

David Foster, President  
Board of Education  
Dr. Patricia I. Wright, Superintendent  
Virginia Department of Education  
P. O. Box 2120  
Richmond, VA 23218

Dear Mr. Wells and Dr. Wright:

The Virginia Coalition for Students with Disabilities submits the following public comment on the proposed *Regulations Governing the Operation of Private Schools for Students with Disabilities in the Commonwealth*. We appreciate the Board and the Department allowing time for additional public comment on the proposed regulations.

If you have any questions about these comments, please contact us at 757-351-1584 or [mhollowell@endependence.org](mailto:mhollowell@endependence.org).

Sincerely,  
Autism National Committee, national  
Autism Society Central Virginia  
Autism Society of Northern Virginia  
Autistic Self-Advocacy Network, Central Virginia Chapter  
Blue Ridge Independent Living Center, Inc., Roanoke  
Children and Adults with Attention Deficit/Hyperactivity Disorder, national  
CJR Enterprises, LLC, Stephenson  
disAbility Resource Center of the Rappahannock, Inc.  
Down Syndrome Association of Greater Richmond  
Down Syndrome Association of Northern Virginia  
Endependence Center, Inc., Norfolk  
ENDependence Center of Northern Virginia, Inc.  
Fairfax Alliance for Appropriate Public Education  
Grafton Integrated Health Network, Winchester  
Independence Empowerment Center, Manassas  
Junction Center for Independent Living, Inc., Wise  
Legal Aid Justice Center, JustChildren Program, statewide  
Mathews County Special Education Advisory Committee  
National Association of Councils on Developmental Disabilities, national  
Parents of Autistic Children of Northern Virginia  
PELE Special Education Advocacy Clinic, Williamsburg  
The Arc of Augusta  
The Arc of Central Virginia  
The Arc of Greater Williamsburg  
The Arc of North Central Virginia  
The Arc of Northern Virginia  
The Arc of the Virginia Peninsula, Inc.  
The Arc of Virginia, statewide  
The Arc South of the James, Colonial Heights

The WHOLE in Autism, LLC, Centreville  
Virginia Association of Centers for Independent Living, statewide  
Virginia Board for People with Disabilities, statewide  
Virginia Down Syndrome Alliance, statewide  
Voices for Virginia's Children, statewide  
Virginia Office for Protection and Advocacy, statewide  
Wrightslaw, national

### **Virginia Coalition for Students with Disabilities**

Comment on proposed ***Regulations Governing the Operation of Private Schools for Students with Disabilities in the Commonwealth***, 8 VAC 20-670-10 et seq.

**Recommendation:** In proposed 8 VAC20-671-650 (Prohibitions), restore the proposed language prohibiting “application of aversive stimuli.” (was 9.)

**Rationale:** Aversive interventions are painful, abusive, and inhumane. They include such practices as electric shock; forcible introduction of foul or burning substances to the mouth, eyes, ears, nose, or skin; use of chlorine bleach and other chemical sprays; freezing or placement in a tub of cold water or shower; forced exercise; deprivation of senses (e.g. blindfolds, blocking devices, mitts on hands); excessively loud noises, use of enemas and similar materials when not medically needed, and the use of prolonged restraint. No person should be subjected to these highly outdated practices. These are not educational practices, and they are not effective. Rather, they are cruel punishment and mistreatment. Causing pain and suffering is never appropriate; many believe use of aversives amount to torture. It is important that every child receive a comprehensive program of positive behavioral supports. Punishment and negative reinforcement strategies incorporate the use of aversive stimuli. These strategies are not educative and have negative side effects.

The U.S. Department of Education has made one of its core principles that “Any behavioral intervention must be consistent with the child’s rights to be treated with dignity and to be free from abuse.” U.S. Dept. of Ed., *Restraint and Seclusion: A Resource Document* 15 (2012) <http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf> . As the American Association on Intellectual and Developmental Disabilities (AAIDD) has explained,

"Eliminating inhumane aversive procedures is a reflection of a growing concern for reducing actions by professionals and others that compromise the lives of persons with an intellectual or developmental disability and their families. Positive behavior support not only should reduce problem behaviors that pose functional barriers to successful life, but also enhance those behaviors that lead to self-determination, independence, productivity, and lifelong learning. Relationships between providers and consumers should foster empowerment of the consumer, enhance choice, and promote integration of persons with intellectual disability or other developmental disabilities into community settings."

*AAIDD Position Statement*, July 12, 2012, [http://www.aamr.org/content\\_169.cfm?navID=55](http://www.aamr.org/content_169.cfm?navID=55); TASH has explained the danger and dehumanizing effect of using aversives and condemned their use, *TASH Resolution Opposing the Use of Aversive and Restrictive Procedures*, 2001.

