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Review of Use of Restrictive Procedures in Minnesota Schools

Prepared in partnership with
National Alliance for Mental Illness (NAMI) Minnesota

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Executive Summary

Project Goals:

The purpose of this project was to assess the statewide implementation of existing Minnesota Laws (Appendix A) regarding the use of seclusion and restraints with special education students. The following information provides insight into compliance with the current law, barriers and strengths in implementing the law, and will serve to inform future policy. The role of the National Alliance on Mental Alliance (NAMI) Minnesota has been to bring together various organizations and schools, which have a vested interest in this legislation, to work towards a compromise that is in the best interest of all parties.

Objectives:

1. Assess compliance with certain aspects of the current legislation.
2. Acquire demographic and frequency data regarding the use of seclusion and restraints in the state of Minnesota.
3. Inform future policy by identifying what barriers and strengths currently exist in implementing the law.

Background:

The use of seclusion and restraints as an intervention in schools is not federally regulated. The lack of national standardization has resulted in the haphazard implementation of such interventions resulting in the injuries, and even the deaths, of numerous students.¹ National attention was garnered after an initial report in 1998, published by the Hartford Courant, cited the dangers of seclusion and restraints. Reports followed from several organizations and these reports advised the Children's Health Act of 2000 and the Substance Abuse Mental Health Services Administration's recommendations. Given the level of emotional and physical stress associated with experiencing and witnessing the use of seclusion and restraints, utilization of such interventions should occur in the rarest of circumstances.

Those who oppose the regulation of seclusion and restraints cite cumbersome paperwork associated with documenting an incident, unclear wording of legislation (i.e., what constitutes an emergency), and time/financial constraints in training staff members district-wide. Opponents also note an alleged increase in safety risks for school staff and other students when dealing with psychiatric and emotional emergencies. To what extent and how consistently de-escalation techniques work, as well as the limits surrounding such methods, are questioned. Disagreement about whether seclusion and restraints should be part of a student's safety plan/IEP also contributes to the lack of clarity of when, or if, restraints should be used. A few cite their effectiveness despite the lack of any studies demonstrating this.

In seeking to promote a healthier school climate, the use of seclusion and restraints appears to be counter-intuitive at times. It has been shown that the use of

seclusion and restraints tend to have the opposite effect of calming down a student, and in fact, initiates the fight-and-flight response.² Decreasing the use of seclusion and restraints is also in-line with implementing evidenced based treatments in school settings and utilizing school-linked mental health services.³ Decreasing or eliminating the use of seclusion and restraints tends to result in more time spent on instruction, less time spent away from the classroom, and fewer legal costs.

Many of the students placed in seclusion and restraints display decreased emotional and behavioral well-being, suggesting the need for continuous training of staff who interact with students on a daily basis as to de-escalate potentially problematic behaviors. However, even the best of teachers argue that de-escalation techniques are not always viable in ameliorating emergency situations. Promoting and integrating the use of Positive Behavioral Intervention Supports (PBIS) within schools is crucial; schools that tend to use PBIS have shown an overall decrease in the use of seclusion and restraints.

³ JESSICA BUTLER, HOW SAFE IS THE SCHOOLHOUSE? AN ANALYSIS OF STATE SECLUSION AND RESTRAINTS LAWS AND POLICIES (Published by the Autism National Committee, January 2012)

² W.K. MOHR & J.A. ANDERSON, FAULTY ASSUMPTIONS ASSOCIATED WITH THE USE OF RESTRAINTS WITH CHILDREN (Journal of Children and Adolescent Psychiatric Nursing, 14(3), 141-151; Official Publication of the Association of Child and Adolescent Psychiatric Nurses, Inc 2001, Published in Debunking the Myths of Restraints and Seclusion in The Alliance to Prevent Restraints, Aversive Interventions, and Seclusion)

³ GLEN DUNLAP, CHERYL OSTRYN, & LISE FOX, PREVENTING THE USE OF RESTRAINT AND SECLUSION WITH YOUNG CHILDREN: *THE ROLE OF EFFECTIVE, POSITIVE PRACTICES* (Technical Assistance Center on Social Emotional Intervention, February 2011)

Report Content

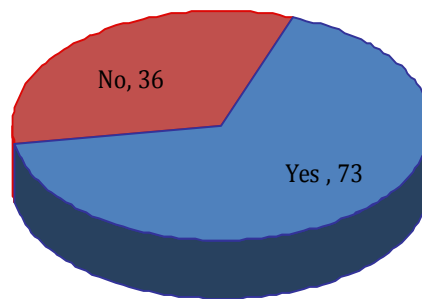
The following is a summary of the responses to questions utilized in our survey. See Appendix B for the survey used. A total of 379 special education directors were identified in the State of Minnesota through the (Minnesota Association of Special Education) MASE website and were requested to complete the survey. Special Education directors from 133 school districts returned responses to the survey. Some respondents chose not to answer all of the survey questions, so the number of respondents to a particular item will be included in the summary. A total of 837,640 students are enrolled statewide and 123,952 of those students classified as special education.

