Response of the New York State Psychological Association
Task Force on Aversive Controls with Children
To the NYS Education Department's Proposed Revised
Aversive Intervention Regulations

December 5, 2006

Background and Overview

In June 2006, the Board of Regents approved emergency regulatory amendments with respect to aversive behavioral interventions, corporal punishment, and time out rooms. The New York State Psychological Association (NYSPA) Task Force on the Use of Aversive Controls with Children (the "Task Force") provided oral and written testimony in response to those amendments. In October 2006, the honorable members of the NYS Board of Regents approved an emergency extension of the amendments and were presented with proposed revised amendments that they will be asked to approve at their January 2007 meeting. Written comment on the proposed revisions and amendments is due by December 15; no public hearings are scheduled.

Consistent with its concern for the welfare and safety of children, the Task Force has reviewed the revised amendments as well as the "Assessment of Public Comments" document compiled by NYSED. The Assessment summarizes comments submitted in response to the June 2006 amendments and provides the Department's response.

The Task Force noted some significant improvements in the proposed revised amendments. In particular, there is now a complete prohibition, without exception, of the use of aversive interventions as planned behavior consequences as part of a behavior intervention plan with preschool children. There is also a section that clarifies what specific aversive interventions would never be permitted, under any circumstances, with school-age students. In addition, there are now sections of the amendments that provide definitions of some of the key terms and greater clarity with respect to Functional Behavioral Assessments, the use of time out rooms, and emergency interventions.

Despite a number of significant improvements in the proposed revised regulations for which we commend the Board of Regents, serious health, safety, and civil liberties concerns and issues remain. The remainder of this response addresses those concerns. Citations in this report are to either: (1) the proposed revised regulatory amendments ("Revised Amendments"), or (2) NYSED's Assessment of Comments on the June 2006 emergency amendments ("Assessment").[1]

"Corporal Punishment"

As defined in the regulations, corporal punishment is "any act of physical force upon a pupil for the purpose of punishing that pupil, except as otherwise provided in [subdivision (c)] paragraph 3 of this [section] subdivision."

[1] *Where underscore has been added by the Task Force for emphasis, it is indicated following the text. Where there is no such notation, underscore was part of the quoted text or material.*

In our previous feedback, the Task Force had strongly urged the Board of Regents to revoke two provisions of § 19.5 (a)(3), as amended in June 2006 concerning the use of "reasonable physical force." The Task Force had noted that permitting the use of "reasonable physical force" for the circumstances described in (iii) and (iv), below, poses an increased risk of serious physical or psychological injury or harm to students and school personnel, is likely to result in discriminatory application with disabled students, and might be experienced as corporal punishment. Unfortunately, those two provisions (iii and iv) are still in the proposed revised amendments:

> [(c)] (3) In situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed, nothing contained in this section shall be construed to prohibit the use of reasonable physical force for the following purposes:
>
> [(1)] (i) to protect oneself from physical injury;
> [(2)] (ii) to protect another pupil or teacher or any person from physical injury;
> [(3)] (iii) to protect the property of the school, school district or others; or
> [(4)] (iv) to restrain or remove a pupil whose behavior is interfering with the orderly exercise and performance of school or school district functions, powers and duties, if that pupil has refused to comply with a request to refrain from further disruptive acts.

By authorizing school personnel to use reasonable physical force "to restrain or remove a pupil whose behavior is interfering with the orderly exercise and performance of school or school district functions, powers and duties, if that pupil has refused to comply with a request to refrain from further disruptive acts," NYSED unacceptably increases the risk of students with disabilities being physically injured or harmed. The language of these provisions essentially authorizes physical restraint and "reasonable physical force" when a student verbally defies a teacher or breaks something as cheap as a crayon. As worded in these provisions, an autistic kindergarten student who refuses to put blocks away, and thereby "interferes with the orderly conduct of the class," can be subjected to physical restraint and physical removal from the classroom.

