

VALUE

Vision and Leadership Uniting Education

July 16, 2007

Mr. Jim Buckheit
Executive Director
State Board of Education
333 Market Street
Harrisburg, PA 17126-0333

Dear Mr. Buckheit:

The VALUE Coalition appreciates this opportunity to comment on proposed 22 PA Code Chapter 14. As you know, VALUE is a coalition of local and state disability advocates and families of children with disabilities. We have participated at the roundtables and the public hearings, and in many respects have been pleased with the State Board's response to our concerns and suggestions. In particular we applaud the additions to the regulations that codify applicable court cases that explain, functionally, the "least restrictive environment" requirement of the IDEA. In *Oberti*, *Girty*, and other decisions, the Third Circuit Court of Appeals has set out the standards for educators to follow, and these standards will now be specifically laid out in state law.

Unfortunately, the version of Chapter 14 that was passed at the May, 2007 State Board meeting retreated dramatically from earlier versions in an area of particular importance to VALUE. Specifically, 22 PA Code §14.133 regulates when professionals can and cannot use physically coercive techniques on the most physically and emotionally vulnerable of our children – children who often do not have the communication skills to tell professionals and families what happened or how they feel. Yet this version of the "Behavior Support" regulation is even less protective of these vulnerable children than current law.

Instead of moving forward to promote the use of positive behavioral approaches; to borrow on the very successful restraint reduction strategies of other systems¹; to prohibit the use of the very dangerous prone restraint; and to ensure that families are always notified and meetings convened when restraints have been used, the regulation is less protective in all of these areas.

¹ The National Association of State Mental Health Program Directors (NASMHPD), through its National Technical Assistance Center (NTAC), has identified Six Core Strategies for the Reduction of Seclusion and Restraint. These strategies have been identified from both the literature and the actual hands-on experiences of seclusion/restraint experts who successfully reduced use in a variety of settings for children and adults. The essential strategies include: (1) leadership towards organizational change; (2) use of data to inform practice; (3) workforce development; (4) use of S/R reduction tools; (5) consumer roles; and (6) debriefing techniques. National Executive Training Institute (NETI). *Training curriculum for the reduction of seclusion and restraint*. Alexandria, VA: National Technical Assistance Center (NTAC), National Association of State Mental Health Program Directors (NASMHPD)

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Because this regulation is central to protecting the health and safety of children with significant disabilities, VALUE's comments will focus only on this issue (although VALUE members will separately also be commenting on other concerns).

That this is a health and safety issue has been acknowledged by health professionals as well as families. In a recent article entitled *Maltreatment of Children with Disabilities*, published in the official Journal of the American Academy of Pediatrics, the authors state:

Although the use of aversive procedures and restraints for children who have disabilities has been fortunately diminishing ... these practices are still used sometimes in homes, schools, programs, and institutions.... Restraints are physical measures ... [which include] "therapeutic holding," which has been repudiated as harmful. During the past 20 years, much research has demonstrated the effectiveness of alternative measures, commonly called "positive behavior supports," to change behavior.²

Proposed 14.133, in its current form, ignores the research and experience of individuals and systems that have committed to and achieved restraint reduction and ultimate elimination, and instead bows to expediency, paperwork reduction, and administrative convenience. Pennsylvania, a long recognized leader in efforts to reduce and eliminate restraints in other human service systems³, must assume a principal role in promoting positive practices that ensure safety for staff and our children within the education system.

Problem/Recommendation #1:

For the first time ever, the regulation defines restraints as "devices or techniques, that last longer than 30 consecutive seconds, designed to control acute, episodic behaviors..." Since only a "restraint" is subject to the standard for use of restraints in 14.133(c), triggers a meeting in 14.133(c)(1), or is maintained and reported as data in 14.133(c)(4), this limitation on what constitutes a restraint has huge consequences.