The Use of Seclusion in Schools

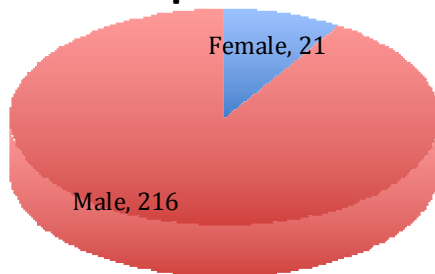
When asked if their school district uses seclusion, a total of 109 individuals responded. The definition of seclusion, as provided in Minnesota legislation, was cited in the survey to promote consistency in reporting. Of respondents, 73 indicated that seclusion was used in their school districts and five of those indicated there was no use of seclusion during the indicated reporting period (defined as August 31, 2011 to January 1, 2012).

Participants were also asked to categorize those secluded by defining characteristics such as age, gender, and disability, in order to gather more information about the use of seclusion in schools. Six of the

Use of Seclusion
Total Respondents: 109



Use of Seclusion by Gender
Total Respondents: 25

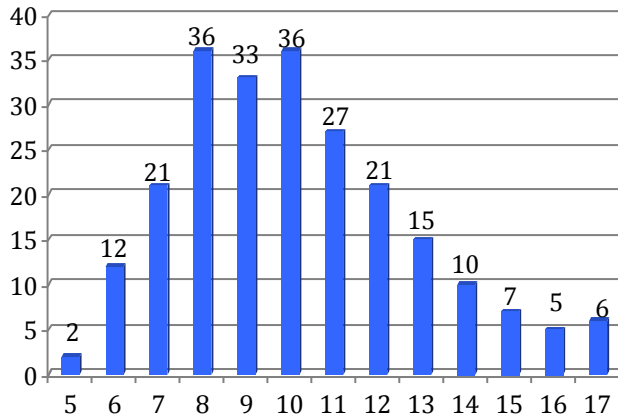


districts that reported use of seclusion did not provide further information. Sixty-two school districts reported seclusion was used a total of 1,011 times throughout the reporting period; five of these schools accounted for 640 of the 1,011 times seclusion was used, or 63%.

During the reporting period, twenty-five respondents reported 216 males and 21 females were placed in seclusion. Twenty-four respondents reported a pattern that

indicated children ages 8 to 11 were the most frequently secluded in Minnesota schools. **The number of students placed in seclusion during the reporting period accounts for**

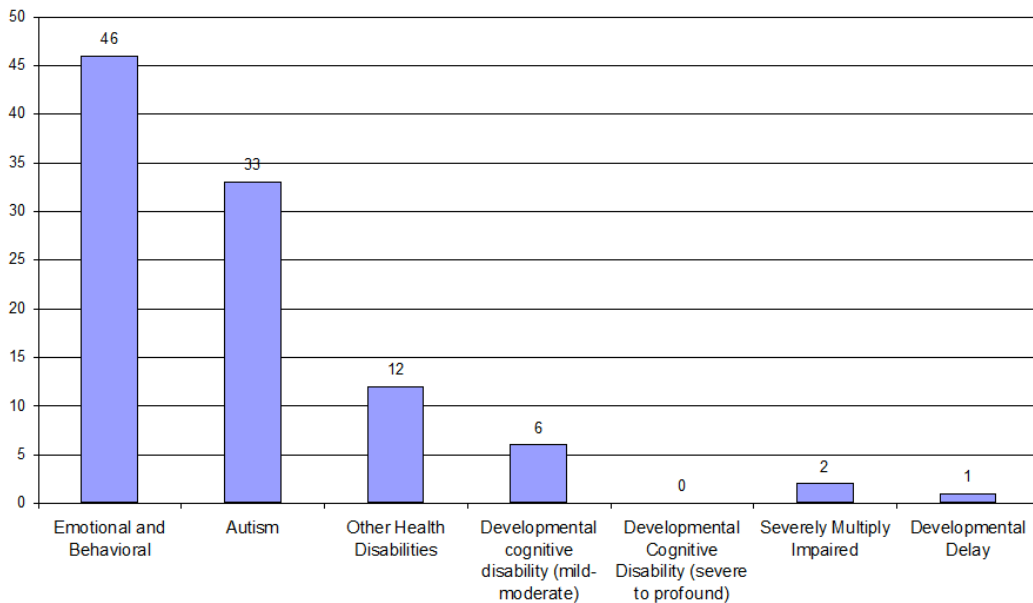
**Use of Seclusion by Age
Total Respondents: 24**



.20% percent of the special education population. Many school districts did not have seclusion rooms registered with the state; however, all of the schools who reported no

registered rooms also reported no use of seclusion. Twenty-one respondents identified the diagnosed disability of each secluded child. The overwhelming diagnosis of children secluded was emotional or behavioral disorders or autism. More often than not, special education directors indicated that a small percentage of children accounted for the use of seclusion in their district. Out of all of the districts that reported use of seclusion, on average, the child most frequently placed in seclusion was secluded 21.4 times.