As a specific example of the risk of physical injury to a student due to authorizing the use of "reasonable physical force" to remove a student, a student with arm tics or vocal tics might be symptomatic at a school function where school personnel who do not know the student might ask the student to "be quiet" or "leave." If the student refused to be quiet (as would be the case when the student cannot stop involuntary vocal tics), the "reasonable physical force" provisions in the regulations would make it permissible for school personnel who neither know the student nor know whether the student has an I.E.P. or behavior plan to try to forcibly restrain and remove that student from the event. Using physical force on a student who is exhibiting tics may not only make the student's tics worse, but can actually result in physical harm to the student.

As a second example of the serious physical risk posed by the regulations' exceptions to the use of physical force at (iii) and (iv), the Epilepsy Foundation of America has stated that using force on a person having a seizure has led to injury or death in reported cases. That same risk exists in school settings where personnel who are not adequately trained in the sometimes sophisticated manifestations of a student's diagnosed disability and/or who do not know a student may confuse certain symptoms of psychomotor epilepsy with voluntary misbehavior and may attempt to use "reasonable physical force" on the student, with tragic results.

The Office of Civil Rights has generally held that "reasonable physical force" or restraint do not violate § 504 when: (a) nondisabled students would be exposed to the same actions, and (b) the purpose is to prevent harm to the student or others. The application of force or restraint for purposes of protecting property, however, is not within the appropriate use of physical restraint as interpreted by most courts, and is certainly not supported by federal statutes or policies of agencies concerned with the safety, welfare, and dignity of disabled children.

Because of the inclusion of (iii) and (iv) as permissible situations in which physical force may be used, disabled students will be placed at differentially greater risk of what is, in effect, the inappropriate and illegal use of physical restraint. The Task Force believes that this differential risk constitutes discrimination on the basis of disability and is violative of 42 USC § 15009 which prohibits exposing developmentally disabled students to any greater risk of harm than that experienced by students in the general population and which *flatly prohibits the use of restraint for anything but an emergency safety situation involving the risk of imminent serious physical harm or injury to persons*. In other words, if "reasonable physical force" to remove a student involves *any* physical restraint, it is flatly barred by 42 USC § 15009 for purposes identified in § 19.5 (a)(3)(iii) and (iv) for any student with a developmental disability.

The Task Force therefore again urges the Board of Regents to delete § 19.5 (a)(3)(iii) and (iv).

"Aversive Interventions"

The Task Force commends the Board of Regents for prohibiting the use of aversive interventions with preschool students without exception. In other respects, however, serious concerns and/or ambiguities remain or are raised by the revisions as described below.

Ambiguity in Provisions

At §19.5 (e)(2), the revised proposed amendments indicate that some aversive interventions will be prohibited, without exception, for school-age children. But at (e), the proposed amendments suggest that students who currently get aversive interventions may continue to get them ad infinitum as long as they are written into the student's IEP during the current school year and/or are still in effect in June 2009. The Task Force encourages the Department of Education to clarify whether the interventions listed in (e)(2) are immediately barred or not, and if so, what is to happen to students currently getting those aversive interventions.

Lack of Full Compliance with Federal Law

Although the State Education Department discusses 42 U.S.C. § 15009 in its Assessment responses and asserts that it is in compliance with that statute, the revised amendments appear to facially violate this federal statute when it comes to permitting aversive interventions *at all* for students with developmental disabilities. Despite the Regents' desire to accommodate the needs of students whose parents assert that only aversive treatments are effective for their children, there is no provision in 42 U.S.C. § 15009 that allows parents to waive their children's protections under this federal statute.

In relevant part, the "Developmental Disabilities Assistance and Bill of Rights Act" of 2000, 42 U.S.C.§ 15009, states:

> (3) The Federal Government and the States both have an obligation to ensure that public funds are provided only to institutional programs, residential programs, and

other community programs, including educational programs in which individuals with developmental disabilities participate, that—

(A) provide treatment, services, and habilitation that are appropriate to the needs of such individuals; and

(B) meet minimum standards relating to—

(i) provision of care that is free of abuse, neglect, sexual and financial exploitation, and violations of legal and human rights and that subjects individuals with developmental disabilities to no greater risk of harm than others in the general population; (underscore added)

Because nondisabled students are not subject to aversive interventions (as they are defined in the proposed regulations), then to the extent that aversive interventions pose any risk of harm at all*,* they cannot be used with students with developmental disabilities in educational programs.