Virginia forbids the use of aversive stimuli is forbidden in certain juvenile programs, 6 VAC 35-51-580 (11); Behavioral Health regulated residential facilities, 12 VAC 35-46-10 (definition), 12 VAC 35-46-

920(11) (prohibition); and certain social services programs, 22VAC40-151-10 (definition), 22VAC40-151-820 (prohibition). For the same reasons, they should be forbidden in Virginia private schools by these regulations. Indeed, increasingly states have moved in the direction of forbidding aversives. North Carolina, for example, has adopted prohibitions on aversives in its public schools, N.C. GEN. STAT. §§ 115C-391.1.

An argument has been made that the prohibition on aversives is repetitive of a prohibition “any action that is humiliating, degrading, or abusive.” This is not true. Aversives are so painful and inhumane, that the VDOE should explicitly ban them. There should never be a question of whether they are banned in Virginia private schools or whether the term “abusive” includes all aversives. Moreover, there are a few people who have insisted over the years that aversives are proper disciplinary and behavioral measures, and therefore, not abusive. For this reason, it is important that the regulation language spell out the prohibition.

As explained below, positive behavioral interventions, including de-escalation, conflict resolution techniques, and a program of positive interventions and accommodations will effectively resolve challenging behaviors while keeping everyone safe. Schools which have implemented positive behavioral programs have been very successful. Positive approaches preserve the dignity of all individuals, and ensure that children and youth are not subject to pain and harm.

Children in private schools, particularly residential ones, need particularly strong protection because they lack the public access present in public schools with various visitors, etc. CNN and other major media have documented stories of children with disabilities in segregated public school settings who were put into abusive situations. No one knew what was happening, and the situations only came to light when other teachers found the children and reported the situations. *Parents of Special Needs Students Say School District Covered Up Abuse*, CNN, broadcast May 15, 2012; James Vaznis, *Restraining Of Students Questioned, Some Wonder Whether Schools Cross The Line*, Boston Globe, May 4, 2009. There is even less ability to report what has happened to children in residential settings, and thus, great care must be taken to be clear about all limits and to protect them from aversive practices.

**Recommendation:** In proposed 8 VAC20-671-650 (Prohibitions), restore the proposed language prohibiting prone face down restraint and add a prohibition on “restraint that is life-threatening, including restraint that restricts breathing.”

**Rationale:** Prone restraint and restraints that are life threatening are inherently dangerous and should be forbidden. The Government Accountability Office (GAO) documented the deaths of 20 students from restraint, four of whom said that they could not breathe. One young teenager with a disability died when his teacher put him in prone restraint because he would not stay in his seat. A student at a private residential school, Jonathan Carey, died because he could not breathe when a school aide sat on top of him. United States Government Accountability Office, *Seclusions and Restraints, Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers* 1, 8, 10-12 (2009).

A child in prone restraint is pinned in a prone, face-down position. Prone restraint causes suffocation. It compresses the child’s ribs so the chest cavity cannot expand, and pushes the abdominal organs up so they restrict the diaphragm and reduce the room for lung expansion. Disability Rights California, *The Lethal Hazard of Prone Restraint: Positional Asphyxiation* 17-18 (2002). The United States Department of Education has concluded, “Prone (i.e., lying face down) restraints or other restraints that restrict breathing should never be used because they can cause serious injury or death. Breathing can also be

restricted if loose clothing becomes entangled or tightened or if the child's face is covered by a staff member's body part (e.g., hand, arm, or torso) or through pressure to the abdomen or chest." U.S. Dept. of Ed., *Restraint and Seclusion: A Resource Document* 16 (2012)

<http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf> . Indeed, "Studies and organizations, including the Joint Commission on Accreditation of Healthcare Organizations, have concluded that prone restraint may predispose a patient to suffocation." National Disability Rights Network, *School Is Not Supposed to Hurt* (2009) 13. In addition to constricting breathing, prone restraint also causes other forms of positional asphyxiation, and therefore, should be forbidden.

Increasingly, states that adopt laws are including provisions banning restraints that impair breathing and prone restraint in the public schools. J. Butler, *How Safe is the Schoolhouse, An Analysis of State Seclusion and Restraint Laws & Policies* 25, 42 (Autism National Committee 2013), <http://www.autcom.org/pdf/HowSafeSchoolhouse.pdf> . Children in private schools, particularly residential ones, need particularly strong protection. Unlike public schools, they often lack public access to visitors and others who can report what has happened. CNN and other major media have documented stories of children with disabilities in segregated public school settings who were put into abusive situations, and no one knew until another teacher found the children and reported the situations. The risks of such incidents happening in residential and private day schools are high, and thus, the regulations need to provide clear, strong protection and forbid prone restraint and all restraints that impair breathing or threaten life in other ways.

