SENATE EDUCATION, HEALTH, AND ENVIRONMENTAL AFFAIRS COMMITTEE
SENATE BILL 705
EDUCATION—PHYSICAL RESTRAINT AND SECLUSION—LIMITATIONS, REPORTING, AND TRAINING

MARCH 2, 2022
POSITION: SUPPORT
Jeannie-Marie Leoutsakos

My name is Dr. Jeannie-Marie Leoutsakos. I'm a Howard County resident and the mother of a 9 year old boy with autism, and I am here in strong support for SB705. I am a statistician (I hold graduate degrees in Biostatistics and Psychiatric Epidemiology) and an associate professor of Psychiatry and Behavioral Sciences at the Johns Hopkins School of Medicine, and I hold a joint appointment in the Department of Mental Health at the Johns Hopkins Bloomberg School of Public Health. Please note that the views expressed here are my own and do not necessarily reflect the policies or positions of Johns Hopkins University/Johns Hopkins Health System.

When my son began Kindergarten in 2017, he would become overwhelmed by the chaotic classroom environment and would attempt to leave it to find someplace quiet. He never tried to leave the building and wasn't in any actual danger, but school staff would chase him, corner him, and restrain him. This only made him run more, and he started fighting when cornered. This happened up to 4 times a day, and within a month things got so bad that he was hospitalized. I would be called to the school to pick him up regularly - and when I got there, sometimes they'd be chasing him down the hallways, sometimes I would find him being pinned to a chair by multiple staff members, or on one occasion he had been confined to a small blue room, was shirtless, drenched in sweat, crying, and begging for water. At home, he was having nightmares about monsters chasing him, and would say things like, "my entire life is going to be a struggle." and "I want to die". It was clear he wasn't safe at school and our only real choice was to pull him out and we now homeschool. Things are better now, but he's not the same kid he was before he entered that school, and he still has nightmares. This is what repeated use of restraint does to kids, and his story is far from unique.

Background

Nationwide and here in Maryland, children who end up being restrained and/or secluded are among the most vulnerable. The majority of restraints and seclusions are imposed on children under the age of 10; In Howard County, for example, the peak age is 7("2020-303" 2020).

In looking at rates of restraint and seclusion, several things stand out. First, this happens a *lot*, (for example in SY 2018-2019 there were 10,050 reported restraint events and 5,317 reported

seclusion events) particularly when you remember that the harm standard requires imminent risk of serious physical harm, and that the children most likely to be restrained and secluded are also the youngest (and smallest) students. The table below shows enrollment incidence rates of restraint and seclusion per 1000 student school years by county for SY 2018-2019, the most recent fully in-person school year for which data are publicly available. For example, Calvert had a total student body of 15936 and reported 750 restraints. As such, its incidence rate was (750*1000/15936)=47.06 restraints per 1000 student school years. Incidence rates range from 0 to 47.06. What this means is that during that school year Calvert County was restraining its students 60 times more often than Prince George's County. Likewise we see variation in incident rates for seclusion, ranging from 37.55 (Frederick County) to 0. Other years for which data exist (2017-2019, 2019-2020, and 2020-2021) also show wide variability.

county	enrollment	totalres	countyirres	totalsec	countyirsec
Calvert	15936	750	47.06	386	24.22
Frederick	42713	1996	46.73	1604	37.55
Charles	27108	757	27.93	391	14.42
Washington	22681	545	24.03	125	5.51
Carroll	25179	508	20.18	177	7.03
Howard	57907	889	15.35	215	3.71
Harford	37826	486	12.85	1153	30.48
Anne Arundel	83300	1002	12.03	0	0
Cecil	15307	157	10.26	195	12.74
Baltimore	113814	1053	9.25	218	1.92
Montgomery	162680	1356	8.34	602	3.7
Caroline	5829	42	7.21	7	1.2
Somerset	2930	21	7.17	0	0
St Mary	17999	102	5.67	78	4.33
Talbot	4674	20	4.28	45	9.63
Dorchester	4785	16	3.34	0	0
Wicomico	14949	48	3.21	0	0
Allegheny	8539	26	3.04	13	1.52
Queen Anne	7749	23	2.97	0	0
Baltimore City	79297	143	1.8	15	.19
Kent	1912	2	1.05	0	0
Garrett	3842	4	1.04	92	23.95
Prince George	132667	104	.78	0	0
Worcester	6810	0	0	1	.15