Given that the Department has already acknowledged that aversive interventions **do** pose such a risk of harm ("Even with these regulatory safeguards, aversive interventions pose significant health and safety risks for students with disabilities." [Assessments, p. 3, underscore added], the Board of Regents cannot permit their use at all without violating 42 U.S.C.§ 15009.

Since the time of our initial Task Force report, the 2nd Circuit has held that 42 U.S.C.§ 15009 applies to public schools, Protection & Advocacy For Persons With Disabilities V. Hartford Bd Of Ed , No. 051240, 2d. Cir., 09/15/06.

The Department stated:

> The revised proposed rule authorizes the child-specific exception for the use of aversive interventions by public and private schools until June 30, 2009, provided that the child specific exception process would continue to be available in subsequent years only for students whose individualized education programs (IEPs) include the use of aversive interventions as of June 30, 2009. (Assessment, pp. 3-4)

According to NYSED, then, aversive treatments are permissible until June 2009 and will continue to be permissible for years after that for students who have aversive treatments in their IEPs prior to June 2009 – despite the fact that this facially violates 42 USC § 15009's firm and unequivocal prohibitions. The Task Force believes that aversive interventions must be barred, without exception, effective immediately. As noted in our past report, the Task Force firmly believes that there should be a total prohibition on aversive interventions as planned behavior consequences within the context of an IEP and BIP. If aversive treatments are needed, they should be handled in the same way that a school or district would handle things if an asthmatic student needed medication and accommodations in school: via collaboration between a physician, the student's parent(s) and the district.

Insufficient Safeguards

Assuming that it was legal to use aversive interventions at all as planned behavior consequences, and we do not think that it is legal to do so for students with developmental disabilities, then the significant concerns raised in our original report concerning necessary health safeguards remain inadequately addressed. Questions concerning aversive interventions for seriously self-injurious or seriously aggressive behaviors are essentially treatment issues, and need to be addressed by appropriately trained and qualified treatment

professionals, regardless of whether treatment is offered in an inpatient setting, a residential school, a BOCES, or a public or private day school.

As noted previously, the Department acknowledges that aversive interventions pose a risk to health and safety ("Even with these regulatory safeguards, aversive interventions pose significant health and safety risks for students with disabilities." [Assessments, p. 3, underscore added]. It is therefore irresponsible and dangerous not to incorporate what the federal government and treatment professionals recognize to be necessary and appropriate safeguards.

Failure to Mandate Medical Assessment. The revised amendments state:

> (5) The panel shall review the written application; the student's IEP; the student's diagnosis(es); the student's functional behavioral assessment; any proposed, current and/or prior behavioral intervention plans for the student, including documentation of the implementation and progress monitoring of the effectiveness of such plans; and other relevant individual evaluations and medical information that allow for an assessment of the student's cognitive and adaptive abilities and general health status, including any information provided by the student's parent. (Revised Amendments, p. 12)

The Task Force concurs that medical information must be reviewed. However, nowhere do the amendments require a full medical evaluation and nowhere do the amendments require that at least one member of the Commissioner's Panel be a licensed physician. The Board of Regents should not assume that a student's CSE is medically sophisticated enough to know that asthma, other medical conditions, and some widely-used medications greatly increase the risk of harm, injury or death when restraint or other aversive interventions are involved. Because no teacher or school psychologist may legally declare an aversive intervention medically safe for a student, the amendments must be revised to incorporate mandatory full medical screening and assessment. The revised amendments requiring the CSE to *invite* the district's physician are inadequate to ensure medical safety of the student as there is no requirement that a physician actually attend. More importantly, there is no requirement that a licensed physician examine the student with respect to identifying any health factors or medical conditions that would be contraindications for the specific aversive intervention that is being considered.