If the 30-second limitation is maintained, a school staff member can physically hold the child for 28 seconds, let go for 2 seconds, grab the child for another 28 seconds, and so forth. A staff member can physically hold the child repeatedly throughout the school day, and for any reason, so long as none of the holds lasts more than 29 consecutive seconds. In none of these situations must the staff member comply with the standard in 14.133(c) (which prohibits the use of restraints for other than protective purposes), report the use of the hold to the parent or convene a meeting, or collect data on the use of repeated holds in accordance with 14.133(c)(4).

² Hibberd, et al., *Maltreatment of Children with Disabilities*. *Pediatrics*. 2007; 119(5):1018 at page 5.

³ Pennsylvania drastically reduced the use of seclusion and restraints in state hospitals. *Special Section on Seclusion and Restraint: Commentary: Reducing the Use of Seclusion and Restraint: A NASMHPD Priority* by Robert W. Glover, Ph.D. at <http://psychservices.psychiatryonline.org/cgi/content/full/56/9/1141>. "Pennsylvania has led the nation in setting an example of what can be accomplished in a state system when the senior state leadership takes on the task of reducing seclusion and restraint and does the work. As Mr. Smith and his colleagues describe in their article, the state created a system of care that became intolerant of coercive measures and restricted their use. Furthermore, the state leaders demonstrated that the role of leadership toward organizational change is mandatory and cannot be delegated. In addition, Pennsylvania's generosity in openly and transparently sharing the story of its journey, including data and descriptions of successful interventions, has been a tremendous benefit to other states."

Moreover, this regulation is impossible to implement. Will all staff who work with or encounter children with challenging behaviors be required to wear watches that count seconds? How can the school document to an upset parent that the restraint was under 30 seconds? And who is counting in an emergency situation when a student is engaged in self-injurious or aggressive behavior so extreme as to require a restraint. It just won't work.

This proposal largely eviscerates the protections in current law. The 30-second standard must be eliminated entirely.

Problem/Recommendation #2:

Since the Roundtables on Chapter 14, VALUE has recommended that §14.133 be entitled "Positive Behavior Support" and that "positive" be added to that term throughout the regulation. The thrust of the regulation and good practice is that children with challenging behaviors respond best when they are approached through positive techniques, and that restraints should be used only in an emergency and as a last resort. This change would help make this point more clearly and emphatically.

Problems/Recommendations #3 and #4:

At 22 PA Code §14.133(c), current law requires that an IEP team be convened whenever there has been, "[t]he use of restraints to control the aggressive behavior of an individual student." The March, 2007 draft adopted our suggestion to require that such a meeting be convened within 10 school days.

The proposed regulations delete that language and substitute the following new language:

(1) When there is evidence to suggest that the emergency use of restrictive procedures, such as restraints may be necessary to ensure a student's safety or the safety of others, parental consent should be obtained. If a restrictive procedure is needed on an emergency basis, parents should be informed and consent for future uses be obtained within 10 school days following the need for the use of a restrictive procedure. The need for restrictive procedures for safety should be noted in the student's IEP.

(2) The use of restraints to control the aggressive and self injurious behavior on the part of an individual student shall cause a meeting of the IEP team within ten school days of the behavior causing the use of restraints unless the use of restraint was consistent with the explicit provisions of the existing IEP and that IEP remains current and appropriate for the student. At this meeting, the team shall consider whether the student needs a behavioral assessment, reevaluation, a new or revised behavior plan, or a change of placement to address the inappropriate behavior.

The first problem is that new 14.133(c)(1) requires that restraints be built into the students' IEP. While there is some justification for ensuring that families participate in deciding when and under what circumstances (if any) restraints should be used, building restraints (rather than positive behavioral techniques and approaches) into the education plan seems problematic. However, recognizing that sometimes a restraint is needed to protect a child, other children, and staff, we can somewhat reluctantly support this approach, but only if it is much more specific

about what must be included. An IEP must include the type and amount of the restraint, who will administer it, what training that person will have, how the use of the restraint will be monitored, and a plan for eliminating the restraint.