Accordingly, VDOE should restore the draft regulatory language forbidding prone restraint. In addition, the regulations should also prohibit life-threatening restraint, including restraints that impede breathing. The Keeping All Students Safe Act introduced in Congress in 2009, 2011, and 2013 by Congressman George Miller and in 2011 by Senator Tom Harkin sought to ban all restraints that impede breathing. This can include prone restraint as well as other forms of restraint that obstruct the ability to breathe.

**Recommendation:** In 8 VAC 20-671-660, strengthen the language so the use of restraint and seclusion is prohibited unless there is an emergency threatening an immediate danger of physical injury and less restrictive measures have failed or would be ineffective to resolve the situation. Also clarify that restraint/seclusion may be used for violent property destruction that threatens immediate risk of physical harm and danger. Currently, the regulation does not require less restrictive measures to have failed or be deemed ineffective; and permits the use of restraint/seclusion for "severe property damage that may result in personal injury." Finally, continue the existing prohibitions on placing a person in a room from which they cannot exit in residential programs, and the proposed ban on placing any child in a room where the door is locked or blocked by furniture, equipment, etc.

**Rationale:** Restraint and seclusion are highly dangerous, resulting in death, injury, and trauma. The Government Accountability Office has documented 20 deaths from restraint alone. Children have died in seclusion, including an Atlanta child who hung himself and died in 2007. Among the reports the GAO collected were a young child who died after she was held face down by staff; kindergarten children who were duct-taped to chairs and who suffered broken arms and bloody noses; a 4 year old who was bruised and suffered traumatic stress disorder after she was restrained in a miniature electric chair by straps. Most of the reports involved children with disabilities. United States Government Accountability Office, *Seclusions And Restraints, Selected Cases Of Death And Abuse At Public And Private Schools And Treatment Centers* 5-8 (2009). The Council for Exceptional Children's Council for Children with Behavioral Disorders has described the "wide variety of injuries and deaths [that] have occurred while

students are in seclusion environments including suicide, electrocution, and self injury due to cutting, pounding, and head banging” and the “widespread” use of restraint in educational and other environments. Council for Children with Behavioral Disorders, *Position Summary on the Use of Physical Restraint Procedures in School Settings*, 34 Behavioral Disorders 223, 224 (2009); Council for Children with Behavioral Disorders, *Position Summary on the Use of Seclusion in School Settings*, 34 Behavioral Disorders 235, 236 (2009).

#### **A. Need to Implement Less Restrictive Measures Before Attempting Restraint/Seclusion**

Unlike harmful restraint/seclusion, less restrictive measures that do not impose harm can resolve challenging behaviors and virtually eliminate the need for dangerous and dehumanizing restraint and seclusion. These measures include conflict management, de-escalation, and evidence-based positive behavioral accommodations and supports. Using such techniques instead will enable school personnel to understand the needs of their students and safely address the source of challenging behaviors – a better result for everyone in the classroom. At present, over 17,000 schools across America “use Positive Behavior Intervention and Support with excellent outcomes. The benefits of Positive Behavior Intervention and Support include reduction in problematic and disruptive behaviors, increased academic achievement scores, and improved school climate and morale – all at significant savings in financial costs as well as the psychological wear-and tear on all involved.” *Beyond Seclusion and Restraint: Creating Positive Learning Environments for All Students*, Hearings Before The Senate Comm. On Health, Education, Labor, And Pensions, 112th Congress (2012) (testimony of Daniel Crimmins, Ph.D., Director, Center for Leadership in Disability, Georgia State University) <http://www.help.senate.gov/imo/media/doc/Crimmins.pdf>

For example, for over 20 years, the Montgomery Public Schools in Virginia have not needed to use restraint/seclusion except in very rare emergencies. Instead, staff use easily-accessible, evidence-based positive behavioral supports for children with even the most difficult behavioral issues and incorporate positive supports in daily work with children. *Beyond Seclusion and Restraint*, U.S. Senate Hearings (2012) (testimony of Cyndi Pitonyak, Coordinator Positive Behavior Interventions and Supports, Montgomery County Public Schools) <http://www.help.senate.gov/imo/media/doc/Pitonyak1.pdf> The Centennial School in Pennsylvania, which serves children in 35 school districts, has cut the use of restraint and seclusion from well over 1,000 occurrences per year to less than ten through the use of positive supports. *Beyond Seclusion and Restraint*, U.S. Senate Hearings (2012) (testimony of Michael George, Director, Centennial School of Lehigh University) <http://www.help.senate.gov/imo/media/doc/George.pdf> Reports and studies have also shown that students and staff are safer when positive interventions and supports, rather than restraint and seclusion, are used in schools. Worker’s compensation costs even decrease.