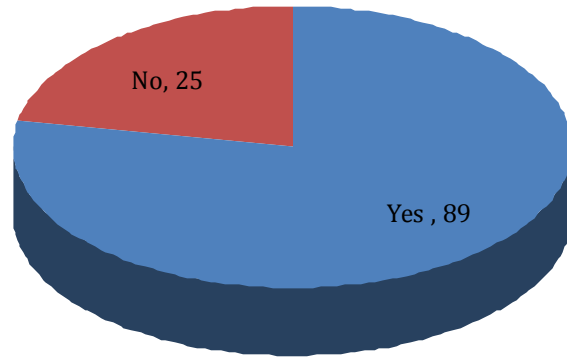
Use of Seclusion by Type of Disability



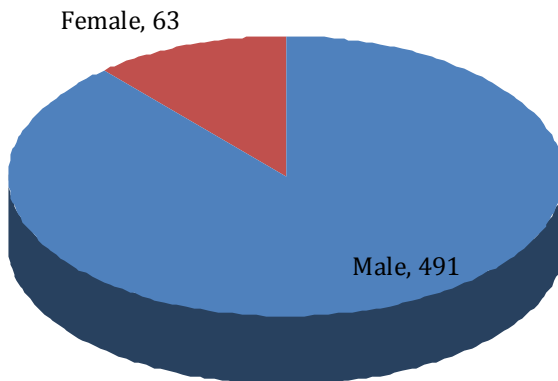
The Use of Restraints in Schools

The survey posed similar questions about the use of restraints in each school district as the use of seclusion. Eighty-nine of 114 respondents indicated the use of restraints in their school district. Of the 89 who reported use of non-prone restraints, 18 reported no use of restraints during the reporting period (between August 31, 2011 and January 1, 2012). Eighteen respondents did not provide further data. Fifty-three school districts reported non-prone restraints were used a total of 2,503 times. Three schools accounted for over 1,300 of the 2,503 times non-prone restraints used, or 52%.

Use of Restraints
Total Respondents: 114
Respondents

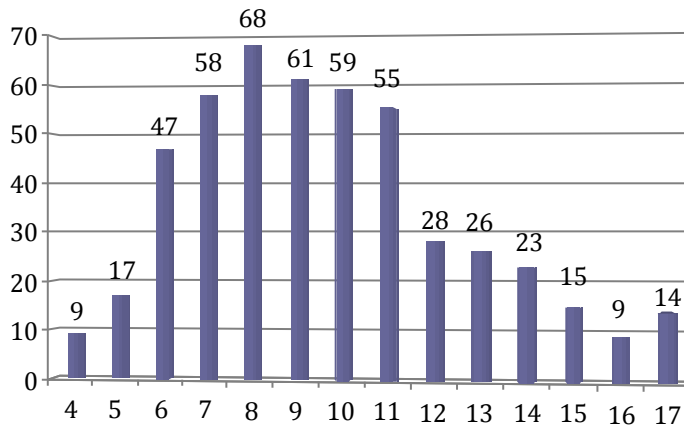


Use of Restraints by Gender
Total Respondents: 114
Schools

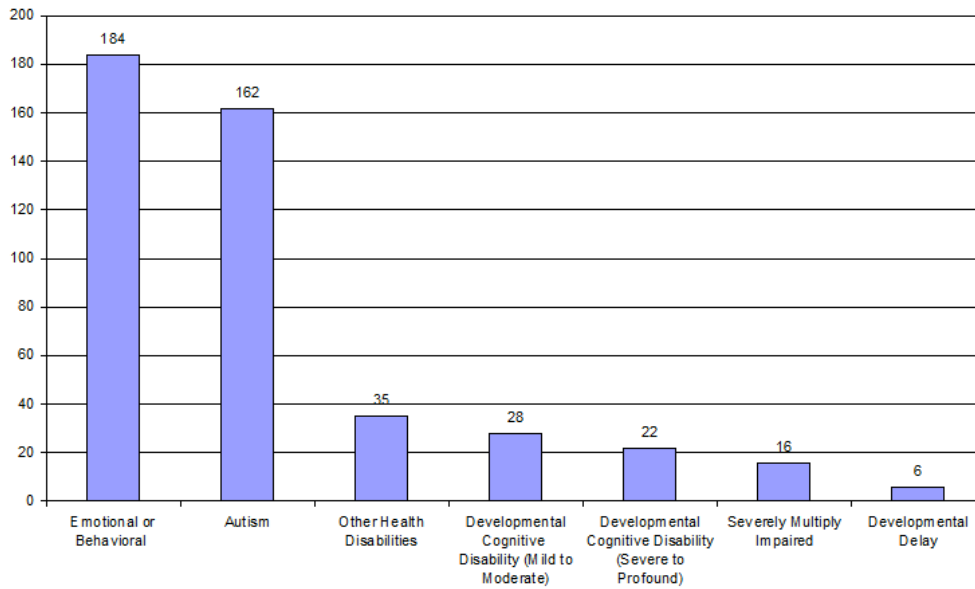


Much like seclusion, students ages 7 through 11 were restrained most often and male students were almost 8 times more likely to be restrained than female students. 114 respondents broke down the use of restraints into categories based on the child's primary diagnosis. Out of 554 children that were reported restrained, data was provided on type of disability for 453, which indicated the overwhelming majority were either diagnosed with autism or an emotional or behavioral disability, much like seclusion.