In many counties in Maryland, African American children are restrained and secluded at far greater rates than white children. The table below shows incidence rate ratios (calculated by dividing the incidence rate for African American children by the incident rate for white children) by county for school year 2018-2019. For example, in Howard County, African American children accounted for 24% of the student body; incidence of restraint of African American children outpaced incidence of restraint of white children by a factor 7.83, and incidence of seclusion of African American children outpaced incidence of seclusion of white children by a

factor of 17.04. Missing values denote counties where no African American child was restrained (or secluded). Care should be taken in interpreting incidence rate ratios from counties with very few African American students (e.g.,Garrett County, Allegheny County) but even with that caveat, it is clear that there are shocking levels of racial disparities in many Maryland counties. Inspection of rates from other years show similar patterns (Maryland State Department of Education 2019).

county	blackfraction	countyirrresblack	countyirrsecblack
Howard	.2400746	7.83	17.04
Somerset	.4593857	4.8	.
Harford	.1951832	4.09	1
Frederick	.1252312	3.85	2.78
Washington	.1357083	3.65	10.33
Montgomery	.2156258	3.62	4.37
Calvert	.1276983	3.62	5.8
Allegheny	.0333763	3.57	22.47
Anne Arundel	.2112725	2.92	.
Caroline	.1454795	2.91	1.71
St Mary	.1828435	2.79	3.25
Baltimore	.3939322	2.39	1.21
Carroll	.0394376	2.11	1.78
Wicomico	.3669811	2	.
Baltimore City	.7857044	1.92	.
Charles	.5564778	1.49	1.36
Talbot	.1583226	1.28	.95
Prince George	.5714006	1.02	.
Cecil	.0947279	1.01	2.27
Dorchester	.4054337	0	.
Queen Anne	.0585882	0	.
Kent	.2280335	0	.
Garrett	.0036439	0	29.21
Worcester	.1842878	.	.

Child level data are only available from the Department of Education Office of Civil Rights for school year 2017-2018 so we look to that dataset for disparity with regard to disability. In SY 2017-2018 Howard County restrained 105 kids with IEPs and 38 kids without IEPs, and secluded 37 kids with IEPs and 7 kids without. There were 5,268 students with IEPs and 51,519 without. As such, the relative risk (analogous to incidence rate ratio but for child level data) for being restrained at least one time for kids with IEPs was (105/5268)/(38/51519) = 27.02. Relative risk of being put in seclusion at least once for a kid with an IEP was (37/5268)/(7/51519) = 51.79. Similar patterns in event-level data are found in subsequent years and again, these disparities are not unique to Howard County. In 2016, the Department of Education Office of Civil Rights issued a ‘Dear Colleague’ letter warning that such disparities could represent a denial of FAPE (free and appropriate public education) to disabled students,

in addition to a violation of their civil rights (United States Department of Education Department for Civil Rights 2016).

The use of restraint and seclusion is problematic for the following reasons:

1) Restraint and seclusion are dangerous for teachers and students. Nationwide, there are hundreds of reports of injuries to staff and students (Kutz 2009). Children have died while being restrained, and children have died in seclusion rooms (Hines 2020; Cohen, Richards, and Chavis 2019). Howard County (and many other counties) does not inform parents of these risks (though they are enumerated in internal training manuals), does not even collect systematic injury data ("2021-230" 2021),and did not inspect all of its seclusion rooms ("2020-303" 2020) for safety as required by MSDE(Salmon 2017) until this past year.

Twenty years ago, after reporting by the *Hartford Courant* exposed hundreds of deaths due to restraint and seclusion in psychiatric hospitals (ERIC M. WEISS With reporting by Dave Altimari et al. 1998), congressional hearings led to new laws restricting their use in those settings. The Children's Health Act of 2000 prohibited restraint and seclusion in a treatment facility unless ordered by a physician (or other licensed independent practitioner), (Bilirakis 2000) and those orders must be reviewed every 24 hrs. It defies logic that schools are currently subject to a far lower standard of care and oversight than hospitals.

2) Restraint and seclusion are traumatic for teachers, students and bystanders. Adults who have been restrained describe the experience as being qualitatively similar to rape or physical assault (Strout 2010; Goren, Singh, and Best 1993). People with a history of trauma will often re-experience that trauma during instances of restraint and seclusion (Hammer et al. 2011). It's common for young children to urinate on themselves in fear (Cohen, Richards, and Chavis 2019).

