exist as well. The OCR serves as the primary administrative enforcement mechanism for Section 504 and the Americans with Disabilities Act (ADA) in relation to schools (Lohrmann-O'Rourke & Zirkel, 1998). Educational cases are frequently handled by the state education agency (SEA), which resolves disputes regarding IDEA using a system of impartial due process hearings and, at the state's option, a second-tier impartial administrative review. All OCR and SEA hearing officer reports may also be appealed to a federal court.

A potentially powerful but underutilized tool for protecting the civil rights of confined or detained youths is the Civil Rights of Institutionalized Persons Act (CRIPA). Established by Congress in 1980, CRIPA provides the Civil Rights Division of the Department of Justice (DOJ) the authority to bring legal action against state and local governments for violating the civil rights of persons institutionalized in publicly operated facilities. Under CRIPA, the Civil Rights Division protects detained or incarcerated juveniles in prisons, jails, psychiatric hospitals, and other publicly operated facilities from dangerous conditions and unsafe practices of confinement (Puritz & Scali, 1998). The Office for Civil Rights has verified that CRIPA would apply to students in school settings. Complaints can be directed to: Special Litigation Section, Civil Rights Division, U.S. Department of Justice, P.O. Box 66400, Washington, DC 20035-6400. 202-514-6255.) However, we located no records that demonstrated the use of CRIPA in relation to the use of restraint in schools.

Court rulings can be grouped into four general categories pertaining to the use of physical restraint: (a) decisions affecting the use of mechanical restraint; (b) decisions affecting the use of ambulatory or manual restraint; (c) professional training pertaining to staff who perform restraint; and (d) individual rights related to the Eighth and Fourteenth Amendments, Section 504, and ADA.

**Mechanical and Ambulatory Restraint**

The preponderance of rulings by the courts, SEAs, and OCR found the use of any type of mechanical restraint other than a time-out or tray chair to be unacceptable and in clear violation of a student's individual rights. Specific rulings by each agency are shown in Table 2. In contrast, the courts, SEAs, and OCR have consistently found that ambulatory restraint may be used without violating an individual's rights or threatening the individual's safety. Specific rulings by each agency are shown in Table 3.

**Professional Training**

In Wyatt v. King (1992), the U.S. Circuit Court determined that staff working with individuals with mental illness required specific training regarding interventions germane to their unique care. The Court stated that training should include psychopharmacology, psychopathology, and psychotherapeutic interventions, as well as interviewing and assessment procedures for determining a patient's mental status. These findings have since been supported by national training prevention programs, which advertise that intensive staff training in schools has reduced assaultive incidences by 80% and resulted in a 77% reduction in disruptive incidents (Crisis Prevention Institute, 2002). Similarly, the states of Pennsylvania and Delaware experienced a 90% reduction in the use of physical restraint in their state mental health facilities after instituting intensive staff training programs. Training included crisis management and crisis prevention procedures for staff, as well as extensive training on methods for determining when and how to conduct physical restraint.

Texas legislation now requires school personnel who use restraint to be trained; its supporting technical assistance materials have identified critical components for training programs (Amendments to 19 TAC Chapter 89, 2002). Courts, hearing officers, and legislation strongly support adequate training before these procedures are employed.

**Individual Rights**

Numerous court cases have addressed patient rights. This section provides a synopsis of all decisions pertaining to an individual's rights.
regarding the Eighth and Fourteenth Amendments, Section 504, and ADA. In essence, the courts have ruled that institutions must take into account a patient’s rights at all times and that any restrictions to individual liberties must be in their best interest. Specific rulings by each agency are shown in Table 4. Perhaps the most influential decision regarding the use of restraint came from the Supreme Court decision Youngberg v. Romeo (1982). The court emphasized its concern that the judicial system should not invade the province of those whose job it is to make medical and custodial decisions. This case was critical in establishing a precedent for the establishment of procedures used to determine whether the use of physical restraint was considered reasonable and hinged on whether staff exercised professional judgment. Professional judgment, the court ruled, was to be considered presumptively valid. This presumption effectively shifted the burden of proof from the caretaker to the individual alleging that the imposition of restraint was unreasonable (Kennedy & Mohr, 2001). However, to ensure the restraint was not being used improperly, the courts determined in Converse v. Nelson (1995) that inappropriate behavioral programs that constitute punishment disguised as treatment should be subject to analysis under Eighth Amendment standards. Finally, as described earlier, CRIPA may also provide a vehicle for advocacy and protection related to the use of restraint.

Summary
A review of state and federal policies regarding the use of physical restraint in schools has resulted in several findings: (a) limited forms of mechanical restraint are permitted; (b) ambulatory restraint performed with trained personnel is authorized; and (c) any agency, including schools, that uses restraint needs to provide professional training for staff who perform these procedures.
Advocacy Statements

While professional organizations and advocacy groups frequently hold differing opinions regarding specific issues, it is important to recognize areas of agreement to promote standardization and policy. Therefore, we reviewed and summarized position statements regarding the use of physical restraint from nationally recognized advocacy groups and professional organizations.

