MCF_Fav_HB 1255.pdf
Uploaded by: Ann Geddes
Position: FAV

HB 1255 – Education – Physical Restraint and Seclusion – Limitations, Reporting and Training

Committee: Ways and Means
Date: March 10, 2022
POSITION: Support

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for a loved one with behavioral health needs. Using personal experience, our staff provide one-to-one peer support and navigation services to family members with a child, youth or adult with a mental health, substance use or gambling issue.

MCF enthusiastically supports HB 1255.

The bill would primarily do five things:

- Prohibit the use of seclusion in public schools and limit its use in non-public schools
- Strictly limit the use of restraint
- Require more data collection on the use of restraint and seclusion in both public and non-public schools and analysis of the data
- Require that MSDE ensure that strong regulations are in place and implemented
- Provide better training of school staff to avoid the use of restraint and seclusion

Children who have significant mental health needs often have experienced trauma in their lives. Studies on Adverse Childhood Experiences (ACEs) consistently show that children who have experienced four or more traumatic events, including physical or mental abuse, parental mental health or substance use problems, domestic violence, bullying, poverty, or community violence, to name a few, are at much greater risk of developing mental health problems such as depression, anxiety, behavioral disorders and suicidality. Behavioral disorders in children include ADHD, Conduct Disorder, and Oppositional Defiant Disorder, behaviors which are often addressed in schools with the use of restraint and seclusion. These interventions can be extremely re-traumatizing to a child.

MSDE has collected data on the use of restraint and seclusion in schools. The number of incidents of restraint and seclusion are alarmingly high. For the 2020-21 school year most students were in virtual education for the entire year, so only the 2018-19 and 2019-March 16,

2020 data are presented here. These are the schools with the highest number of restraints in 2018-19, compared with 2019-March 2020:

Incidents of restraint – 2018-19		2019 - March 2020
Frederick County:	1,966	599
Montgomery County:	1,356	778
Baltimore County:	1,053	926
Anne Arundel County:	1,002	834
Howard County:	889	616

Frederick County, under a US. Department of Justice Order, showed a decline, as did Montgomery and Howard Counties. Baltimore and Anne Arundel Counties were on track, had the school year not ended in March, to reach or surpass their number of restraints used in the 2018-19 school year.

These are the schools with the highest number of seclusions in 2018-19, compared with 2019-Marach 2020.

Incidents of seclusion 2018-19		2019 – March 2020
Frederick County:	1,604	348
Harford County:	1,153	817
Montgomery County:	602	615
Charles County:	391	36
Baltimore County	218	330

While the incidents of seclusion declined in both Frederick (again, under a US Justice Department Order) and Charles Counties, Harford County showed no decline and Montgomery and Baltimore Counties saw an increase.

Clearly, despite various efforts, the problem of the use of restraint and seclusion has not gone away.

Students with disabilities, especially those who have been determined to have an Emotional Disability (ED) under the Individuals with Disabilities Education Act, are far more likely to experience restraint and seclusion than other students. Students coded with ED experienced the highest number of incidents of restraint and seclusion of all disability groups. Students coded with ED are also much more likely to be youth of color. In the 2019 – March 2020 school year, students with ED were restrained 1,732 times and subject to the use of seclusion 1,265 times in public schools. These numbers increase significantly for students coded ED in non-public schools.

Schools with well-trained personnel do not resort to the traumatizing interventions of restraint and seclusion. Children with mental health disabilities are not subjected to further re-traumatization. Instead, school personnel know how to implement policies, procedures and

practices designed to alleviate the impact of trauma. These have been well-researched and have a strong evidence-base, and include relationship-building, helping traumatized children regulate their emotions, and collaborating across child-serving systems to coordinate care.

HB 1255 puts a number of mechanisms in place to reduce the use of restraint and seclusion. Therefore we urge a favorable report.

Ann Geddes
Director of Public Policy
The Maryland Coalition of Families
10632 Little Patuxent Parkway, Suite 234
Columbia, Maryland 21044
Phone: 443-926-3396
ageddes@mdcoalition.org

Maryland HB1255 Written Testimony_Croy.pdf
Uploaded by: Elena Croy
Position: FAV

I am a resident of New Jersey writing favorably for Maryland House Bill 1255, Education – Physical Restraint and Seclusion – Limitations, Reporting, and Training. I am relieved that Maryland is taking this step toward creating safer environments for children who are entrusted to the care of knowledgeable, well-informed adults in school settings, both public and private. Neighboring states and even those further away will look to Maryland for their own courage in passing laws banning restraint and seclusion.

Thank you for realizing that we can change processes, which this bill aims to do, but we can't erase trauma. By changing the process by which we help children through their feelings and outlets for those feelings, we have the opportunity to prevent traumatic experiences of being secluded and restrained. My 4-year-old daughter was victimized in her New Jersey public school by her teacher with packing tape, and the system of accountability failed her. I am thrilled Maryland has this opportunity to reframe the conversation in 21st century terms to what it means to discipline a child and how that discipline will forever affect their trajectory through their school years and beyond.

Sincerely,
Elena Croy

Education Advocacy Coalition 2022 Testimony.pdf
Uploaded by: Ellen Callegary
Position: FAV

Education Advocacy Coalition

for Students with Disabilities

HOUSE WAYS AND MEANS COMMITTEE
HOUSE BILL 1255
EDUCATION—PHYSICAL RESTRAINT AND SECLUSION—LIMITATIONS, REPORTING, AND TRAINING
MARCH 10, 2022
POSITION: SUPPORT

The Education Advocacy Coalition for Students with Disabilities (EAC), a coalition of approximately 40 organizations and individuals concerned with education policy for students with disabilities in Maryland, strongly supports House Bill 1255, which would 1) prohibit the use of seclusion in public schools and further regulate its use in nonpublic special education schools; 2) require collection of additional data about the use of restraint and seclusion with students in public and nonpublic schools, 3) require analysis of that data; 3) require the Maryland State Department of Education to develop an accountability system to ensure that the strong regulations and guidance in place in Maryland are implemented fully, and 4) would increase the ability of school staff to better meet the needs of their students by addressing gaps in professional development, thereby reducing the reliance on restraint and seclusion, an outdated means of behavior management. As was discussed at length during the hearings on Senate Bill 786 and its companion House Bill in 2017 and in hearings on legislation proposed in 2020 and 2021, restraint and seclusion can be aversive, trauma-inducing and dangerous, often resulting in injury to students and sometimes to school staff as well. On occasion, including in Maryland, these interventions can be fatal.

Senate Bill 786, which was enacted and became effective on July 1, 2017, required, for the first time, collection and reporting of data regarding the use of restraint and seclusion in public and nonpublic schools throughout the state. By December 1st of each year, MSDE must issue a report to the General Assembly with data, disaggregated by a number of categories including age, race and ethnicity, disability, placement, gender and jurisdiction. The legislation also required the appointment of a workgroup to make recommendations to the Maryland State Department of Education (MSDE) regarding revisions to the Code of Maryland Regulations. The workgroup issued its report; MSDE adopted some, but not all, of the recommendations, and new regulations were finalized in 2018, strengthening the protections in place for students. Subsequently, MSDE issued strong guidance clearly reiterating that restraint and seclusion may be used only when a student poses "imminent serious physical harm to self or others" and that this term means "[a] substantial risk of death; [e]xtreme physical pain; [p]rotracted and obvious disfigurement; or [p]rotracted loss or impairment of the function of a bodily member, organ or mental faculty." Because all students, those with and without disabilities, are covered by the legislation and regulations, MSDE lodged responsibility for implementation and oversight of the legislation and regulations with its Division of Student Support, Academic Enrichment & Educational Policy. EAC members and many others hoped and expected that with stronger regulations and strong guidance from MSDE, and with the training requirements also included in Senate Bill 786, the incidence of restraint and seclusion would decrease.