Failure to Mandate Evaluation by Psychiatrist or Licensed Psychologist. In its revised amendments, the Regents did not incorporate evaluation of a student by a board-certified psychiatrist or a licensed psychologist or certified school psychologist with expertise in the student's disabilities. In response to the Task Force's previous comments, the Department responded:

> The regulations have been revised to delete the requirements in proposed section 200.22(f)(2)(x) that indicated behavioral intervention plans be designed and supervised by qualified professionals in accordance with their respective areas of professional competence as this is self-evident and because behavioral intervention plans are often developed by teams of qualified individuals. (Assessment, pp. 19-20).

While the Task Force recognizes the accomplishments of masters' level school psychologists in dealing with the more routine behavioral interventions, if a CSE is considering an aversive treatment for a student with serious or refractory self-injurious or other-injurious behaviors, then this is a treatment issue and the situation requires treatment specialists and warrants full treatment protections. CSEs should never be permitted to grant themselves a child-specific

waiver unless the CSE includes a licensed physician who has examined the student and who can certify that the proposed aversive treatment is safe and a licensed psychologist or board-certified child psychiatrist who has assessed the student and who can state that there are no psychiatric or psychological contraindications to the use of the proposed aversive treatment.

As one example of why evaluations by licensed mental health professionals are necessary when dealing with severely symptomatic students, research conducted in New York in a special education day school and treatment program found that 11 out of 12 pre-adolescent students with serious behavior problems had undiagnosed Bipolar Disorder or met most of the criteria for Bipolar Disorder. School personnel and the students' CSEs had failed to recognize or identify the students as having Bipolar Disorder and were treating and educating them with diagnoses of Attention Deficit Hyperactivity Disorder and Conduct Disorder (Isaac, 1992). By mandating assessment by a board-certified child psychiatrist or licensed psychologist who may identify other clinical problems that are treatable via positive supports or other protocols that may not have been used by school personnel, referrals for aversive treatments may be reduced.[2] Assessment by a board-certified child psychiatrist or licensed psychologist is also essential to identify any psychiatric or psychological contraindications to use of aversive treatments or restraint.

<u>Lack of Necessary Expertise by Those Implementing the BIP</u>. Whereas the original amendments did not indicate who was actually qualified to administer an aversive intervention, the revised regulations state that:

> Aversive interventions shall be administered by appropriately licensed professionals **or** certified special education teachers in accordance with Part 80 of this Title and sections 200.6 and 200.7 of this Part or under the direct supervision and direct observation of such staff. (Revised Amendments, p. 16; boldface added for emphasis by Task Force)

Treatment should not be administered or provided by non-treatment personnel. Schools, BOCES, school/residential treatment centers and other covered entities must be required to hire or bring in treatment professionals to train staff, administer aversive therapies, supervise, and monitor any aversive therapy. Allowing a paraprofessional to administer aversive therapy under the supervision of a special education teacher increases the risk of injury, harm, or death for disabled students.

<u>Lack of Medical and Psychological Monitoring Safeguards</u>. The revised amendments do not contain medically necessary evaluation, observation, and involvement of appropriately trained medical personnel to participate in determination, planning, and monitoring of aversive interventions and emergency safety interventions. If aversive treatment interventions, restraint, and time out rooms are used in schools, then the regulations must adopt – at a minimum -- the protections specified in 42 CFR 483.356—Subparts G and H, and 42 USC§ 290ii and 42 USC § 290jj. None of the training outlined by the revised amendments is sufficient to enable