In 1998 the American Medical Association (AMA) reviewed existing restraint guidelines and attempted to coordinate the development of updated national guidelines for the safe and clinically appropriate use of restraint techniques for children and adolescents. In a 1999 report, the AMA supported the development and use of guidelines currently issued by the American Academy of Child and Adolescent Psychiatry (AACAP), the American Academy of Pediatrics, and the American Psychiatric Association regarding restraint, while encouraging future empirical studies on physical restraint with children and adolescents across all settings (AMA, 2001).

AACAP’s policy statement suggests that institutions that use physical restraint establish procedures and policies addressing the circumstances in which restraint is permissible. AACAP also calls for documentation procedures, as well as inservice training requirements for all staff. They recommend that physical restraint be used only as an emergency intervention to maintain safety and that it be implemented in a manner sensitive to the child’s particular developmental level, specific vulnerabilities, and overall treatment goals (AACAP, 2000). The American Psychiatric Association policy statement is similar to AACAP’s, but expresses concerns regarding Children’s Health Act terminology, specifically that this legislation defines physical restraint so broadly that it essentially encompasses any unwanted touching that might reduce an individual’s ability to move freely (American Psychiatric Association, 2002). This definition would classify commonly used escort procedures as a type of physical restraint.

Finally, the position statement by the International Society of Psychiatric and Mental Health Nurses (ISPN) claims that restraint

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<th>Jurisdiction</th>
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<td>Federal Court</td>
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<tr>
<td>Garland Independent School District v. Wilks (1987)</td>
<td>Restraining a child with autism engaged in aggressive and self-injurious behavior was not considered to be excessive or to violate the child’s constitutional protection from cruel and unusual punishment.</td>
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<tr>
<td>State Education Agency</td>
<td></td>
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<tr>
<td>Florence (SC) County No.1 School District (1987)</td>
<td>Determined school personnel had not violated a student’s Section 504 rights while restraining him to prevent harm, despite language in the individualized education program forbidding corporal punishment.</td>
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<td>Office of Civil Rights</td>
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<tr>
<td>Ohio County Public Schools (1989)</td>
<td>Did not find evidence to support parent’s claim that a teacher used excessive force in restraining a student.</td>
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<tr>
<td>Wells-Ogunquit (ME) County Schools (1990)</td>
<td>School district did not violate a student’s Section 504 rights when using a physical restraint to control violent behavior.</td>
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<tr>
<td>Gateway (CA) v. Unified School District (1995)</td>
<td>Determined that a student’s behavior modification plan permitted the use of physical restraint.</td>
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should be used as a last resort and only when less restrictive alternatives have failed. ISPN recommends that family members be informed immediately after the use of a restraint and that the child receive a debriefing from the caregivers in clear words that the child can understand. The organization claims the debriefing process is necessary to minimize negative effects related to patients’ experiences of being restrained. ISPN also advocates training all staff members on the cycle of aggression, verbal intervention skills, and critical thinking strategies designed to select the least restrictive intervention that is best suited to the presenting needs of the child (ISPN, 1999).

Parents and advocacy groups have argued for the outright banishment of physical restraint, claiming its usage unfit for man, woman, or beast (Williams & Finch, 1997). Many nationally recognized advocacy groups have posted position statements regarding the use of physical restraint on their Web sites. The National Alliance for the Mentally Ill recently posted a position statement supporting the Children’s Health Act of 2000 regarding the use of physical restraint and proposed similar standards be established for schools (National Alliance for the Mentally Ill, 2001). Another group, the Child Welfare League of America, called for a minimum national standard of training in behavior management techniques, especially in the area of deescalation. In addition, it called for future research to develop a better understanding of what crisis prevention models work best for specific situations (Child Welfare League of America, 2002). More

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<td><strong>Federal Court</strong></td>
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<tr>
<td>Jackson v. Bishop (1968)</td>
<td>Interventions not professionally indicated and unnecessarily restrictive may violate a patient’s 14th Amendment liberty interest.</td>
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<tr>
<td>Parham v. J.R. (1979)</td>
<td>Supreme Court determined children did not enjoy the same degree of constitutional protection as adults.</td>
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<tr>
<td>Bell v. Wolfish (1979)</td>
<td>Supreme Court stressed that innocent persons have a right to be free from punishment.</td>
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<tr>
<td>Youngberg v. Romeo (1982)</td>
<td>Supreme Court ruled that persons involuntarily committed to state institutions have a constitutionally protected liberty interest under the due process clause of the 14th Amendment to reasonably safe conditions of confinement and freedom from unreasonable bodily restraint. These were fundamental liberties that can be limited only by an overriding, nonpunitive state interest.</td>
</tr>
<tr>
<td>Farmer v. Brennan (1994)</td>
<td>Supreme Court ruled that restraint violated the prohibition against cruel and unusual punishment when used in correctional facilities and that prison officials have a duty to provide humane conditions of confinement and can be held liable for acting with deliberate indifference to the health or safety of an inmate.</td>
</tr>
<tr>
<td>Converse v. Nelson (1995)</td>
<td>Massachusetts Superior Court ruled that inappropriate behavioral programs that constitute punishment disguised as treatment should be subject to analysis under 8th Amendment standards.</td>
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<tr>
<td><strong>Office of Civil Rights</strong></td>
<td></td>
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<tr>
<td>Chicago (IL) Public Schools District (1993)</td>
<td>Determined that a district’s failure to monitor and respond to conditions at a private school for students with severe cognitive disabilities violated the student’s Section 504 and Americans with Disabilities Act rights.</td>
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recently, the Autism National Committee has called upon Congress and state legislatures to limit the use of restraint on children with disabilities to brief, emergency situations involving serious threat of injury to the person with disabilities or to others. They are also asking for standardized reporting procedures following a restraint, with an investigation of circumstances leading to the incident to develop supports and accommodations for the prevention of future restraint (Autism National Committee, 2000).