Unfortunately, that has not been the case. The General Assembly has now received four reports from MSDE covering the 2017-18, 2018-19, 2019-20 and 2020-21 school years. The incidence of restraint and seclusion remains extremely high in many jurisdictions. Frederick County reported just under 2000

restraint incidents during the 2018-19 school year, a marginal decrease from the previous year, but jumped from 837 incidents of seclusion to 1604, the highest of any jurisdiction in the state. In fact, the United States Department of Justice concluded a lengthy investigation recently, entering into an agreement with Frederick County that requires the immediate cessation of the use of seclusion and a host of other corrective actions, both student-oriented and systemic. Many districts disproportionately restrain and seclude students of color, such as Montgomery, where during the 2018-19 school year, 72% of the restraint incidents and 77% of the seclusion incidents involved students of color. This was no different in the 2019-20 school year, when 530 of the 778 ((68%) restraint incidents and 75% of the seclusion incidents in Montgomery County involved students of color. Also notable is that in the 2019-20 school year, the year in which school buildings closed in mid-March because of the coronavirus pandemic, the number of restraint incidents increased in Baltimore City, Garrett County, Harford County and Worcester County, and the number of seclusion incidents increased in Allegany County, Baltimore County, Dorchester County, Montgomery County, Washington County, and Worcester County. Across all districts, the vast majority of students who are restrained and placed in seclusion are students with disabilities and the majority are in elementary school. Notably, students in nonpublic special education schools are also restrained and placed in seclusion at a high rate. Also notable is that several local school systems (Anne Arundel County, Baltimore City, Caroline County, Prince George's County, Somerset County and Wicomico County) prohibit the use of seclusion, as do a number of nonpublic special education schools that serve students with complex disabilities.

House Bill 1255 is needed because it would address some of the gaps illuminated by the Senate Bill 786 Implementation process. MSDE's Division of Student Support, Academic Enrichment & Educational Policy collects the data required by Senate Bill 786 but does no analysis of the data and makes no effort to identify school districts or nonpublic schools that may be violating the regulations. The Division makes no attempt to identify trends or to target districts with a high use of restraint and seclusion for support, professional development or enforcement. Part of the reason there has been no data analysis or follow up with districts is because MSDE's Division of Student Support, Academic Enrichment & Educational Policy, unlike the Division of Early Intervention and Special Education, has no accountability structure in place to ensure compliance with the regulations. In addition to the data already required to be reported to MSDE by local school systems, public agencies and nonpublic schools, House Bill 705 would require reporting of individual student data from a student's school to the local school system and to MSDE if a student is restrained (or secluded if in a nonpublic school) 10 or more times in a school year. House Bill 1255 would also require MSDE to verify the data and to develop an accountability system to ensure compliance and to take responsibility for reducing the use of restraint and seclusion in public and nonpublic schools.

Finally, although the importance of teacher preparation and professional development were recognized with a limited attempt to address these critical issues even in the initial 2003 legislation enacted by the General Assembly, it has become increasingly evident that many teachers enter their classrooms unprepared to meet the academic and behavioral needs of their students. By requiring additional training, House Bill 1255 recognizes and makes a more robust effort to address this issue.

For these reasons, the EAC supports House Bill 1255. For more information, please contact Leslie Seid Margolis, Chairperson, at lesliem@disabilityrightsmd.org or 410-370-5730.

Respectfully submitted,

Rene Averitt-Sanzone, The Parents' Place of Maryland
Linda Barton, MSED, Educational Consultant
Elizabeth Benevides, Howard County Autism Society
Ellen A. Callegary, Law Offices of Ellen A. Callegary, P.A.
Rich Ceruolo, Parent Advocacy Consortium
Michelle Davis, ABCs for Life Success
Jennifer Engel Fisher, Weinfeld Education Group, LLC
Ann Geddes, Maryland Coalition of Families
Kalman Hettleman, Independent Advocate
Morgan Horvath, M.Ed., Abilities Network
Rosemary Kitzinger and Marjorie Guldan, Bright Futures, LLC
Rachel London, Maryland Developmental Disabilities Council
Leslie Seid Margolis, Disability Rights Maryland
Mark B. Martin, Law Offices of Mark B. Martin, P.A.
Ellen O'Neill, Atlantic Seaboard Dyslexia Education Center
Ronza Othman, National Federation of the Blind of Maryland
Maria Ott, Attorney
Rebecca Rienzi, Pathfinders for Autism
Jaime Seaton, BGS Law
Ronnetta Stanley, Loud Voices Together
Guy Stephens, Alliance Against Seclusion and Restraint
Maureen van Stone, Mallory Legg, and Alyssa Thorn, Project HEAL at Kennedy Krieger Institute
Daya Chaney Webb, IMPACT Advocacy
Liz Zogby, Maryland Down Syndrome Advocacy Coalition
Also joining testimony: Shanetta Martin, Maryland Education Coalition

HB1255
Uploaded by: Guy Stevens
Position: FAV

ALLIANCE AGAINST SECLUSION RESTRAINT

Guy Stephens
Alliance Against Seclusion and Restraint
P.O. Box 875
Solomons, Maryland 20688

Ways and Means Committee
11 Bladen Street
Annapolis, Maryland 21401

Members of the committee,

My name is Guy Stephens. I am a father and the executive director of the Alliance Against Seclusion and Restraint. I am writing to you today on behalf of the Alliance Against Seclusion and Restraint (AASR), as well as the children and families who attend Maryland Public Schools. AASR is a Maryland nonprofit corporation operating through a fiscal sponsorship with Players Philanthropy Fund. We are a community of over 17,000 parents, self-advocates, teachers, school administrators, paraprofessionals, attorneys, related service providers, and others working together to influence change in the way we support children who may exhibit behaviors of concern. The mission of AASR is to educate the public and to connect people who are dedicated to changing minds, laws, policies, and practices so that restraint, seclusion, suspension, expulsion, corporal punishment, and other harmful practices are reduced and eliminated from schools across the nation and beyond. Our vision is safer schools for students, teachers, and staff.

About three years ago, my neurodivergent son was illegally restrained and secluded for the last time. The experience left him traumatized and afraid to return to school. As a result, he finished the remainder of the school year in a home and hospital program. Before our family's experience, I would have never imagined that children were routinely restrained and secluded in schools across the state. I talked to my son about what had happened to him. I made a promise to him that I would do anything in my power to make sure it never happened to him again.

Since my son was restrained and secluded, I've had the opportunity to talk to parents from all over the country. Jennifer Tidd's autistic son Quentin was restrained and/or secluded at least 745 times. This despite the fact that the Department of Education Office for Civil Rights (OCR) has said in a Dear Colleague letter[1] (2016) that OCR would likely not find the repeated use of restraint and seclusion to be a justified response where alternative methods also could prevent imminent danger to self or others. Ultimately Ms. Tidd joined a lawsuit with the Autistic Self Advocacy Network (ASAN), the Council of Parent Attorneys and Advocates (COPAA), CommunicationFirst, and several other families against Fairfax County Public Schools in Virginia for unlawful restraint and seclusion practices. The lawsuit was settled, and as part of the agreement, seclusion practices will be banned in all Fairfax County Public Schools and private schools that have contracts with the school system by the start of the 2022-2023 school year. Kristi Kimmel's son Zeke, who is autistic and nonspeaking, was secluded 206 times and restrained 71 times in less than one school year in the Frederick County School system. In 2021, the Department of Justice investigated Frederick County Public Schools, which found that the school district unnecessarily and repeatedly secluded and restrained students as young as five years old in violation of Title II of the Americans with Disabilities Act (ADA). Under the settlement, Frederick County will end the use of seclusion, overhaul its restraint practices, and train staff on the use of appropriate behavioral interventions for students with disabilities. These are just two of hundreds of stories I've heard from parents whose children have been restrained, secluded, and traumatized.