---

[2] *As but one example, the environmental, behavioral, and counseling approach one might take with a student diagnosed with Asperger's Syndrome may be significantly different than that taken with a student with Bipolar Disorder. Because the proposed revised amendments do not mandate a psychiatric or clinical psychology evaluation for any student being considered for aversive interventions, it is quite possible that school personnel are missing important diagnostic pieces that could lead to effective interventions based on positive supports. The Task Force takes no position on the issue of the relative merits and risks associated with aversive interventions vs. psychoactive medications. Instead, we focus on the possibility of important positive supports having been overlooked or not even assessed if CSEs are not required to arrange for professional evaluations in complex cases.*

nonmedical personnel to accurately assess whether a student is experiencing significant medical distress or psychiatric problems during or following an aversive intervention or an emergency intervention. Additionally, the proposed amendments authorize an aide or paraprofessional to administer aversive interventions under the supervision of a special education teacher, which may include a student being involuntarily placed in a time out room, under the direct observation of a special education teacher. There is no requirement, however, that any such aide, paraprofessional or other staff below the level of special education teacher be trained in health and psychiatric/psychological indicators of medical crisis or psychiatric/psychological trauma: thus, the person actually observing the child in the time out room may simply have no idea that s/he is observing what is actually an acute medical or psychiatric emergency. Without training, it is extremely difficult for an arms' length observer to differentiate between a child who is sleeping and a child who is comatose. While special education teachers may have come into contact with this kind of information, the likelihood that aides and paraprofessionals have is minimal.

Amendments Unsupported by Research

The Board of Regents eliminated options which might be necessary or appropriate as part of an aversive treatment intervention. In its response to public commentary, the Department states:

> Because certain forms of aversive intervention are manifestly inappropriate by reason of their offensive nature or their potential negative physical consequences, or both, proposed section 200.22(e) has been revised to add that no child-specific exception to the Regents prohibition on the use of aversive interventions shall be granted for interventions used as a consequence for behavior intended to induce pain or discomfort that include any of the following: ice applications, hitting, slapping, pinching, deep muscle squeezes, use of an automated aversive conditioning device, the combined simultaneous use of physical or mechanical restraints and the application of an aversive intervention; withholding of sleep, shelter, bedding, bathroom facilities; denial or unreasonable delays in providing regular meals to the student that would result in a student not receiving adequate nutrition; the placement of a child unsupervised or unobserved in a room from which the student cannot exit without assistance; or other stimuli or actions similar to the described interventions. (Assessment, pp. 6-7)

And the revised amendments state:

> (vii) […] In the event the aversive intervention fails to result in a suppression or reduction of the behavior over time, alternative procedures shall be considered that do not include increasing the magnitude of the aversive intervention. (Revised Amendments, p. 15)

The Task Force recognizes that the motivation underlying the prohibition on automated aversive conditioning devices and the prohibition against increasing intensities was out of concern for safety and humane treatment of students, but notes that treatment decisions are best left to fully qualified, on-site treatment professionals who are familiar with peer-reviewed research and treatment protocols.

Restraint

The Task Force's initial report reviewed a number of reports and discussions describing the significant risk of injury, harm, or death associated with the use of restraint, and provided information on specific factors that could exacerbate the risks. Our review of the revised amendments suggests that necessary protections have not been incorporated.

McAfee et al. (2006) have published a paper on public policy on physical restraint of disabled students in public schools. Their paper provides a useful review of court opinions as well as a chart comparing states to each other on various provisions in state regulations.

For purposes of their paper, the authors defined restraint as "the use of bodily force designed to limit a student's freedom of movement" (i.e., they did not consider mechanical or chemical restraints in their policy analysis). To summarize just a few of McAfee's major points based on analysis of court opinions and other rulings from agencies such as the U.S. Office of Civil Rights (OCR):

> (a) the Supreme Court held that restraint is legally limited to protection of self and others [Addington v. Texas, 441 U. S. 418 (1979)];
> (b) restraint used in residential schools requires greater scrutiny and protection than restraint used in public schools; and
> (c) restraint may only be used when aggressive behavior interferes with the student's ability to benefit from programming or poses a threat to the safety of others;

Since the time of the Supreme Court decision, 42 U.S.C. § 15009 has provided even greater clarification on the very restricted appropriate use of restraint with developmentally disabled students, regardless of how they may have been classified educationally under I.D.E.A.

