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Restraint and/or Seclusion of Children

Restraint and Seclusion are traumatizing procedures that are used to control or modify challenging behaviors through the application of force or isolation.

Two kinds of restraint are currently applied to children in schools and inpatient settings. *Physical restraint is a procedure by which a person or persons forcefully use their body(ies) to effectively and immediately control or immobilize another person. It is sometimes referred to as ambulatory restraint, manual restraint, physical intervention, or therapeutic holding. It does not include physically escorting a child to a safe location by touching or holding the hand or arm. Mechanical restraint is the use of objects or devices in order to restrict a child's freedom of movement. Such objects and devices include: taping the child's arms and legs to a chair, strapping a child into an adaptive positioning chair, wrapping a child in a weighted blanket, or otherwise restricting movement with belts, straps, or handcuffs. Mechanical restraint does not include medical immobilization, orthopedically prescribed devices or mechanical supports that assist in balance or movement and that are used for their original therapeutic purpose, or to vehicle safety straps.*

Seclusion is the involuntary confinement of a child alone in a room or other kind of confined enclosure that is locked or otherwise prevents the child from exiting. It is not a "timeout" or other intervention that does not physically isolate the child from others.

"Children have been restrained or secluded for such actions as failing to do class work, being unable to pay attention due to disability issues, pushing items off desks, tantrums or other educational disruptions, as a substitute for positive behavioral supports and for convenience, punishment, and the like. Some children have remained in seclusion/restraint until they can sit perfectly still, show a happy face, or do other tasks unrelated to an emergency. Children with significant disabilities may be unable to respond to such commands and yet pose no threat of danger." (**How Safe Is The Schoolhouse? An Analysis of State Seclusion and Restraint Laws and Policies** by Jessica Butler, published by the Autism National Committee.)

A review of the literature on the impacts of restraint and seclusion on children in public schools and treatment facilities has convinced the Kansas Mental Health Coalition that these procedures are traumatic, sometimes result in injury or death, and are always devoid of any educational or clinical benefit to the child. It is clear that these procedures are applied disproportionately to children with disabilities and minority children. On the other hand, there is no longer any doubt that children, as well as school and treatment facility staff, can be kept safe by using evidence-based positive behavioral interventions and supports.

We support current efforts to regulate ongoing use of restraint and seclusion because it is important and necessary to do all we can to reduce the probability of injury and death from their use. We particularly support Congressional bills, S. 2036 and H.R. 1893, which will forbid the use of restraint except in emergencies threatening the physical safety of the child or others. The House bill limits the use of seclusion to threats of physical harm and the Senate bill bans it altogether. Both bills require schools to notify parents on the same day that their child is restrained or secluded, in order to allow them to seek prompt medical care for concussions or injuries and to work with the school to prevent recurrences. Both bills ban restraints that impede breathing and dangerous mechanical and chemical restraints. They will ensure that teachers have the tools and resources they need to prevent challenging behaviors. The bills enhance public oversight by requiring data collection and reporting.

While regulation is a positive first step, elimination of restraint and seclusion is our ultimate objective. Allowing one more child to be injured physically or emotionally is not acceptable.

The KMHC recognizes that changing institutional culture is never easy, especially when new and unfamiliar technology must be learned and applied. It will take strong and committed leadership as well as provision of the necessary resources to implement the shift from traumatizing force and isolation to evidence-based positive behavioral interventions and supports. However, so long as these traumatic and dangerous procedures continue to be allowed in Kansas, we will continue to advocate against their lawfulness and for the training and resources to make this change possible.