Let me share I learned from my research and advocacy work. Children with disabilities, Black and brown children, and children with a trauma history are most restrained and secluded. Many assume it is more common with older students, and it is not. It is most often children as young as 5,6,7 and 8 years old. According to OCR[2],

[1] Dear Colleague Letter: Restraint and Seclusion of Students with Disabilities. (2016, December 28). U.S. Department of Education's Office for Civil Rights. Retrieved February 13, 2022, from https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201612-504-restraint-seclusion-ps.pdf

[2] *2017–18 Civil Rights Data Collection Report*. (2019, December 15). Department of Education Office of Civil Rights. Retrieved February 13, 2022, from https://www2.ed.gov/about/offices/list/ocr/docs/restraint-and-seclusion.pdf

students with disabilities make up around 13% of the enrollment in public schools yet account for 80% of physical restraints and 77% of seclusions. Reflecting on these numbers, it is clear that this is a civil rights issue, and we must do something to protect the civil rights and human rights of our most vulnerable children. I'm sure that many of you have someone you love with a disability, consider the potential impact.

In my extensive research, the next thing I wanted to understand was the impact of restraint and seclusion. I found that restraint and seclusion result in trauma, injuries, and even death. Trauma can impact students, teachers, and staff. The very act of physically restraining or secluding a child will trigger a fight or flight response in the brain. Being held to the ground or forced into a seclusion room is traumatizing. Trauma can lead to changes in the brain that lead children to be fearful and hypervigilant, often leading to an increase in distress behaviors, which may have been what caused them to be restrained and secluded in the first place. It is also traumatic for the other children who may be witnessing a classmate being physically restrained or secluded.

Injuries are common in restraint and seclusion instances. Children and educators have suffered from broken bones, head trauma, scratches, bruises, seizures, brain injuries, and other injuries[3][4]. Children, teachers, and staff are more likely to be injured[5] performing a physical restraint or seclusion. While we often hear proponents of restraint and seclusion say that they feel it is necessary to keep everyone safe, the truth is the most significant opportunity for injuries occurs during the events. Sadly there have been many deaths over the last several decades due to physical restraint and seclusion in our schools. Cornelius Frederick, a student in Michigan, died in May of 2021 after being placed in a prone restraint because he threw a sandwich in a cafeteria. Max Benson, a young autistic student in California, died in November 2018

[3] *Our History*. (2021, April 22). Ukeru Systems. Retrieved February 13, 2022, from https://www.ukerusystems.com/who-we-are/our-history/
[4] *Understanding the Risks of Physical Restraints*. (2022, January 1). Crisis Prevention Institute. Retrieved February 13, 2022, from https://www.crisisprevention.com/CPI/media/Media/elearning/flex/PDF_NCI-Risk-of-Restraints.pdf
[5] A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services. (2010, March 1). Substance Abuse and Mental Health Services Administration. Retrieved February 13, 2022, from https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-1.pdf

after being placed in a prone restraint in his school. These are lives that should not have ended this way.

I wanted to address some common misinformation about the use of restraint and seclusion. One of the things we often hear is that physical restraint is safe. Some might even tell you that it is therapeutic. Physical restraint is intended as a crisis intervention only intended for life-threatening situations; it is not a therapeutic intervention[6]. The only safe restraint is when all parties willingly participate, such as occurs in training. In real-life situations, physical contact leads individuals into a fight or flight response, where children will do all they can to escape. The staff is also likely to enter into a fight or flight response, increasing the chance that someone will be injured or worse.

We also hear the myth that seclusion is a safe and calming intervention. Nothing could be further from the truth. Nothing is calming about being thrown into a room against your will, alone, while someone holds the door shut. Initially, children may respond by kicking, screaming, and beating on the walls to escape. Eventually, lacking the developmental capacity to self-regulate, children's brains will begin to shut down, and they may enter a survival state - this is not calm.

The final myth I would like to address is that there are no other choices, that restraint and seclusion are necessary. This belief is not valid. There are many alternative approaches to better support our children. Grafton Integrated Health in Virginia developed a method called Ukeru[7], a trauma-informed alternative to restraint and seclusion. Grafton eliminated seclusion in all the schools and residential facilities it manages and now teaches the approach to other schools. Dr. Bruce Perry, a leading trauma expert, developed the Neurosequential Model[8], proven to reduce the use of

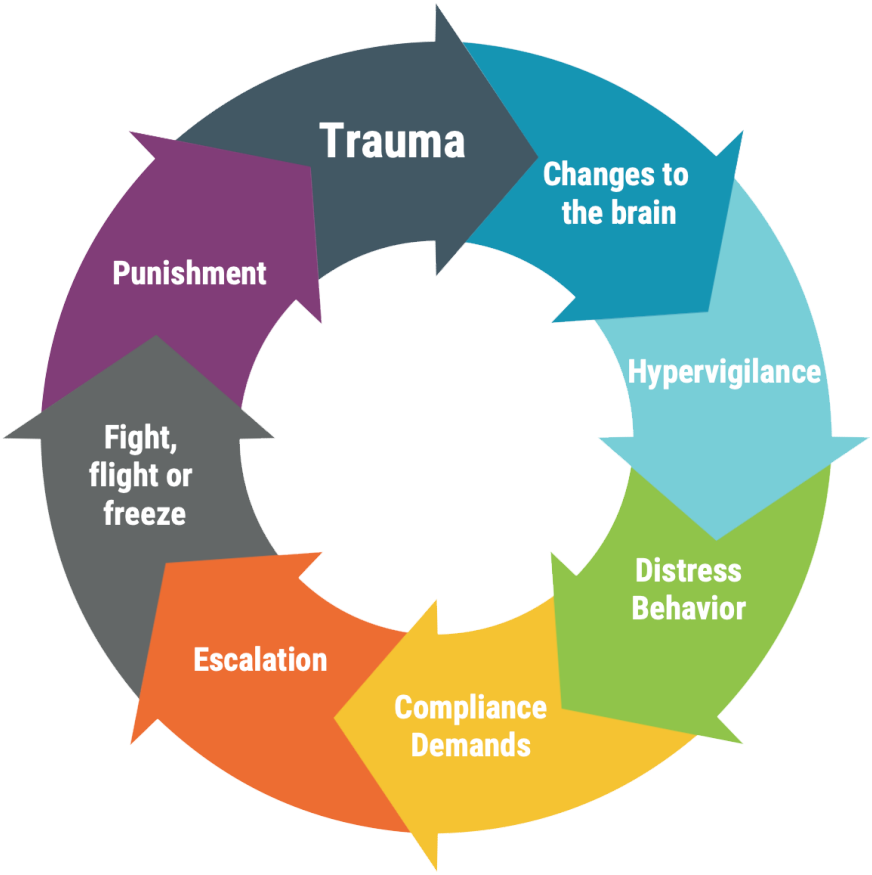
---

[6] Stephens, G. (2021, February 1). Prone restraint is neither safe nor is it therapeutic. Alliance Against Seclusion and Restraint. Retrieved February 13, 2022, from https://endseclusion.org/2021/02/01/prone-restraint-is-neither-safe-nor-is-it-therapeutic/

[7] Home. (2021, October 14). Ukeru Systems. Retrieved February 13, 2022, from https://www.ukerusystems.com

[8] The Neurosequential Model in Education. (2020, August 26). Sussex Psychology. Retrieved February 13, 2022, from https://sussexpsychology.co.uk/the-neurosequential-model-in-education/

restraint in trauma-exposed youth[9]. Dr. Ross Greene developed the Collaborative and Proactive Solutions Model[10], an evidence-based approach to minimize restraint, seclusion, suspensions, expulsions, and corporal punishment.