Use of Restraints by Age Total Respondents: 114 Schools



Use of Restraints by Type of Disability



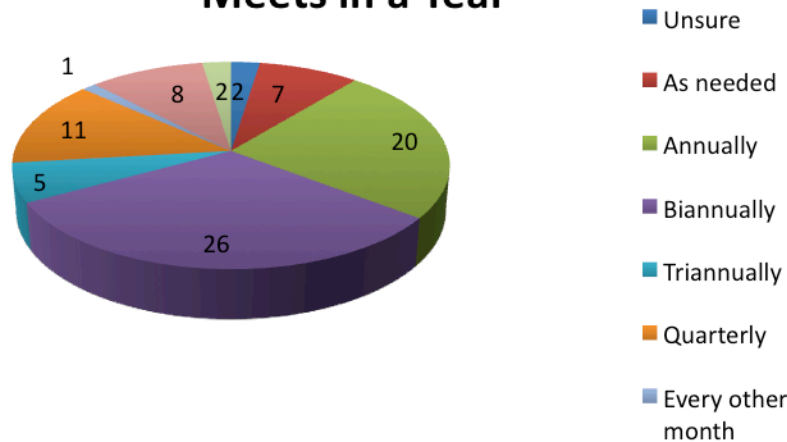
The Use of Oversight Committees

The survey's next section of questions revolved around the use of an oversight committee in schools that use seclusion and/or restraint. The purpose of the oversight committee is to assess compliance with restrictive procedures and to

monitor their use. Minnesota law, stating the standards for the use of restrictive procedures, requires that any school that intends to use restrictive procedures must make a restrictive procedures plan that includes how the school will monitor and review the procedures. This plan must include post-use debriefings and convening an oversight committee.⁴

Of 101 respondents, 87 reported use of an oversight committee and 14 reported no

How Often Oversight Committee Meets in a Year



use of an oversight committee. Some of the most common professions represented on oversight committees included: School Psychologist, Special Education Coordinator, Special Education Teacher, General Education Teacher, General Administrator, Para Professionals, Principal and CPI trainer. Less common professions on oversight committees included: Vice Principal, Social Worker, Behavior Specialist, Superintendent, Mental Health Professional, Parents and Executive Director of School Board.

The survey went on to ask about the frequency and the circumstances for which the oversight committee would meet. The majority of oversight committees met two times a year; however, committees met anywhere from once a year to twice a month.

In order to gauge school districts’ thoughts about the use of these committee, the survey included various open-ended questions with a variety of prompts, such as if the committee made a difference in the use of these restrictive procedures and if so, what were some of the perceived benefits.

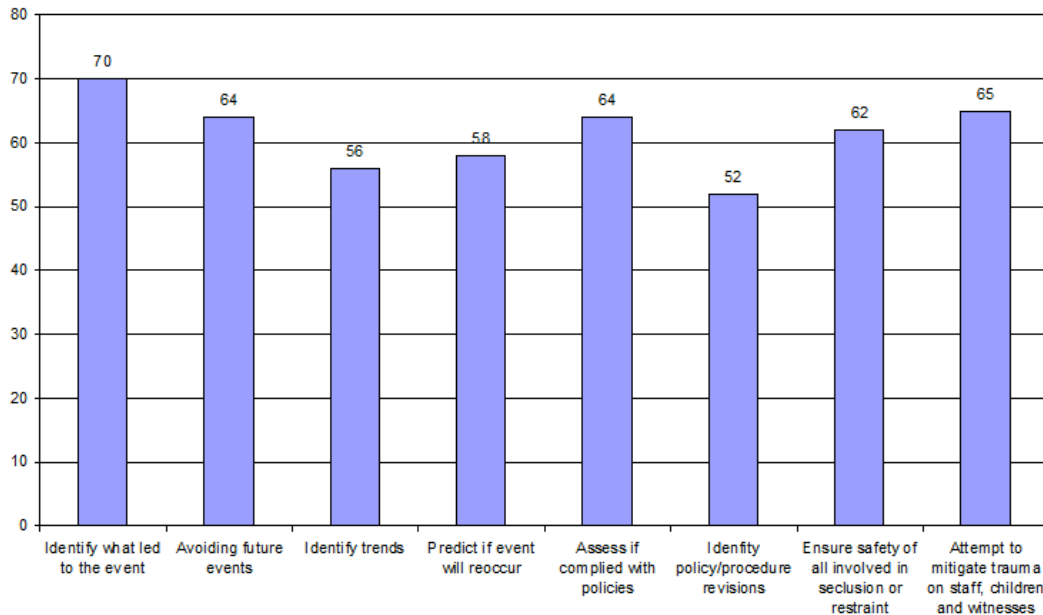
Out of the districts that indicated the use of oversight committees, 17 said the committee has not yet had a reason to meet as there were no restrictive procedures used, 9 mentioned that the committee has not made a difference and the rest of the respondents mentioned a variety of benefits including: developing proactive strategies, accountability, clarification and input on practices, data review, better evaluative practices, training purposes, learning the law, developing district policy, and increasing confidence. Eleven

⁴ Minn. Gen. Laws ch. 96, art. 3§ 11 (2001).

districts do not have an oversight committee and 8 of those districts indicated that they used either seclusion or restraint, which puts them outside of Minnesota law.

In addition to use of an oversight committee, the use of post-use debriefings was also included in the survey. Of 102 respondents, 86 districts indicated the use of post-use debriefings, while 2 did not, despite using restrictive procedures, which is contrary to Minnesota law requirements.