3) Restraint and seclusion lead to increased aggression (Jones and Timbers 2002; Magee and Ellis 2001; Goren, Singh, and Best 1993). These kids are struggling, and when you restrain or seclude them you do nothing but add anger, fear, and distrust, and this perpetuates the cycle (Greene 2009). When you solve a problem with a kid by putting your hands on him, you've just taught him to solve problems with people by putting their hands on them. This is why you have kids being restrained and secluded repeatedly. Restraint and seclusion are not behavior interventions - they *worsen* behavior.

The Resource Document from the US Department of Education states that restraint and seclusion are "violent, expensive, largely preventable, adverse events" and contribute to a cycle of workplace violence. (United States Department of Education 2012) Every time a kid is restrained or secluded it means that their behavior intervention has *failed (Curie 2005)*, and failed so spectacularly that students or staff were put at risk of serious physical harm.

Why do behavior interventions fail? The behaviorism-based reward systems (PBIS) used in many Maryland public schools to change student behaviors are based on operant conditioning. Operant conditioning is based on research done by B.F. Skinner in the 1940s and 1950s with

rats and pigeons (Staddon and Cerutti 2003). It's 2022 and we know a lot more about the *human* brain, about how children learn, and about the effects of trauma.

We now know that challenging behaviors are the result of unmet needs or lagging skills, not lack of motivation, and rewards don't teach the skills these kids need. Rewards simply don't work (and are harmful) if the target behavior is something the child is not currently capable of. The answer is to identify the underlying problem, and to solve it, collaboratively (Greene 2009). These methods (Collaborative and Proactive Solutions) have been used to dramatically decrease conflict and hence the use of restraint and seclusion on pediatric inpatient psychiatric units (Greene, Ablon, and Martin 2006; Martin et al. 2008; Black et al. 2020) and in schools (Lewis 2015).

I'll give you one very simple, but illustrative example of this approach. My son's classroom was at the far end of a hallway and at the beginning of each school day he would have to walk through a sea of several hundred other kids to get there. Like many autistic children he can't handle the sensory experience of all that noise and of so many people touching him. He would "windmill" his arms to create space around him and to get people away from him, and he'd end up hitting other kids. The school responded by stationing an additional staff member by the front door and initiating a system of rewards and punishments for this behavior. This is a standard cookie-cutter approach. It was labor intensive, and it wasn't working. I asked what I thought was the obvious question: "Did you ask him why he was doing it?" This question was met with silence and shrugs. That afternoon, I discussed the situation with my son - I explained that what he was doing might hurt someone, listened to his explanation, and encouraged him to come up with a solution - and he did. His solution was that instead of entering through the front door, he would walk around the side of the building, knock on the door next to his classroom, and his classroom teacher would open the door and let him in. His classroom teacher was happy to do this, and the problem was solved to everyone's satisfaction. It's really that simple, and because I've engaged in this type of exercise with my son repeatedly, he has learned to problem solve more effectively on his own, and we have been aggression free since he left public school.

Collaborative and Proactive Solutions, or approaches like it, can greatly decrease conflicts, but in the event that a situation does still escalate, there are also more humane crisis intervention strategies, such as Ukeru, a physical alternative to restraint and seclusion. After Grafton Integrated Health Network developed Ukeru, they reduced staff injury rates, worker's compensation costs, and staff turnover, and improved staff morale and patient treatment outcomes (Sanders 2009). In short, it was better for *everyone*. Ukeru has been adopted by hundreds of hospitals and schools nationwide, including Calvert County Public Schools, in Maryland ("Calvert County Archives - Ukeru" 2021) and Loudoun County Public Schools, in Virginia ("Ad Hoc Committee on Special Education - Final Report" 2019). Calvert County went from 750 restraints and 386 seclusions in SY 2018-2019 to 70 restraints and 78 seclusions in SY 2019-2020 after switching to Ukeru.

There are several parts of this bill that I want to highlight. It requires case review for children who are restrained repeatedly and promotes the use of better, safer alternatives (such as Ukeru) - had this law been in effect earlier, things might not have gotten so bad for my son, and many other kids like him.

It requires MSDE to develop a system to ensure that regulations related to restraint and seclusion are actually being followed by schools, and that data on restraint and seclusion that is collected annually is actually analyzed.

This bill takes an important step toward ensuring the safety and civil rights of Maryland's most vulnerable children and I urge you to vote favorably.

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