Over the past forty years, there has been a tremendous increase in the knowledge base about the brain, nervous system, human development, and behavior. Our knowledge now includes understanding the role of toxic stress and trauma on the structure of the developing brain and brain functioning. State-dependent functioning, the polyvagal theory, bottom-up versus top-down learning and control, and the differences between

[9] Hambrick, E. P., Brawner, T. W., Perry, B. D., Wang, E. Y., Griffin, G., DeMarco, T., Capparelli, C., Grove, T., Maikoetter, M., O'Malley, D., Paxton, D., Freedle, L., Friedman, J., Mackenzie, J., Perry, K. M., Cudney, P., Hartman, J., Kuh, E., Morris, J., . . . Strother, M. (2018). Restraint and Critical Incident Reduction Following Introduction of the Neurosequential Model of Therapeutics (NMT). Residential Treatment for Children & Youth, 35(1), 2–23. https://doi.org/10.1080/0886571x.2018.1425651

[10] Greene, R., & Winkler, J. (2019). Collaborative & Proactive Solutions (CPS): A Review of Research Findings in Families, Schools, and Treatment Facilities. Clinical Child and Family Psychology Review, 22(4), 549–561. https://doi.org/10.1007/s10567-019-00295-z

intentional behaviors and stress behaviors (flight, fight, freeze) are all part of this new understanding[11]. However, despite all this progress, students with disabilities and Black and brown students who cannot meet the behavioral expectations are often not supported or accommodated; instead routinely punished.

Today, we know the brain areas implicated in the stress response include the amygdala, hippocampus, and prefrontal cortex[12]. We also know that traumatic stress can be associated with lasting changes in these brain areas. The amygdala detects threats in the environment and activates the "fight or flight" response. The use of restraint and seclusion can lead to actual changes in the brain. Children who have been traumatized may not feel safe and may enter a hypervigilant state, leading to distress behaviors when the child becomes overwhelmed or triggered. When demands on a child are made that they cannot meet, the situation may escalate. The current approach in many classrooms that focuses on compliance may lead to a fight, flight, or freeze response, leading to punishment and retraumatization, feeding the classroom trauma cycle.

It is time to shift to approaches that are relationship-based, trauma-informed, neuroscience-aligned, developmentally appropriate, individualized, biologically respectful, and collaborative to support all children, teachers, and staff in schools across the nation. This is a critical moment in time for moving forward. We need to base safer schools around current neuroscience to help us face the challenges that currently face the nation. The COVID-19 pandemic has increased stress and led to significant trauma for many as families suffered from loss and a changing world. Due to the increased stress and trauma, our teachers and staff are likely to face more children in distress that need connection, not compliance and safety, not consequences. So many children face nothing but consequences, and the outcomes are devastating.

---

[11] Tolley, B. (2022, January 19). A twenty-first century approach to supporting all students. Alliance Against Seclusion and Restraint. Retrieved February 13, 2022, from https://endseclusion.org/research/a-twenty-first-century-approach-to-supporting-all-students/

[12] Andrewes, D. G., & Jenkins, L. M. (2019). The Role of the Amygdala and the Ventromedial Prefrontal Cortex in Emotional Regulation: Implications for Post-traumatic Stress Disorder. Neuropsychology Review, 29(2), 220–243. https://doi.org/10.1007/s11065-019-09398-4

When I said to you that what happened to my son has changed my life, it was no exaggeration. Three years ago, I started a national organization called the Alliance Against Seclusion and Restraint. I have volunteered thousands of hours to research this issue and promote positive change to make our schools safer for students, teachers, and staff. We have advocated for changes to local policy and state and federal law. We have produced hundreds of hours of educational content related to reducing and eliminating the use of restraint and seclusion. Today we have over 17,000 members from across the world in the Alliance Against Seclusion and Restraint community. Our community includes parents, self-advocates, teachers, administrators, paraprofessionals, and others dedicated to finding better ways to support children and educators.

In the name of behavior, children are restrained, secluded, suspended, expelled, and subjected to corporal punishment. We can make classrooms across the nation safer for students, teachers, and staff by reducing and eliminating restraint and seclusion. We have reviewed the research and what we have found is that there is no data to support the use of seclusion in a school setting (perhaps any setting). Seclusion leads to increased aggression and more frequent challenging behaviors. Seclusion should be prohibited across the nation as it has been in several states, including Hawaii, Georgia, Nevada, Texas, and Pennsylvania. Like the Government Accountability Office[13] (GAO), we are concerned the use of seclusion and restraint is often underreported by school districts and poses a significant danger to children. We agree with the United Nations[14] that the use of seclusion and restraint violates fundamental human rights.

Three years ago, I examined data that resulted from 2017 legislation that required school districts and nonpublic schools to report the use of restraint and seclusion. In the first report, I learned that my school district, Calvert County Public Schools

[13] K-12 Education: Education Should Take Immediate Action to Address Inaccuracies in Federal Restraint and Seclusion Data [Reissued with revisions on July 11, 2019.]. (2019, November 26). U.S. GAO. Retrieved February 13, 2022, from https://www.gao.gov/products/gao-19-551r

[14] OHCHR | Convention on the Rights of the Child. (89–11-20). United Nations Human Rights. Retrieved February 12, 2022, from https://www.ohchr.org/en/professionalinterest/pages/crc.aspx

(CCPS), had the highest rate of seclusion and the second-highest rate of restraint when viewed against enrollment. This data prompted me to reach out to my local board of education to raise awareness and promote change. I successfully worked with our school district to change our policy, practice, and training.

Interestingly, the district with the highest use of restraint and the second-highest use of seclusion was Frederick County Public Schools (FCPS). I am sure you know that the Department of Justice recently investigated FCPS.

In the 2017/2018 school year, Calvert County Public Schools (CCPS) reported 576 instances of restraint and 701 instances of seclusion. In the current school year, CCPS has reported 14 instances of restraint and just three instances of seclusion. The district has been proactive, which may have helped them avoid an investigation by the Department of Justice.

Today I ask you to be proactive in supporting a favorable outcome for HB1255.

Respectfully,

Guy Stephens
Founder and Executive Director
Alliance Against Seclusion and Restraint

HB1255_Leoutsakos_Favorable.pdf
Uploaded by: Jeannie-Marie Leoutsakos
Position: FAV

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 incidence 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 incidence 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.

During the senate hearing for SB705, a number of individuals speaking on behalf of nonpublic schools requested an amendment to include behavior analysts among the list of professionals who may authorize and supervise the use of seclusion. I urge you strongly to reject this request. Already the list of professionals for schools is laxer than what is required in hospitals (hospitals require a licensed independent practitioner, so for example, an RN would not be able to order seclusion in a hospital). Additionally, I would draw your attention to the position statement of ABAI (Applied Behavior Analysis International) which is the professional organization to which many behavior analysts belong. It may be found here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3089400/

In this position statement, ABAI advocates the fringe position that "When used in the context of a behavior intervention plan, seclusion in some cases serves both a protective and a therapeutic function."