The revised amendments fail to adequately protect the health and safety of students exposed to restraint -- particularly when it is used for emergency purposes. In response to the Task Force's previous recommendations, the Department responded:

> While we agree that it would be most appropriate to know if there are any medical or psychological contraindications for use of physical force with a student, it is not practicable to require a physical or psychological examination of the student prior to intervening during an emergency situation for the first time. The proposed regulation has been revised to require documentation of the emergency intervention be submitted to school administration and medical personnel. The need for an assessment of the student's emotional status following an emergency intervention is best left to school and family. (Assessment, p. 35).

We concur that in unanticipated emergencies, it is not possible or practicable to screen or assess first. However, for students who have restraint or aversive interventions in their plan, it is both possible and necessary. Additionally, once a student has been exposed to one emergency intervention, that should trigger an assessment process with an eye towards future possible emergencies. Awareness of medical or psychological contraindications and post-intervention assessment and review are not a matter of "most appropriate." They are "necessary and appropriate." We also note that the federal government requires assessment following certain interventions in restrictive settings for a reason, and the Department's position of leaving the decision as to whether to assess the student up to the school and family places the student at increased risk of harm, injury, and civil rights deprivation.

As the Department has noted, appropriate staff training in crisis de-escalation as well as safe restraint procedures is crucial to ensuring the safety of students. Language in the revised amendments as applied to staff training should be changed to require training in "research-validated safe and therapeutic crisis de-escalation techniques and research-validated safe and therapeutic emergency physical restraint interventions."

The proposed amended regulations also do not require immediate parental notification regarding the emergency and methods used to cope with it by school personnel. If parents are to have children with disabilities appropriately treated by outside licensed professionals, immediate information regarding behavioral crises may be extremely important as the behavior leading to an emergency intervention might be, for example, the result of a newly-administered psychoactive medication. A treating psychiatrist may wish to reevaluate use of this medication in light of the behavioral emergency, but will need to know the exact or precise description of the emergency situation and how the staff handled the student. An outside treating professional also will need to know that the "emergency" may have been destruction of a school's crayon. And for children who may have difficulty in communicating, parents obviously need to know that an "emergency," which may have resulted in restraint and a child being put in a time out room, for example, occurred at school so as to understand why the child may have come home and is exhibiting upset or distress.

Time Out Rooms

As amended, the regulations now provide a definition of a time out room, distinguish between time out rooms and "seclusion," and provide some minimal protections regarding its use. The Task Force commends the Regents for the improvements made, and in particular, the emphasis on the use of a time out room as a non-punitive location to facilitate restoration of self-control. We note the following unresolved concerns about the proposed amendments for this section:

1. Despite the Department's response suggesting that because time out rooms are part of the IEP, they require parental consent, the Task Force believes that the language of (4) below will confuse parents as to their rights and that it is incumbent upon the Regents to ensure that the language makes clear that the district may not simply "inform" parents that their child will be subjected to the use of a time out room, but also that they have the right to consent or to deny consent to the use of time-out rooms, with the exception that no consent is required if there is an actual safety emergency involving the risk of imminent serious physical injury to the student or others. The current language:

> (4) The school district shall inform the student's parents prior to the initiation of a behavioral intervention plan that will incorporate the use of a time out room for a student and shall give the parent the opportunity to see the physical space that will be used as a time out room and provide the parent with a copy of the school's policy on the use of time out rooms. (Revised Amendments, p. 8)

should be amended to read:

> (4) The school district shall obtained written informed consent from the student's parents prior to the initiation of a behavioral intervention plan that will incorporate the use of a time out room for a student and shall give the parent the opportunity to see the physical space that will be used as a time out room and provide the parent with a copy of the school's policy on the use of time out rooms.