Frequently, the behaviors that result in restraint or seclusion can be predicted. Behavioral issues can be avoided when school staff take the time to understand what causes them, and then use this knowledge to deploy less restrictive de-escalation techniques to prevent most situations from becoming dangerous. *Senate Testimony of Daniel Crimmins, supra; Testimony of Cyndi Pitonyak (Montgomery Virginia Public Schools), supra*. The bills introduced in Congress by Senator Harkin in 2011 and Congressman George Miller in 2009, 2011, and 2013 emphasize the need to prevent the use of restraint or seclusion unless less restrictive measures would fail or be deemed ineffective, and to use them only when there is an immediate danger of physical harm.

Positive behavior supports work because they incorporate effective strategies that have been scientifically and professionally derived, incorporate the use of functional assessment leading to a behavior intervention plan that addresses the unique needs of the individual, and have an educative purpose in that they teach new behaviors.

Consequently, the proposed Virginia regulation should prohibit the use of restraint and seclusion unless less restrictive measures have failed or would be ineffective to resolve the emergency.

#### **B. Restraint/Seclusion Must Be Limited to Immediate Risks of Physical Injury, not Property Destruction That May Cause Injury**

The proposed regulations would permit restraint and seclusion for “severe property damage that may result in personal injury.” This is too weak. Because restraint and seclusion are so dangerous, they should only be used when there is an immediate risk of physical injury or physical harm. U.S. Dept. of Ed., *Restraint and Seclusion: A Resource Document 14-15* (2012) <http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf> . If the Department wishes, it could include clarifying language stating that restraint and seclusion may be used for violent property destruction that threatens immediate danger of physical injury. Most experts do not consider preventing property damage to be a valid basis for using restraint or seclusion. Instead, these practices may only be used when the threat of property destruction is violent and could result in substantial physical harm to an individual (for example, someone throwing heavy objects when others are nearby, endangering them). Reece L. Peterson (Professor, University Of Nebraska), *Developing School Policies & Procedures For Physical Restraint And Seclusion In Nebraska Schools*, A Technical Assistance Document 20 (Nebraska Dept. of Educ. 2010), [http://www.education.ne.gov/documents/Restraint-Seclusion\\_final\\_guidance\\_document\\_6-22-10.pdf](http://www.education.ne.gov/documents/Restraint-Seclusion_final_guidance_document_6-22-10.pdf) . Dr. Peterson is a nationally-known expert on restraint and seclusion, who has been asked to testify before Congress on these issues.

As Cyndi Pitonyak of Montgomery County, Virginia public schools explained, “Restraint and seclusion may be necessary tools in the immediate urgency of an emergency situation when the alternative is serious injury, but restraint and seclusion are not teaching tools. They do not prevent crisis behavior and they do not teach positive alternatives.” *Beyond Seclusion and Restraint*, U.S. Senate Hearings (2012) (testimony of Cyndi Pitonyak, Coordinator Positive Behavior Interventions and Supports, Montgomery County, Virginia Public Schools) <http://www.help.senate.gov/imo/media/doc/Pitonyak1.pdf>

#### **C. State Fire Codes and Rooms From Which Children Cannot Exit**

The proposed regulation states that the door to any seclusion room may be kept shut only when a staff member is personally securing it and must immediately disengage when the staff member steps away. This forbids placing children in rooms where the door is locked or blocked (by furniture, equipment, cheap childproofing, etc.) Virginia’s fire code prohibits placing any people in rooms from which the exit is blocked, and it is important that the regulations comply with the fire code.

#### **D. Continue the Existing Bans on Seclusion in Residential Programs**

Under current Virginia regulation, children in residential facilities may not be placed in rooms from which they cannot exit because a door is locked or blocked and they cannot open it. See 22 VAC 40-151-810 (residential facilities operated by the Department of Social Services), and programs operated by the Department of Behavioral Health 12VAC35-46-910 (residential programs operated by the Department of

Behavioral Health). Children in residential settings are in highly restrictive environments and therefore need a very high level of protection. There is no evidence that forbidding seclusion in these environments has led to any harm. Virginia should continue these bans on seclusion.