Similarly, the position statement for another professional organization, may be found here: https://cdn.ymaws.com/www.apbahome.net/resource/collection/1FDDBDD2-5CAF-4B2A-AB3F-DAE5E72111BF/Restraint_Seclusion_.pdf

In this position statement, APBA (Association of Professional Behavior Analysts), also refer to the "safe and effective use of restraint and seclusion procedures as components of carefully considered, properly implemented comprehensive treatment plans for dangerous and destructive behavior problems."

This position (that seclusion is therapeutic) has been refuted by much of mainstream psychiatry, and, frankly, common sense. Many of the papers cited in defense of this position are from the 1970s and 1980s, and would meet neither the ethical nor the methodological standards of today. This cited literature is appalling by any modern standard, referring to children as "retardates" (Barton, et al, 1970) and describing the use of electric shocks and squirting of lemon juice in patients' mouths as aversives (Favell et al, 1978). Behavioral analysts are the last people on earth you want deciding if seclusion is appropriate. The amendment has been requested not because of behavior analysts' relationships with their students, but because behavior analysts are relatively inexpensive and plentiful in these nonpublic schools, thus allowing these schools to continue "business as usual". Some of these schools (e.g., Kennedy Krieger, Sheppard Pratt, and Ivymount) record *thousands* of restraints and seclusions each year.

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.

References

"2020-303." 2020. 2020. https://mpia.hcpss.org/requests/2020-303.

"2021-230." 2021. 2021. https://mpia.hcpss.org/requests/2021-230.

"Ad Hoc Committee on Special Education - Final Report." 2019. https://go.boarddocs.com/vsba/loudoun/Board.nsf/files/BDCKRT532353/$file/DRAFT%20Ad%20Hoc%20Committee%20for%20SPED%20Final%20Report%20June%202019.pdf.

Bilirakis, Michael. 2000. *Children's Health Act of 2000*. https://www.congress.gov/bill/106th-congress/house-bill/4365.

Black, Valerie, Candace Bobier, Baiju Thomas, Fiona Prest, Chris Ansley, Barbara Loomes, Glenda Eggleston, and Helen Mountford. 2020. "Reducing Seclusion and Restraint in a Child and Adolescent Inpatient Area: Implementation of a Collaborative Problem-Solving Approach." *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists* 28 (5): 578–84.

"Calvert County Archives - Ukeru." 2021. 2021. https://www.ukerusystems.com/tag/calvert-county/.

Cohen, Jodi S., Jennifer Smith Richards, and Lakeidra Chavis. 2019. "Children Are Being Locked Away, Alone and Terrified, in Schools across Illinois. Often, It's against the Law." November 19, 2019. https://features.propublica.org/illinois-seclusion-rooms/school-students-put-in-isolated-timeouts/.

Curie, Charles G. 2005. "SAMHSA's Commitment to Eliminating the Use of Seclusion and Restraint." *Psychiatric Services* 56 (9): 1139–40.

ERIC M. WEISS With reporting by Dave Altimari, Dwight F. Blint, Kathleen Megan, Courant Staff Writers Additional research was contributed by Sandy Mehlhorn, Jerry LePore, and John Springer. 1998. "Hundreds of the Nation's Most Vulnerable Have Been Killed by the System Intended to Care for Them." October 11, 1998. https://www.courant.com/news/connecticut/hc-xpm-1998-10-11-9810090779-story.html.

Goren, Suzanne, Nirbhay N. Singh, and Al M. Best. 1993. "The Aggression-Coercion Cycle: Use of Seclusion and Restraint in a Child Psychiatric Hospital." *Journal of Child and Family Studies* 2 (1): 61–73.

Greene, Ross W. 2009. *Lost at School: Why Our Kids with Behavioral Challenges Are Falling Through the Cracks and How We Can Help Them*. Simon and Schuster.

Greene, Ross W., J. Stuart Ablon, and Andrés Martin. 2006. "Use of Collaborative Problem Solving to Reduce Seclusion and Restraint in Child and Adolescent Inpatient Units." *Psychiatric Services* 57 (5): 610–12.

Hammer, Joseph H., Justin Springer, Niels C. Beck, Anthony Menditto, and James Coleman. 2011. "The Relationship between Seclusion and Restraint Use and Childhood Abuse among Psychiatric Inpatients." *Journal of Interpersonal Violence* 26 (3): 567–79.

Hines, Alice. 2020. "Deadly Restraints Are Being Used on Children at Youth Homes and Schools." 2020. https://www.vice.com/en/article/7k9b89/deadly-restraints-are-being-used-on-children-at-youth-homes-and-schools.

Jones, Robert J., and Gary D. Timbers. 2002. "An Analysis of the Restraint Event and Its Behavioral Effects on Clients and Staff." *Reclaiming Children and Youth; Bloomington* 11

(1): 37–41.
Kutz, Gregory D. 2009. “Seclusions and Restraints: Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers. Testimony Before the Committee on Education and Labor, House of Representatives. GAO-09-719T.” *US Government Accountability Office*. https://eric.ed.gov/?id=ED505313.
Lewis, Katherine Reynolds. 2015. “What If Everything You Knew About Disciplining Kids Was Wrong?” *Mother Jones*, 2015. https://www.motherjones.com/politics/2015/07/schools-behavior-discipline-collaborative-proactive-solutions-ross-greene/.
Magee, S. K., and J. Ellis. 2001. “The Detrimental Effects of Physical Restraint as a Consequence for Inappropriate Classroom Behavior.” *Journal of Applied Behavior Analysis* 34 (4): 501–4.
Martin, Andrés, Heidi Krieg, Frank Esposito, Dorothy Stubbe, and Laurie Cardona. 2008. “Reduction of Restraint and Seclusion through Collaborative Problem Solving: A Five-Year Prospective Inpatient Study.” *Psychiatric Services* 59 (12): 1406–12.
Maryland State Department of Education. 2019. “Restraint and Seclusion: Data Collection, Findings, and Recommendations (2018-2019).” https://endseclusion.org/wp-content/uploads/2020/01/msar-11125-restraint-and-seclusion-report.pdf.
Salmon, Karen B. Letter to Members of the State Board of Educaiton. 2017, September 19, 2017. http://www.marylandpublicschools.org/stateboard/Documents/09192017/TabD-RestraintandSeclusion.pdf.
Sanders, Kim. 2009. “The Effects of an Action Plan, Staff Training, Management Support and Monitoring on Restraint Use and Costs of Work-Related Injuries.” *Journal of Applied Research in Intellectual Disabilities: JARID* 22 (2): 216–20.
Staddon, J. E. R., and D. T. Cerutti. 2003. “Operant Conditioning.” *Annual Review of Psychology* 54: 115–44.
Strout, Tania D. 2010. “Perspectives on the Experience of Being Physically Restrained: An Integrative Review of the Qualitative Literature.” *International Journal of Mental Health Nursing* 19 (6): 416–27.
United States Department of Education. 2012. “Restraint and Seclusion: Resource Document,” May. https://www2.ed.gov/policy/seclusion/restraint-and-seclusion-resource-document.html.
United States Department of Education Department for Civil Rights. 2016. “Dear Colleague Letter: Restraint and Seclusion of Students with Disabilities,” December 28, 2016. https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201612-504-restraint-seclusion-ps.pdf.