Elements of Debriefing Session

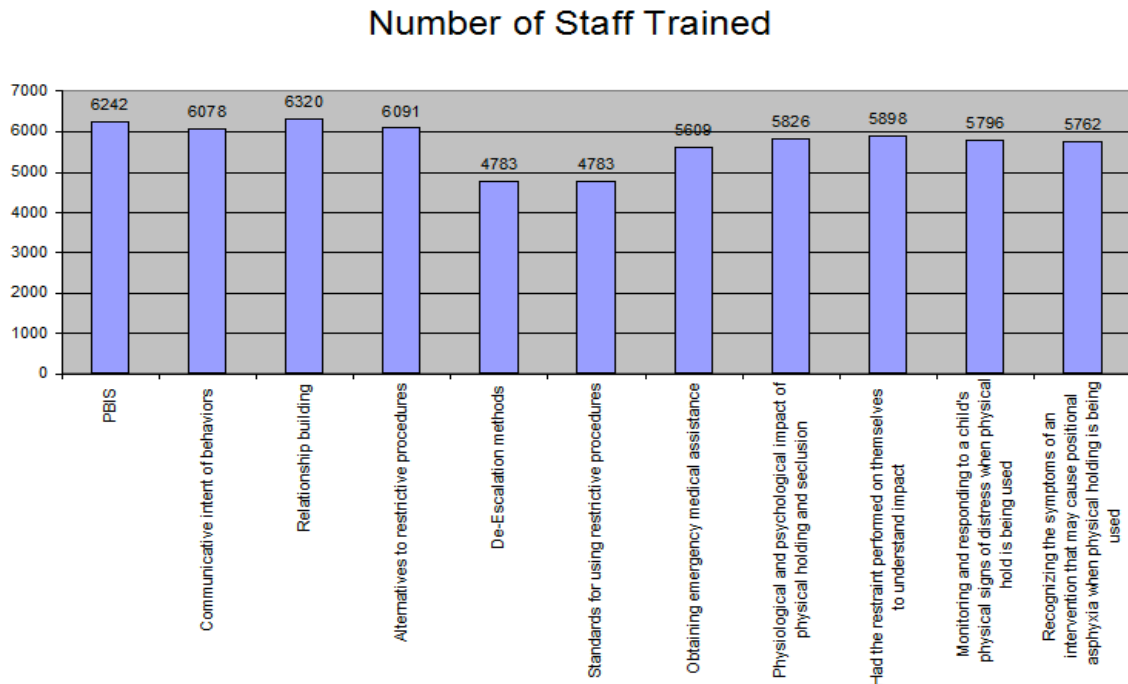


Teachers, Psychologists, Principals, Para professionals, Support Staff, Social Workers, Parents, Administrators and “all individuals involved in the incident” were commonly involved in post-use debriefings. IEP managers and mental health professionals were also mentioned.

The survey also addressed if written descriptions of restrictive procedures existed. Out of 90 respondents, 83 reported there was a written description of the list of restrictive procedures used, whereas 7 reported there was not. When it came to accessibility on the district websites, out of a total of 87 respondents, 58 reported the written description was posted on the district’s website whereas 29 reported no description was posted on the district’s website.

After the use of seclusion and restraints, the majority of school districts reported IEP meetings were scheduled. Most IEP meetings were conducted if the use of seclusion or restraints occurred twice within 30 days; some school districts reported IEP meetings were conducted after the use of every seclusion or restraint.

The survey also assessed the number of staff trained in 11 different areas, as seen below. Areas with the most trained staff were Relationship Building and PBIS. Areas with the fewest trained staff were Standards for Using Restrictive Procedures and De-Escalation Methods.



In assessing if the training was provided by external organizations, out of 86 respondents, 47 reported the training was not conducted by external organization; 39 reported training is provided by external organizations such as private psychologists/agencies, and service cooperatives.

When no external organization was cited as providing training to staff, professions most often identified as trainers included: CPI trainers, school psychologists, special education teachers, special education directors/coordinators/supervisors/teachers, nurses, behavioral coordinator/coaches, PCMA trainers, social workers, and highly trained paraprofessionals,

Another area assessed was the utilization of PBIS and school-linked mental health services. Out of 78 respondents, 78 schools were identified as part of the formal PBIS cadre. Related to the use of school linked mental health services, out of 84 respondents, 61 reported utilization of such services. Fifty two out of 84 respondents reported schools in their district utilized other services for mental health support such as the use of social workers, county workers, and collaboration with private and public organizations.

Key Findings and Respondent Recommendations

The majority of students placed in seclusion and restraints were males, between the ages of 7-11, and diagnosed with emotional/behavioral disorders or autism. On average, less than 20% of schools reported that a small number of children significantly accounted for the number of students placed in seclusion or restraints.

Given the responses of the survey, it appears consensus exists that the law has resulted in schools being more proactive in their approach to working with students. The majority of schools who responded utilized some form of standardized training, such as CPI, to educate staff. In addition, virtually all schools maintained documentation of training that had been completed.

Additional benefits of the legislation cited by respondents included fewer overall restraints, which is consistent with previously cited research. In addition, more continuity in communication with parents was reported as well as the increased utilization of PBIS, school-linked mental health services and even other services in the community. Awareness of peak times and of patterns was beneficial in identifying if, and when, more staff needed to be present. Also, respondents reported an overall increase in the number of staff who were trained and, also, correctly trained in various techniques. Positive school climates and improved documentation were cited as additional strengths, resulting from the legislation. Implementing debriefing techniques was also beneficial for staff to process what had transpired and overall, there was consensus about improved oversight/structure that was uniform across school districts.

Assistance in funding and allocating time to integrate specific aspects of the legislation, such as training and time to complete paperwork, appear to be the biggest barriers for school districts. The amount of paperwork that requires completion may be remedied by having an online system where data is centrally input, which also may make it more efficient for state-wide reporting purposes. Another concern central to the legislation, which was most often cited, was the time and resources needed to conduct IEP meetings, if required as part of a student's IEP. Many staff felt conducting IEP meetings if two incidents occurred within 30 days was not viable.