The second problem is that 22 PA Code 14.133(c)(2) no longer requires that an IEP meeting be convened whenever a restraint has been used. Under the new language, an IEP meeting need not be convened if “the use of restraint was consistent with the explicit provisions of the existing IEP and that IEP remains current and appropriate for the student” (although how one can tell whether the IEP remains appropriate without an IEP meeting is hard to understand).

On the other hand, there may be situations in which it is anticipated that the child’s behavior will recur frequently, and neither the staff nor the parent see a gain in a meeting each time it (and the restraint) occurs. An example would be a child who repeatedly tries to elope from the classroom. But the parent should always be informed that a restraint has been used, and it should be up to the parent to decide whether the meeting should be convened.

Here is amended language that incorporates these suggestions:

(1) When there is evidence to suggest that the emergency use of restrictive procedures, such as restraints, may be necessary to ensure a student’s safety or the safety of others, parental consent should be obtained. If a restrictive procedure is needed on an emergency basis, parents should be informed and consent for future uses be obtained within 10 school days following the need for the use of a restrictive procedure. The need for restrictive procedures for safety, the specific type and amount of the procedure that can be used, which staff are authorized to use the procedure and the staff training required, how the administration of the procedure will be monitored, and the plan for eliminating the use of the restrictive procedure, should be noted in the student’s IEP.

(2) The use of restraints to control the aggressive and self injurious behavior on the part of an individual student shall cause a meeting of the IEP team within ten school days of the behavior causing the use of restraints unless the parent, after written notice, agrees in writing to waive the meeting and the use of restraint was consistent with the explicit provisions of the existing IEP and that IEP remains current and appropriate for the student. At this meeting, the team shall consider whether the student needs a behavioral assessment, reevaluation, a new or revised behavior plan, or a change of placement to address the inappropriate behavior.

Problem/Recommendation #5:

In the March, 2007 draft, prone restraints were added to 22 PA Code 14.133(e), a list of “aversive techniques of handling behavior [which] are considered inappropriate and may not be used by agencies in educational programs.” In the current draft, prone restraints are still discouraged, but are permitted if “determined necessary by a physician and documented in the student’s current IEP.”

Prone restraints should be absolutely prohibited as they were in the March, 2007 draft of the regulations. According to the Coalition Against Institutionalized Child Abuse, there have been over 73 restraint deaths of children nationally in the last 18 years, with the most often cited restraint type as prone position.⁴ Three Pennsylvania youth have died during imposition of

⁴ See <http://www.caica.org/RESTRAINTS%20Death%20List.htm>

prone restraints in the last three years. Countless others were seriously injured during “takedown.” The fact that prone restraints are dangerous and should not be used to control behavior was acknowledged by the Department of Public Welfare, which has banned prone restraints in state mental retardation centers and state mental health hospitals, and issued draft regulations prohibiting the use of prone restraints in psychiatric residential treatment facilities. The State Board should follow DPW’s lead and similarly prohibit its use.

If the State Board is unwilling to prohibit prone restraints altogether, it must make clear that the physician who authorizes its use must be the person who is caring for the child on an on-going basis, and therefore is most likely to know whether the child has a heart condition, a respiratory problem, is taking medication, etc. If prone restraints are to be permitted in some circumstances, 22 PA Code 14.133(e) should be amended as follows:

- (e) The use of face down prone restraints is prohibited in educational programs, unless determined necessary by the child’s primary care physician and documented in the student’s current IEP.

We greatly appreciate this opportunity to offer input on proposed Chapter 14 and urge your most serious consideration of our proposal. We would be happy to provide the State Board and the IRRC with any other information that might be useful.

Very truly yours,

Sallie Lynagh
on behalf of the
VALUE Coalition

CC: Arthur Coccodrilli, Chair, Independent Regulatory Review Commission
The Honorable James J. Rhoades, Senate Education Committee
The Honorable Jeffrey E. Piccola, Senate Education Committee
The Honorable James R. Roebuck, Jr., House Education Committee
The Honorable Jess M. Stairs, House Education Committee
The Honorable Dennis O’Brien, Speaker, House of Representatives
The Honorable Barbara McIlvaine Smith, Chair, Subcommittee on Special Education