2022-03-10 HB 1255 (Support).pdf
Uploaded by: Steven Sakamoto-Wengel
Position: FAV

BRIAN E. FROSH
Attorney General

ELIZABETH F. HARRIS
Chief Deputy Attorney General

CAROLYN QUATTROCKI
Deputy Attorney General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

FACSIMILE NO.

WRITER'S DIRECT DIAL NO.

410-369-8122

March 10, 2022

To: The Honorable Vanessa E. Atterbeary
Chair, Ways and Means Committee

From: Hannibal G. Williams II Kemerer
Chief Counsel, Legislative Affairs, Office of the Attorney General

Re: HB 1255 – Education – Physical Restraint and Seclusion – Limitations, Reporting, and Training – **Support**

The Office of Attorney General urges this Committee to favorably report HB 1255. If passed, the bill would accomplish four important goals. First, the bill would prohibit a public agency from using seclusion as a behavioral health intervention for a student. Second, it would prohibit a public agency from using physical restraint or a nonpublic school from using physical restraint or seclusion as a behavioral health intervention for a student, except under limited circumstances. Third, it would require the State Department of Education to develop an accountability system to measure compliance with anti-seclusion regulations. Finally, it would require the adoption of positive behavioral intervention training for educators.

Under the Due Process Clause of the Fourteenth Amendment, a person has constitutionally protected liberty interests to be free from unreasonable bodily restraints. *See* U.S. Const. amend. XIV; *see also Youngberg v. Romeo*, 457 U.S. 307 (1982). In *Youngberg*, the Supreme Court held the respondent had a constitutionally protected liberty interest under the due process clause of the Fourteenth Amendment to freedom from unreasonable bodily restraints, and such minimally adequate training as reasonably might be required to protect these interests. 457 U.S. 307.

This bill would reduce the use of practices (i.e., restraint and seclusion) which can negatively impact the physical and emotional well-being of the student. It would also require training for the adoption of the positive behavioral interventions. This makes this bill consistent with both the Due Process Clause of the Fourteenth Amendment and the Supreme Court's holding in *Youngberg*. *See* U.S. Const. amend. XIV; *see also* 457 U.S. 307.

For the foregoing reasons, the Office of the Attorney General urges a favorable report of House Bill 1255.

cc: Committee Members

HB 1255 - Support - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FAV

March 8, 2022

The Honorable Vanessa E. Atterbeary
House Ways & Means Committee
House Office Building – Room 131
Annapolis, MD 21401

RE: Support – HB 1255: Education – Physical Restraint and Seclusion – Limitations, Reporting, and Training

Dear Chairman Atterbeary and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS/WPS support House Bill 1255: Education – Physical Restraint and Seclusion – Limitations, Reporting, and Training (HB 1255). Limiting the use of restraint and seclusion should always be the goal of schools and behavioral health institutions. Unfortunately, the limited use of restraints and seclusion is sometimes needed for the safe treatment and education of those with developmental delays and emotional disturbances. Therefore, it is critical that whenever those means are used, each use should be analyzed in order to determine the necessity and alternative approaches. This type of analysis is required under the CFR for youth residential treatment centers; similar analysis requirements should be required for school settings. In addition, those using restraints/seclusion should always be educated on trauma-informed care.

HB 1255 will help ensure that the use of restraints/seclusion is limited in school settings and when used appropriate monitoring occurs to make sure the interventions are necessary and not over or misused. For all the reasons above, MPS/WPS urges this honorable committee to give a favorable report to HB 1255.

If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee

HB1255_Restraint&Seclusion_KennedyKrieger_Support.
Uploaded by: Emily Arneson
Position: FWA

Kennedy Krieger Institute

DATE: **March 10, 2022** **COMMITTEE: House Ways and Means**
BILL NO: **House Bill 1255**
BILL TITLE: **Education – Physical Restraint and Seclusion – Limitations, Reporting, and Training**
POSITION: **Support with amendment**

Kennedy Krieger Institute supports House Bill 1255 - Education – Physical Restraint and Seclusion – Limitations, Reporting, and Training

Bill Summary:
House Bill 1255 restricts the use of physical restraint within a public agency or nonpublic school. An entity may only utilize physical restraint after all other methods are determined ineffective, including less intrusive, nonphysical interventions, and when the restraint is necessary to protect the student or another individual from serious harm. The bill bans the use of seclusion within a public agency and bans the intervention in nonpublic schools unless assessment for contraindication in students who may be secluded occurs and identified clinical professionals, familiar with the students, are on sight in the nonpublic school. Additionally, the bill outlines required observation of interventions, time limitations, data collection requirements, and standardization of data reporting to include intervention duration, both mean, and range, and control for enrollment size. The reporting will include specific reporting requirements for students subject to multiple interventions. These additional data will enhance the Maryland State Department of Education's (MSDE) ability to generate recommendations on policy changes and professional development opportunities to reduce the use of restraint and seclusion. Lastly the bill requires public agencies and nonpublic schools to conduct annual review of policy and professional development in an ongoing effort to reduce the use of physical restraint and seclusion (for nonpublic).

Request for Amendment:
This legislation includes a list of licensed health care professionals who must be involved in the assessment, observation, and decision making regarding any use of seclusion. We request behavior analysts, licensed by the Maryland Department of Health, and critical to the education and treatment of our students, be included in that list.

Background:
Section 7-1102.1 of the Education Article of the Annotated Code of Maryland requires the MSDE to report annually on the findings and recommendations of data collected by public and nonpublic schools on the use of physical restraint and seclusion.

Data are currently collected using an online survey for reporting: (1) Number of physical restraints and seclusion incidents, disaggregated by the student's jurisdiction, disability, race, gender, age, and type of placement; and (2) Professional development provided to designated school personnel related to positive behavioral interventions, strategies, supports, and trauma-informed interventions.

While these reports are welcome in providing transparency in school use of physical restraint and seclusion, they do not provide sufficient data for an analysis which MSDE can use to formulate guidance, professional development, and accountability. Further, duration of seclusion, also a crucial portion of data, is not included.

Rationale:

Kennedy Krieger Institute is home to a nationally recognized "Blue Ribbon School of Excellence" comprehensively committed to providing innovative special education and clinical services for children, adolescents and young adults with a wide range of learning, emotional, physical, neurological and developmental disabilities.

Our mission is to enable students to reach their potential academically, socially and behaviorally. We are committed to protecting all students and staff, ensuring that they share a safe environment to learn and grow. It is this commitment that requires us to provide our support in the effort to adequately and carefully regulate the use of physical restraint and seclusion.

Physical restraint and seclusion are serious, last-resort techniques for ensuring safety. Each must be carefully designed and implemented by highly trained staff. The use of these interventions must be immediately balanced against the risk of failing to intervene in the presence of imminent danger to a person. Efforts to improve safety for students, when the risk requires the use of either restraint or seclusion, must be supported. In that effort we support the necessity of oversight in the use of restraint and seclusion by licensed health care professionals, trained to assess students' physical, behavioral, and mental health. These professionals must be familiar with the interventions being applied and with the students involved.

The enhanced collection and use of data to increase student safety is also critical in the effort to reduce these procedures. It is essential that MSDE's division of Student Support, Academic Enrichment and Educational Policy be provided the resources, financial and structural, to support this mission. Expanded data collection and the beginning of meaningful analysis will allow MSDE to develop guidance, professional development opportunities, and accountability regarding restraint and seclusion. Kennedy Krieger has met with the highly committed professionals in this agency, critical to student safety, and we understand they must be given the tools, both in personnel and infrastructure they request. An unfunded mandate will not provide what all students need.