Less frequently cited, yet other concerns, associated with the legislation included the perception of less safety for students and staff; however, increased safety for students and staff was also cited as a strength of the legislation. Also, respondents reported some difficulty in retraining staff regarding expectations when working with students and overcoming old "ideologies." Few respondents cited that without the use of seclusion and restraints, some respondents reported students were suspended at higher rates; consequently, there was also concern about potential lawsuits and hesitance by staff to utilize restraints or seclusion.

As a result of the strengths and barriers identified, changes in the law proposed by respondents include not eliminating the use of prone restraints, decreasing the frequency of IEP meetings that need to occur after the use of seclusion and restraints, and

clarification of definitions such as what constitutes an “emergency” and “time out room.” Also, a few respondents proposed repealing parts of the Minnesota statutes as to be in line with federal regulations as Minnesota regulations are stricter. In addition, others felt that the use of seclusion and restraints led to students having to display more intense and aggressive actions before either could be used.

2012 Legislative Session

During the 2012 legislative session, several changes regarding the use of restrictive procedures occurred, as follows:

Seclusion and Restraints

At the very end of last year's session, the legislature allowed schools to continue to use prone restraints for one year and required them to report on their use to the Minnesota Department of Education. The department was to provide the legislature with a report in February of this year. The report found that prone restraints were used and that it tended to be in schools that served high needs students. As a reminder, a bill governing the use of seclusion and restraints was passed in 2009 and went into effect on August 1, 2011.

After quite a bit of discussion, a compromise was reached. School districts will be allowed to use prone restraints with children ages five and older for one more year. Prone restraints are now defined in the law as placing a child in a face down position. The law expands the definition of "physical holding" to specify that it must be "used to effectively gain control of a child in order to protect the child or other person from injury," and it adds stricter provisions that prohibit schools from using physical holding that restricts or impairs a child's ability to communicate distress; places pressure or weight on a child's head, throat, neck, chest, lungs, sternum, diaphragm, back, or abdomen; or results in straddling a child's torso. School districts must continue to report the use of prone restraints on a form provided by the Department of Education and the department will publish the data on a quarterly basis. Districts will now be required to submit by July 1, 2012 summary data on the use of all restrictive procedures, including the number of incidents, total number of students on which the procedures were used, the number of resulting injuries, and relevant demographic data.

The Department of Education, in collaboration with stakeholders, must develop a statewide plan by February 1, 2013 to reduce school districts' use of restrictive procedures and report to the legislature on measurable goals for doing so, along with what resources, training, technical assistance, mental health services and collaborative efforts are needed to significantly reduce school districts' use of prone restraints. NAMI understands that this is a complex issue and we need to make sure that the resources that are needed to support children are identified along with increasing the efforts to reduce the use of all restrictive procedures. Chapter 146

NAMI Minnesota Recommendations

In reviewing the data obtained through the survey, and subsequent discussion during the 2012 Legislative Session, NAMI Minnesota makes the following recommendations:

1. The Minnesota Department of Education (MDE) should take a stronger oversight role, ensuring that school districts understand and are complying with the components of the legislation. MDE needs to ensure that districts are:
 - registering their seclusion rooms with the state
 - creating and utilizing oversight committees

MDE could assist districts by creating templates for standardized protocols for school districts to use such as a written description of restrictive procedures, having a list of recommended training providers, ensuring more collaboration with children's mental health providers for training, and creating an easy on-line reporting system.

2. That the state needs to address the barriers for accessing more intensive mental health services such as CTSS, day treatment, partial hospitalization, and residential placement for high need students who are experiencing frequent use of seclusion or restraints. Schools cannot do it alone and some of these children may need more than the school can provide, such as intensive mental health services.

3. The legislature should continue to support schools that want to use positive behavioral intervention services and should increase the number of school-linked mental health services.

4. The legislature should create a state fund to provide standardized intensive training to school staff so that they have more tools to address behaviors and symptoms and to prevent them from escalating and so that schools do not have to use their limited resources.

5. The law should be amended to provide clarification for definition of what constitutes an "emergency."

6. A consensus should be developed among stakeholders to provide clarification of how often (frequency) an IEP meeting needs to be held, given the time and financial constraints cited by respondents and whether there are other options that can be used to discuss the use of restrictive procedures.

Appendix A (Law)

125A.0942 STANDARDS FOR RESTRICTIVE PROCEDURES.

Subdivision 1. Restrictive procedures plan.

Schools that intend to use restrictive procedures shall maintain and make publicly accessible a restrictive procedures plan for children that includes at least the following:

- (1) the list of restrictive procedures the school intends to use;
- (2) how the school will monitor and review the use of restrictive procedures, including conducting post-use debriefings and convening an oversight committee; and
- (3) a written description and documentation of the training staff completed under subdivision 5.

Subd. 2. Restrictive procedures.

(a) Restrictive procedures may be used only by a licensed special education teacher, school social worker, school psychologist, behavior analyst certified by the National Behavior Analyst Certification Board, a person with a master's degree in behavior analysis, other licensed education professional, paraprofessional under section 120B.363, or mental health professional under section 245.4871, subdivision 27, who has completed the training program under subdivision 5.