The Task Force recommends the inclusion of material that appears in boldface below for the revised amendments on p. 9:

> (6) **No room used for "time out" or seclusion purposes shall have a door with a lock and no device, such as a chain and padlock, shall be used at any time to keep the door closed.** The use of locked rooms or spaces for purposes of time out is prohibited **and no furniture or objects may be used to block the door from the outside; no person may hold the door closed from the outside. Each student placed in such a room shall be informed, prior to being placed therein, that she or he can leave the room at any time.**

The Task Force recommends the inclusion of material that appears in boldface below for the revised amendments on p. 9:

> (8) The school shall establish and implement procedures to document the use of the time out room, including**, at a minimum, a record for each student showing the date and time of each use, a detailed account of the incident that led to use of time out room, the amount of time that the student was in the time out room, and** information to monitor the effectiveness of the use of the time out room to decrease specified behaviors **which resulted in the student being placed in the room.**

With respect to (9), below, the Task Force is uncertain whether the provision would exclude BOCES facilities from the requirements listed in this section. If so, the Task Force notes that BOCES facilities should not be exempt from complying with the minimal standards of this section: In fact, insofar as many districts place students with what they view as more severe disabilities in BOCES programs and schools, *all restrictions on the use of restraints and time out rooms should be specifically applicable to each BOCES since the likelihood of unwanted behaviors and harm to students due to inappropriate or unsafe use of restraints and time out rooms at BOCES may be greater, overall, than the risk to students with disabilities in less restrictive placements*.

> (9) For an education program operated pursuant to section 112 of the Education Law and Part 116 of this Title, if a provision of this section relating to use of time out rooms conflicts with the rules of the respective State agency operating such program, the rules of such State agency shall prevail and the conflicting provisions of this section shall not apply.

In its response to public comments, the Department notes:

> The decision as to whether to inform the student that the room is unlocked is best left to the staff supervising the student in consideration of the individual needs and concerns for the physical and psychological well-being of the student. (Assessment, p. 26)

Because the staff supervising the student are generally neither qualified mental health professionals nor qualified medical professionals, and because the amendments should be designed to provide necessary safeguards, the decision as to whether to inform the student that the room is unlocked cannot be left to the discretion of the supervising staff (who under the proposed regulations is most likely to be a special education teacher). Additionally, failure to notify the student that the door is unlocked may increase the student's agitation, thereby protracting the amount of time that the student spends in the time out room. In light of these

concerns, the Task Force recommends that the regulations be revised to require explicit notification to the student that the door is unlocked.

Emergency Interventions

The revised regulations contain provisions that attempt to clarify the definition and appropriate use of emergency interventions, but review of these provisions indicates that the regulations are not restricted to “emergency safety situations” even though the term “emergency” is used.

While the Task Force concurs with the Department that “reasonable physical force” may be needed to protect a staff member from serious physical injury or another student from serious physical injury, and that such situations may properly be viewed as “safety emergencies,” in the opinion of the Task Force, a student who is disruptive to a classroom, school, or district function and who refuses to comply with a request to leave does not create an “emergency” situation or a need for “emergency interventions.” To be consistent with federal statutes and regulations, the term “emergency interventions” should be reserved only for those emergency safety situations in which there is an *imminent risk of serious physical injury to the student or others*.

The Task Force therefore strongly recommends that the “emergency interventions” provisions only apply to 19.5.(a)(3(i) and (ii) and reiterates its firm advice to revoke (iii) and (iv). Amendments concerning emergency interventions should be revised as follows (new language in boldface):

> (1) For purposes of this subdivision**, emergency means a situation in which there is an imminent risk of serious physical injury to the student or others.**
>
> (2) Use of emergency interventions. (i) Emergency interventions shall be used **only in situations in which there is an emergency, as defined in (1)** and alternative procedures and methods not involving the use of physical force**, but which do include the use of research-validated protocols for behavioral crises defusing have been attempted, but failed, or** cannot reasonably be employed.
>
> (ii) Emergency interventions shall not be used as a punishment, ~~or~~ as a substitute for systematic behavioral interventions that are designed to change, replace, modify or eliminate a targeted behavior**, or to address any behavior that does not pose an imminent risk of serious physical injury to the student or others.**
>
> (3) Staff training. Staff who may be called upon to implement emergency interventions shall be provided with appropriate training in **research-validated behavioral crisis defusing protocols and** safe and effective restraint procedures in accordance with section 100.2(l)(1)(i)(g) of this Title, and 200.15(f)(1) of this Part, as applicable. **Such staff shall have current certification from the authority or organization which provided the training.**
>
> (4) Documentation. The school must maintain documentation on the use of emergency interventions for each student, which shall include the name and date of birth of the student; the setting and the location of the incident; the name of the staff or other persons involved; a **detailed** description of the incident and the emergency intervention used, including duration; a statement as to whether the student has a current behavioral intervention plan; and details of any injuries sustained by the student or others, including staff, as a result of the incident. The parent of the student shall be notified **in writing**