Lastly, requiring public agencies and nonpublic schools to review, improve, and report efforts to reduce the use of physical restraint and seclusion is the logical next step in any effort improving services. Kennedy Krieger employs an internal Continuous Quality Improvement (CQI) process, based on literature from clinical settings employing physical restraint and seclusion, to review all aspects of the use of restraint and seclusion in our schools. This review includes types of physical restraints, durations of interventions, as well as the comparison of trends within and across years both for individual students and student cohorts. This process is critical in understanding our success or failure in treating and educating our students. A state-wide process with the initial steps required for the analysis of these interventions should not be envisioned as a punishment for schools serving students who may present behavior requiring restraint and seclusion. Rather, it must be envisioned and supported as a state-wide CQI effort to reduce the use of physical restraint and seclusion with each individual student. Every program in Maryland would benefit from the discussion and dissemination of this work.

In consideration of all these critical issues Kennedy Krieger Institute requests a favorable report with amendment on House Bill 1255.

HB1255_FWA_Linwood Center_Ed. - Physical Restraint

Uploaded by: Pam Kasemeyer

Position: FWA

TO: The Honorable Vanessa E. Atterbeary, Chair
Members, House Ways and Means Committee
The Honorable Eric Ebersole

FROM: Pamela Metz Kasemeyer

DATE: March 10, 2022

RE: **SUPPORT ONLY IF AMENDED** – House Bill 1255 – *Education – Physical Restraint and Seclusion – Limitations, Reporting, and Training*

For more than 60 years, Linwood Center has been providing life-changing programs and services for children and adults living with autism and related developmental disabilities. Linwood currently supports children and adults on the autism spectrum from jurisdictions throughout the State of Maryland. Linwood is among the relatively few programs in the United States and in the State of Maryland that provides comprehensive education and residential programs throughout the lifespan under one service umbrella. Linwood offers program continuity from childhood into adulthood, developing lifelong relationships with individuals living with autism from elementary school through retirement and old age. Linwood's accredited nonpublic special education program and licensed residential programs provide intensive positive behavioral supports and long-term educational and vocational services to Maryland's autism community. Linwood respectfully offers its **support** for the provisions of House Bill 1255, **only if the legislation is amended**.

House Bill 1255 proposes to address the use of restraint and seclusion in the educational setting. It prohibits the use of both restraint and seclusion in public schools. For nonpublic special education schools, it provides a framework for the limited use of restraint and seclusion as a behavioral intervention for a student under certain circumstances, including a limited list of health care professionals who are authorized to use seclusion as a behavioral intervention. The legislation also requires the State Department of Education to develop an accountability system to measure compliance with provisions adopted on the use of physical restraint and seclusion.

While Linwood has no objection to establishing a statutory framework for the limited use of restraint and seclusion, it does strongly object to the failure to include licensed behavioral analysts (LBAs) in the list of health professionals authorized to use seclusion as a behavioral intervention. LBAs have the education, training, and expertise that aligns their skills and practice with those necessary to comply with the requirements of this legislation.

LBAs are licensed health care professionals regulated by the Board of Licensed Professional Counselors and Therapists. Their training is extensive and may in some cases be more rigorous than other professions listed in the bill regarding behavior for students with special needs. COMAR 10.58.16.11 explicitly states "The licensed behavior analyst is ultimately responsible for the design and

implementation of behavior analytic services that are in the best interest of the student. Behavior analysis involves the design, implementation, and evaluation of systematic instructional and environmental modifications to produce socially significant improvement." By excluding LBAs from the list of recognized health care professionals authorized to use seclusion as a behavioral intervention, the legislation not only does a disservice to the profession but dramatically undermines the ability of Linwood and other nonpublic schools and agencies to appropriately and safely address the behavior challenges faced by the students we serve.

Linwood is committed to utilizing the best practices with evidence-based methodologies in serving the needs of the children living with autism and related developmental disabilities. To that end, Linwood supports the efforts to reduce the use of restraint and seclusion that are reflected in this legislation. Linwood also supports the proposed requirements for enhanced data collection that will provide a more comprehensive and balanced understanding of the use of these interventions.

However, despite Linwood's support for the objectives of the bill and the majority of its provisions, absent an amendment to include LBAs in the list of recognized health care professionals, Linwood must respectfully request an unfavorable report. Absent authorization of LBAs, Linwood will be unable to appropriately ensure the safety and well-being of the students we serve, and it will undermine our ability to aide in the development of positive behavioral improvements. With the adoption of its requested amendment, Linwood would request a favorable report.

For more information call:
Pamela Metz Kasemeyer
410-244-7000

HB1255 Restraint and Seclusion 3.10.22.pdf
Uploaded by: Jeanette Ortiz
Position: UNF

ANNE ARUNDEL
COUNTY PUBLIC SCHOOLS
2644 Riva Road, Annapolis, MD 21401 | 410-222-5000 · 301-970-8644 (WASH) · 410-222-5500 (TDD) | www.aacps.org

HB1255 EDUCATION – PHYSICAL RESTRAINT AND SECLUSION – LIMITATIONS, REPORTING, AND TRAINING

March 10, 2022
WAYS AND MEANS COMMITTEE

OPPOSE

Jeanette Ortiz, Esq., Legislative & Policy Counsel (410.703.5352)

Anne Arundel County Public Schools (AACPS) opposes **HB1255 Education – Physical Restraint and Seclusion – Limitations, Reporting, and Training**. This bill prohibits a public agency from using seclusion as a behavioral health intervention for a student. It also prohibits a public agency from using physical restraint and a nonpublic school from using physical restraint or seclusion as a behavioral health intervention for a student, except under certain circumstances. The bill requires MSDE to develop an accountability system to measure compliance with regulations adopted on the use of physical restraint and seclusion.

AACPS supports the basic tenets of this legislation – the need to reduce restraint and seclusion, and the benefits of implementing trauma-informed decision-making, as appropriate. AACPS does not utilize seclusion within AACPS schools. However, nonpublic schools serving AACPS students use seclusion as necessary. Accordingly, the restriction on nonpublic schools will impact these schools. In addition, the district has concerns with the proposed changes to seclusion practices, which are significant, as well as some of the IEP requirements set forth in the bill. One particular area of concern is the requirement to conduct a review of a student's seclusion during a change of placement meeting or during an annual review as these meetings may not be timely. Another concern is the requirement that a health care practitioner – defined as a physician, psychologist, or social worker – be on site when a student has been secluded. It is not clear how a physician would be in a school setting on a regular basis to observe a student during a seclusion.

AACPS has concerns with and does not support the extensive reporting requirements outlined in the legislation, the additional training requirements, or the need for State intervention into local practices. While well intentioned, this bill includes a heavy documentation and accountability process regarding restraint and seclusion reporting, practices, professional development, data, and changes to practice that are burdensome and overreaching. While AACPS supports any practices that decrease the need for restraint and seclusion as well as trauma-informed interventions, this bill proposes analysis of data that is reported annually without defining what that analysis would look like, the purpose of the analysis, or who would conduct the analysis. The bill further requires changes based on the undefined analysis regardless of whether the undefined analysis is even needed. It also requires State intervention regarding the sufficiency of current training and requires that a local school system remedy any gaps identified by MSDE without providing the standards that would be required to make such a determination. Accordingly, we recommend that these provisions be stricken from the bill.