(b) A school shall make reasonable efforts to notify the parent on the same day a restrictive procedure is used on the child, or if the school is unable to provide same-day notice, notice is sent within two days by written or electronic means or as otherwise indicated by the child's parent under paragraph (d).

(c) When restrictive procedures are used twice in 30 days or when a pattern emerges and restrictive procedures are not included in a child's individualized education program or behavior intervention plan, the district must hold a meeting of the individualized education program team, conduct or review a functional behavioral analysis, review data, consider developing additional or revised positive behavioral interventions and supports, consider actions to reduce the use of restrictive procedures, and modify the individualized education program or behavior intervention plan as appropriate. At the meeting, the team must review any known medical or psychological limitations that contraindicate the use of a restrictive procedure, consider whether to prohibit that restrictive procedure, and document any prohibition in the individualized education program or behavior intervention plan.

(d) An individualized education program team may plan for using restrictive procedures and may include these procedures in a child's individualized education program or behavior intervention plan; however, the restrictive procedures may be used only in response to behavior that constitutes an emergency, consistent with this section. The individualized education program or behavior intervention plan shall indicate how the parent wants to be notified when a restrictive procedure is used.

Subd. 3. Physical holding or seclusion.

Physical holding or seclusion may be used only in an emergency. A school that uses physical holding or seclusion shall meet the following requirements:

(1) the physical holding or seclusion must be the least intrusive intervention that effectively responds to the emergency;

(2) physical holding or seclusion must end when the threat of harm ends and the staff determines that the child can safely return to the classroom or activity;

(3) staff must directly observe the child while physical holding or seclusion is being used;

(4) each time physical holding or seclusion is used, the staff person who implements or oversees the physical holding or seclusion shall document, as soon as possible after the incident concludes, the following information:

(i) a description of the incident that led to the physical holding or seclusion;

(ii) why a less restrictive measure failed or was determined by staff to be inappropriate or impractical;

(iii) the time the physical holding or seclusion began and the time the child was released; and

(iv) a brief record of the child's behavioral and physical status;

(5) the room used for seclusion must:

(i) be at least six feet by five feet;

(ii) be well lit, well ventilated, adequately heated, and clean;

(iii) have a window that allows staff to directly observe a child in seclusion;

(iv) have tamperproof fixtures, electrical switches located immediately outside the door, and secure ceilings;

(v) have doors that open out and are unlocked, locked with keyless locks that have immediate release mechanisms, or locked with locks that have immediate release mechanisms connected with a fire and emergency system; and

(vi) not contain objects that a child may use to injure the child or others;

(6) before using a room for seclusion, a school must:

(i) receive written notice from local authorities that the room and the locking mechanisms comply with applicable building, fire, and safety codes; and

(ii) register the room with the commissioner, who may view that room; and

(7) until August 1, 2012, a school district may use prone restraints under the following conditions:

(i) a district has provided to the department a list of staff who have had specific training on the use of prone restraints;

(ii) a district provides information on the type of training that was provided and by whom;

(iii) prone restraints may only be used by staff who have received specific training;

(iv) each incident of the use of prone restraints is reported to the department within five working days on a form provided by the department or on a district's restrictive procedure documentation form; and

(v) a district, prior to using prone restraints, must review any known medical or psychological limitations that contraindicate the use of prone restraints.

The department will report back to the chairs and ranking minority members of the legislative committees with primary jurisdiction over education policy by February 1, 2012, on the use of prone restraints in the schools.

Subd. 4. Prohibitions.

The following actions or procedures are prohibited:

(1) engaging in conduct prohibited under section 121A.58;

(2) requiring a child to assume and maintain a specified physical position, activity, or posture that induces physical pain;

(3) totally or partially restricting a child's senses as punishment;

(4) presenting an intense sound, light, or other sensory stimuli using smell, taste, substance, or spray as punishment;

(5) denying or restricting a child's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the child's functioning, except when temporarily removing the equipment or device is needed to prevent injury to the child or others or serious damage to the equipment or device, in which case the equipment or device shall be returned to the child as soon as possible;

(6) interacting with a child in a manner that constitutes sexual abuse, neglect, or physical abuse under section 626.556;

(7) withholding regularly scheduled meals or water;

(8) denying access to bathroom facilities; and

(9) physical holding that restricts or impairs a child's ability to breathe.

Subd. 5. Training for staff.

(a) To meet the requirements of subdivision 1, staff who use restrictive procedures shall complete training in the following skills and knowledge areas:

(1) positive behavioral interventions;

(2) communicative intent of behaviors;

(3) relationship building;

(4) alternatives to restrictive procedures, including techniques to identify events and environmental factors that may escalate behavior;

(5) de-escalation methods;

(6) standards for using restrictive procedures;

(7) obtaining emergency medical assistance;

(8) the physiological and psychological impact of physical holding and seclusion;

(9) monitoring and responding to a child's physical signs of distress when physical holding is being used; and

(10) recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding is used.

(b) The commissioner, after consulting with the commissioner of human services, must develop and maintain a list of training programs that satisfy the requirements of paragraph (a). The district shall maintain records of staff who have been trained and the organization or professional that conducted the training. The district may collaborate with children's community mental health providers to coordinate trainings.

Subd. 6. Behavior supports.

School districts are encouraged to establish effective school wide systems of positive behavior interventions and supports. Nothing in this section or section 125A.0941 precludes the use of reasonable force under sections 121A.582; 609.06, subdivision 1; and 609.379.