Recommendations for Use of Physical Restraint in School Settings

After reviewing the compilation of research, legislation, case law, and position statements regarding the use of physical restraint, it appears that schools should use extreme caution when contemplating the use of physical restraint procedures. The following recommendations regarding restraint procedures, staff training, notification, and monitoring seem to combine the best practices emerging from our review and would be appropriate for any school that would employ physical restraint.

Restraint Procedures

Restraint should never be performed as a means of punishment or to force compliance from a student. In addition, physical restraint procedures should never be performed by untrained personnel. Through numerous rulings, the courts have established that very limited forms of mechanical restraint are permissible with students in a school setting and that physical or ambulatory restraint should be administered only when the safety of the student, peers, or staff members is at risk.

When physical restraint is administered, staff must use the safest method available, using the minimal amount of force necessary to protect the student and others from physical injury or harm. Once a restraint is used, it should be discontinued as soon as possible. In addition, no restraint should be administered in such a manner that prevents a student from breathing or speaking. The student’s physical status, including respiration and skin color, should be monitored continuously throughout the restraint procedure.

Professional Training

All staff members who work with students with E/BD should be required to receive specialized training in conflict deescalation, crisis prevention, and behavior management techniques. Staff should receive specialized training and recurring updates in the use of physical restraint before any such procedures are used. Physical restraint should never be used unless the person doing it is trained specifically in the particular technique to be used. Training should include recognition of the various phases of the cycle of aggression, verbal deescalation strategies, and restraint and counseling procedures. Staff should also receive certification in first aid and cardiopulmonary resuscitation (CPR) in the event of an emergency related to restraint.

Reporting and Parent Notification

Procedures for reporting and notification should be in place. Following the administration of a physical restraint, a staff member who administered the restraint should verbally notify an administrator as soon as possible. Within 24 hours, a written report should be provided to the administrator responsible for maintaining an ongoing record of all physical restraint conducted by the school. In addition, the administrator should verbally inform the student’s parents or guardians of the restraint as soon as possible. Written reports to the parents, including a description of the event and staff involved, should be postmarked no later than 3 working days following an incident.

Advocacy

Policies, procedures, and legislation, even if noble in intent, are all but meaningless if not enforced. The guidelines for schools regarding the use of physical restraint on children are the result of decades of professional practice, state and federal legislation, case law, and grassroots efforts by advocacy groups, all concerned with the safety of children. To ensure that empirically based best practices are developed and become common practice among schools, it is incumbent upon various professional and advocacy organizations to monitor and hold school districts (as well as other agencies) across the nation accountable. These organizations need to act as watchdog agencies monitoring the compliance of
schools to ensure that children are kept out of harm’s way.

**Recommendations for Further Research**

It is evident that there is a strong need for additional research regarding the use of physical restraint with students across all settings. Areas for future research include the following:

- The extent to which schools currently employ physical restraint, and if so, which of the restraint systems are used.
- The nature of the antecedents or behavior that precipitated restraint.
- The Diagnostic and Statistical Manual diagnoses (American Psychiatric Association, 2002), special education category (if applicable), or other characteristics of students who receive restraint.
- The intended purposes or goals of restraint.
- The efficacy of restraint procedures in achieving these goals.
- The potential outcomes or side effects, including injuries and fatalities, as a result of the use of restraint in schools.
- The training level of the staff who actually perform restraint.
- The degree to which procedures for deescalation of student behavior are used before, during, and after restraint.

Using the data compiled in states that require reporting will be very useful in beginning to address some of these issues and make it more likely that restraint will be used safely.

**Conclusion**

Due to the current risk of student injuries and the mortality rates associated with the use of physical restraint, immediate action is required to ensure that schools employing restraint do not jeopardize student safety. Based on the review of case law, legislation, and recommended procedures from both professional organizations and advocacy groups, there is a need for clear standards regarding the use of restraint procedures in schools, as well as mandatory training of staff before they use restraint. Improved and standardized record keeping and notification of administrators and parents of incidents in which restraint occurs are also important. Additional research is needed to define situations in which restraint is appropriate in schools, as well as its effectiveness in containing or preventing violent or destructive behavior. Unless these recommendations are heeded and action is taken, headlines will continue to appear across our nation describing these preventable fatalities.

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