It is important to note that a 2017 task force studied this issue and released a report with recommendations on the use of restraint and seclusion. The task force, which consisted of experts on this subject matter from around the State, reached two overarching conclusions. First, it determined that the regulatory framework at

the time should be maintained except in those areas where specific revisions have been recommended. Second, the task force determined that while some areas required regulatory enhancement, others could be addressed through additional guidance from MSDE. State regulations on restraint and seclusion were amended as a result. The requirements set forth in the amended State regulations limit the use of restraint and seclusion and more clearly defined the term "seclusion", among other things. Under current regulations, physical restraint may only be used if 1) there is an emergency situation and physical restraint is necessary to protect a student or other person from imminent, serious, physical harm after other less intrusive, nonphysical interventions have failed or been determined inappropriate; 2) the student's behavioral intervention plan or IEP describes specific behaviors and circumstances in which physical restraint may be used; or 3) the parents of a nondisabled student have otherwise given written consent for the use of physical restraint while a behavior intervention plan is being developed. The regulations also specify when and how seclusion may be used. It is also important to note that physical restraint and seclusion may only be used by school personnel who are trained in their appropriate use.

Finally, this legislation also creates and unfunded mandate. AACPS will likely be required to hire additional staff to fulfill the various reporting and training requirements set forth in the bill.

Accordingly, AACPS respectfully requests an **UNFAVORABLE** committee report on HB1255.

HB 1255 physical restraint and seclusion - PSSAM O

Uploaded by: Mary Pat Fannon

Position: UNF

Mary Pat Fannon, Executive Director
P.O. Box 12040
Baltimore, Md 21281
410-935-7281
marypat.fannon@pssam.org

Bill:	HB 1255 – Education – Physical Restraint and Seclusions – Requirements, Reporting and Training
Date:	March 10, 2022
Position:	Oppose
Committee:	House Ways and Means Committee
Contact:	Mary Pat Fannon, Executive Director

This bill prohibits specified public agencies, and nonpublic schools with specified exceptions, from using seclusion and physical restraint as a behavioral health intervention for a student. Before using seclusion as a behavioral health intervention for a student in a nonpublic school, a health care practitioner must possess specified credentials, have received relevant training, and be clinically familiar with the student. If a student in a public school, or placed in a nonpublic school by the local school system, is physically restrained 10 or more times in a school year, the school must notify the local school system and the Maryland State Department of Education (MSDE) at the earliest opportunity. If a student enrolled in a public agency that is not a public school is physically restrained 10 or more times in a school year, the public agency must notify MSDE at the earliest opportunity. Among other reporting requirements is a report on the number of physical restraints incidents each student who had at least one incident disaggregated by multiple factors.

The Public School Superintendents' Association of Maryland (PSSAM), representing all twenty-four local school superintendents, **opposes HB 1255;** however, we are interested in working with the sponsor and the committee to address these concerns and work towards potential solutions.

The goal of every educator, especially special educators, is to use the least restrictive form of discipline. The use of restraint and seclusion has significantly diminished over the years, with many systems reporting that they do not use seclusion at all except in an emergency situation. Additionally, many of our special education directors indicate that many elements of the bill reflect current operations and procedures.

In 2017 the General Assembly created a task force and convened a group of experts charged with examining all practices and procedures related to behavioral interventions in school including the use of restraint and seclusion. The task force recommended comprehensive reforms that were adopted under COMAR 13A.08.04. These regulations limit the use of restraint and seclusion and more clearly defined the term "seclusion," among other things. Under the regulations restraint may only be used if there is an emergency situation and physical restraint is necessary to protect a student or other person from imminent, serious, physical harm after other less intrusive, nonphysical interventions have failed or been determined inappropriate. Second, physical restraint may only be used if the student's behavioral intervention plan or IEP describes specific behaviors and circumstances where it is necessary. Lastly, physical restraint may only be used if the parents of a nondisabled student have otherwise given written consent for its use while a behavior intervention plan is being developed. The regulations also specify when and how seclusion may be used, and that it may only be used by school personnel who are trained in their appropriate use.

These fairly recent reforms that include safety measures, parental consent, and professional development have been implemented and are having success in school systems since their enactment. They allow for the good judgement of teachers to provide the safest environment for ALL students in a classroom. Again, while the use of restraint and seclusion is extremely limited, there are situations where it is necessary. For instance, it is not uncommon that entire classes are removed from a classroom if one student is having an episode where he/she is not only a danger to themselves, but also creates an unsafe situation for the rest of the students. Not only is this a traumatic situation to witness and experience, it also is a major disruption to the delivery of education to all students.

Finally, MSDE has announced their intention to conduct a thorough review and recommend changes to the use of restrain and seclusion in schools in the coming month. We welcome this review and are happy to work with the Department by engaging some of our special education leaders to discuss current practices and identify any gaps in current practices that prompted this legislation. We strongly urge the committee to let the Department conduct their expert review without predetermined legislative mandates.

For the reasons stated above, PSSAM **OPPOSES HB 1255** and requests an **unfavorable** committee report.

HB1255
Uploaded by: Andrew Tress
Position: INFO

Maryland
DEPARTMENT OF
JUVENILE SERVICES

217 East Redwood Street
Baltimore, MD 21201

Boyd K. Rutherford
Lt. Governor

Larry Hogan
Governor

Sam Abed
Secretary

Date: **March 10, 2022**
Bill # / Title: **HB 1255 Education – Physical Restraint and Seclusion – Limitations, Reporting, and Training**
Position: **Letter of Information**

The Department of Juvenile Services (DJS or department) is providing information on HB 1255, and supports the Sponsor's amendment.

In 2021, the Maryland General Assembly passed legislation (SB0497/CH0147)[1] that established the Juvenile Services Education Program (JSEP) board. On July 1, 2022, the JSEP will oversees and provides educational programming to all juveniles placed in DJS-operated detention and residential facilities.

Unique safety risks exist within DJS detention and residential settings that distinguish the Juvenile Services Education Program from other public agencies and nonpublic schools.

The 2017 Task Force on Restraint and Seclusion[2], which informed many of the changes contained in HB 1255, did not contemplate the security considerations of DJS detention and residential programs, including the need to prevent escapes. As a public safety agency, DJS must prioritize the safety and security of our facilities, the public, and the young people within our care.

Safeguards are currently in place, including multiple reporting requirements and independent oversight of restraint and seclusion practices occurring in DJS-operated facilities.

- ✓ Extensive Monitoring and Reporting of DJS use of seclusion and restraints:
  - Juvenile Justice Monitoring Unit (JJMU) monitors all DJS facilities and issues quarterly reports, which contain detailed information on incidents of both restraint and seclusion in each DJS facility.
  - The DJS Performance Report[3], posted on the website, reports the utilization of all DJS initiatives, including the use of time out period and restraints.
  - Amendments in HB0139[4] - Correctional Education - Juvenile Services Education Program and Correction Education Teachers require JSEP to report on the use of seclusion and restraints.

The proposed amendment maintains the safety and security of detention and committed facilities, while ensuring all reporting regarding utilization is shared with the State Board.

Amendment
On page 3, after line 12 insert:
"**(A) THIS SECTION DOES NOT APPLY TO THE JUVENILE SERVICES EDUCATION PROGRAM.**";

in lines 13, 15, and 22, strike "**(A)**", "**(B)**", and "**(C)**", respectively, and substitute "**(B)**", "**(C)**", and "**(D)**", respectively; and in line 29 strike "**(D)**" and substitute "**(E)**".

On page 5, in line 1, strike "**(D)**" and substitute "**(E)**".

[1] https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0497/?ys=2021rs
[2] https://marylandpublicschools.org/programs/Pages/TFRS/index.aspx
[3] https://djs.maryland.gov/Documents/publications/DJS-Performance-Report-December-2021.pdf
[4] https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/hb0139