within 24 hours, or within 2 hours if any injury has been sustained to the student or others. ~~and~~ **D**ocumentation of emergency interventions shall be reviewed by school supervisory personnel and, as necessary, the school nurse or other medical personnel.

(5) Applicability. For an education program operated pursuant to section 112 of the Education Law and Part 116 of this Title, if a provision of this section relating to emergency interventions conflicts with the rules of the respective State agency operating such program, the rules of such State agency shall prevail and the conflicting provision of this section shall not apply.

With respect to (5), above, the Task Force notes that BOCES facilities should be held to the same minimum standards as public schools and should not be permitted to operate with fewer protections with respect to emergency interventions, although they are certainly encouraged to set a higher standard as their minimum.

Consistent with policy advice developed by McAfee et al., the Task Force also recommends adding a provision to this section of the amendments that would automatically trigger a review:

(6) Review. If emergency interventions are required for a student with a behavior intervention plan, the student's team shall convene within three school days to review the data and to consider whether they need to alter the behavior intervention plan and whether all necessary supports were in place and implemented and whether proper emergency procedures were used.

The Task Force also notes that if there is no BIP in place that includes detailed plans for handling crises and an emergency safety situation occurs that results in an emergency intervention involving restraint, physical force, or time out room, then the student's CSE should be convened to develop a BIP that includes provisions for the prevention of further safety emergencies and a detailed plan as to how they will be handled, with such plan being developed within 10 days of the "emergency."

Summary

The revised amendments provide greater clarity and protections but still appear to be violative of federal law, still fail to incorporate medically necessary evaluations, necessary psychiatric/psychological assessments, minimally acceptable health and safety precautions for students exposed to aversive interventions or restraints, and fail to address the issue of discriminatory application of physical interventions with disabled students.

NYSPA continues to offer its resources and assistance to the Board of Regents and State Education Department in this matter.

Chair: Leslie E. Packer, Ph.D.

Members:
Caroline S. Clauss-Ehlers, Ph.D.
June Feder, Ph.D.
George Groth, Psy.D.
Kirkland Vaughans, Ph.D.

References

42 CFR 483.356-- Subpart G--Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric. Retrieved August 5, 2006 from: http://www.access.gpo.gov

42 CFR 483.450-- Subpart H--Condition of participation: Client behavior and facility practices.. Retrieved August 5, 2006 from: http://www.access.gpo.gov

42 USC§ 290ii and 42 USC § 290jj Retrieved July 26, 2006 from http://caselaw.lp.findlaw.com/casecode/uscodes/42/chapters/6a/subchapters/iii-a/parts/h/sections/section_290ii.html and http://caselaw.lp.findlaw.com/casecode/uscodes/42/chapters/6a/subchapters/iii-a/parts/i/sections/section_290jj.html

Developmental Disabilities and Assistance Bill of Rights Act, 42 USC § 15009.

Isaac, G. (1992). Misdiagnosed bipolar disorder in adolescents in a special educational school and treatment program. *Journal of Clinical Psychiatry*, *53(4)*:133-6.

McAfee, J., Schwilk C., & Mitruski, M. (2006). Public Policy on Physical Restraint of Children with Disabilities in Public Schools. *Education and Treatment of Children*, *29* : 711 - 728.

Rehabilitation Act of 1973, Title 29 U.S.C., § 794 (1973).