History:

2009 c 96 art 3 s 11; 1Sp2011 c 11 art 3 s 2,12

NOTE: This section, as added by Laws 2009, chapter 96, article 3, section 11, is effective August 1, 2011. Laws 2009, chapter 96, article 3, section 11, the effective date.

Link to website: <https://www.revisor.mn.gov/statutes/?id=125A.0942>

Appendix B (Survey)

The information from this survey will only be used to gather qualitative feedback and statistical data. Data will be aggregated and not reported by school district.

1. Does your school district use seclusion? (Confining a child alone in a room from which egress is barred. Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion).
2. If yes, how many times was seclusion used (between August 31, 2011 to January 1, 2012)?
3. If yes, how many children were placed in seclusion?
 - a. Total number of children
 - b. Number of Males
 - c. Number of Females
 - d. Breakdown by age (ages 4-17)
 - e. What is the breakdown by Special Education category? (categories: Emotional or Behavioral Disorders, Autism Spectrum Disorders, Other Health Disabilities, Developmental Cognitive Disability (mild to moderate), Developmental Cognitive Disability (severe to profound), Severely Multiply Impaired, Developmental Delay)
4. Did you notice that a small percentage of children accounted for those placed in seclusion?
5. If yes, how often were the TOP three children placed in seclusion?
6. Does your school district use restraints? (Physical intervention intended to hold a child immobile or limit a child's movement and where body contact is the only source of physical restraint. The term physical holding does not mean physical contact that: (1) helps a child respond or complete a task; (2) assists a child without restricting the child's movement; (3) is needed to administer an authorized health-related service or procedure; or (4) is needed to physically escort a child when the child does not resist or the child's resistance is minimal). Minn. Stat. § 125A.094(c).
7. How many times were non-prone restraints used?
8. How many children were placed in non-prone restraints?
 - a. Total number of children
 - b. Number of Males
 - c. Number of Females
 - d. Breakdown by age (ages 4-17)
 - e. What is the breakdown by Special Education category? (categories: Emotional or Behavioral Disorders, Autism Spectrum Disorders, Other Health Disabilities, Developmental Cognitive Disability (mild to moderate), Developmental Cognitive Disability (severe to profound), Severely Multiply Impaired, Developmental Delay)

9. Did you notice that a small percentage of children accounted for those placed in restraints?
10. If yes, how often were the TOP three children placed in restraints?
11. Does your school district use an oversight committee?
12. What professions are represented on the committee? (i.e. teachers, parents, psychologists, social workers, etc.)
13. How often does the oversight committee meet?
14. How has the committee made a difference?
15. Does your school district conduct post-use debriefings?
16. What professions are represented in the post-use debriefings? (i.e. teachers, parents, psychologists, social workers, etc.)
17. If yes, participants in the debriefing: (check all that apply)
 - a. Identify what led to the event
 - b. Identify how to avoid repeating the event in the future
 - c. Identify trends
 - d. Identify if the behavior may occur again leading to restraint or seclusion
 - e. Assess if policies were followed
 - f. Identify potential need(s) for policy/procedure revisions
 - g. Ensure safety of all involved in seclusion or restraint
 - h. Attempt to mitigate trauma on staff, children, and witnesses
18. Is there a written description of the list of restrictive procedures used?
19. Is the written description posted on the district's website?
20. When parents are notified of the use of seclusion and/or restraints, what happens next? (check all that apply)
 - a. IEP meeting is scheduled
 - b. Coordination/referral to resources such as school linked mental health services, etc.
 - c. Other:
21. How often were IEP meetings conducted after the use of seclusion and/or restraints?
 - a. After every seclusion and/or restraint
 - b. If two incidents occur in thirty days
 - c. When a pattern emerges

22. How many schools in your district have a seclusion room registered with the state?
23. How many staff in your district have received training in the following areas? (Enter how many people for each option):
- Positive behavioral interventions
 - Communicative intent of behaviors
 - Relationship building
 - Alternatives to restrictive procedures, including techniques to identify events and environmental factors that may escalate behavior
 - De-escalation methods
 - Standards for using restrictive procedures
 - Obtaining emergency medical assistance
 - Physiological and psychological of physical holding and seclusion
 - Had the restraint performed on themselves to understand impact
 - Monitoring and responding to a child's physical signs of distress when physical hold is being used
 - Recognizing the symptoms of an interventions that may cause positional asphyxia when physical holding is being used
24. Is there documentation of the trainings your school district staff has completed?
25. Is the training provided to staff conducted by external organizations?
26. If no external organization was used, who within the school district conducts the training? (identify by profession i.e. special education director, trained psychologists, trained social workers, etc.)
27. Regardless of the use of external or internal training, did you use a specific type of training program (such as a CPI, etc.)?
28. How many schools in your district are part of the formal PBIS cadres?
29. Do any of the schools in your district utilize school linked mental health services?
30. Do any of the schools in your district utilize any other services for mental health support?
31. What would you consider to be the top 3 barriers of implementing the law (time constraints, confusion about law terminology, etc.)?
32. What would you consider to be the top 3 benefits of implementing the law (fewer restraints, awareness of peak times when restraints occur and accordingly having more staff accessible, etc.)?
33. What part(s) of the law would you like to see changed?

34. What school district are you reporting for?

35. Please provide the following information in case we have follow up questions.
Please note that your information will only be reported in aggregate format.

Name
Phone
Email