**Recommendation:** Amend proposed 8VAC20-671-630 (Behavior intervention) so that defines positive behavioral interventions as evidence-based practices, instruction, and assistance that improve academic and social outcomes, rather than defining it in terms of teaching children to manage their own behavior. Specifically, require that each school develop and implement written policies and procedures that emphasize positive behavior interventions, meaning a school-wide systematic approach to embed evidence-based practices and data-driven decisionmaking to improve school climate and culture in order to achieve improved academic and social outcomes, and increase learning for all students, including those with the most complex and intensive behavioral needs; and encompasses a range of systemic and individualized positive strategies to reinforce desired behaviors, diminish reoccurrence of challenging behaviors, and teach appropriate behaviors to students.

**Rationale:** It is too limiting to define positive behavioral supports in terms of teaching children to manage their own behavior. Appropriate positive behavioral intervention plans include comprehensive evidence-based behavioral accommodations, supports, and interventions that create a positive learning environment which improves both academic and social outcomes for students. VDOE has long promoted this view. See [http://www.doe.virginia.gov/instruction/response\\_intervention/training/institute/2012/lamm\\_nickel\\_y\\_anek/pbis\\_with\\_families\\_and\\_community.pdf](http://www.doe.virginia.gov/instruction/response_intervention/training/institute/2012/lamm_nickel_y_anek/pbis_with_families_and_community.pdf) (defining school-wide positive behavioral supports as “A framework for establishing the social culture and behavioral supports needed for a school to be an effective learning environment (academic and behavior) for all students.”) [http://www.doe.virginia.gov/instruction/response\\_intervention/training/cohort/2011/nov/positive\\_behavior\\_support.pdf](http://www.doe.virginia.gov/instruction/response_intervention/training/cohort/2011/nov/positive_behavior_support.pdf) (defining positive behavioral supports as “PBS is the application of evidence-based strategies and systems to assist schools to decrease problem behavior, increase academic performance, increase safety and establish positive school cultures.”) Addressing problem behavior is a team effort. See Functional Behavioral Assessment, Behavioral Intervention Plans, And Positive Intervention And Supports: An Essential Part Of Effective Schoolwide Discipline In Virginia 3-4 (VDOE 2005-06). Moreover, positive behavior supports incorporate effective strategies that have been scientifically and professionally derived, incorporate the use of functional assessment leading to a behavior intervention plan that addresses the unique needs of the individual, and have an educative purpose in that they teach a different behavior.

The proposed regulation needs to be brought in line with this vision. A claim that the only need is to teach children to manage their own behavior assumes that all behavior is willful and children simply need to be taught to control it. This creates a significant risk that schools will not use appropriate positive interventions and resort to dangerous restraint/seclusion when children do not control their own behavior. As noted above, the use of positive behavioral support programs enables schools to largely eliminate the use of restraint and seclusion, as well as create environments in which children can thrive and learn. As the U.S. Department of Education has determined, “Behavioral strategies to address dangerous behavior that results in the use of restraint or seclusion should address the underlying cause or purpose of the dangerous behavior.” U.S. Dept. of Ed., Restraint and Seclusion: A Resource Document 18 (2012) <http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf>



**Recommendation:** Eliminate proposed 8VAC20-671-630 (E) that would permit the inclusion of restraint, seclusion, and potentially aversives in a formal behavior management programs. Replace it with a provision forbidding the inclusion of restraint and seclusion in any student's behavior management plan (and ban aversives, as stated above).

**Rationale:** Restraint and seclusion are emergency interventions to be used only in crises in which they are necessary to prevent an imminent threat of physical injury. It is not appropriate to put them in any formal behavioral plan for students. Planned use of restraint and seclusion as an intervention is inconsistent with preventing and reducing their use; including restraint and seclusion in formal behavior management plans and programs will increase, rather than decrease their use. Instead of using less-restrictive alternatives, schools will turn to restraint and seclusion. Too often, parents have been misled into consenting to restraint and seclusion in their child's formal educational plan only to find out their children have been abused, injured, and traumatized.

Connecticut allows seclusion in children's IEPs. In 2012, the media reported that Connecticut children were confined to "scream rooms." There were some apparent injuries in the rooms and children screamed because they were traumatized. A superintendent suggested that seclusion was regularly used on an almost daily basis because it was included in the children's IEPs. Shawn R. Beals, *Angry Parents, Scared Students Seek Answers About Farm Hill School 'Scream Rooms,'* Hartford Courant, Jan. 12, 2012.

The proposed regulation seems to suggest that using such techniques would be consistent with sound therapeutic practice. "Seclusion and restraint are not evidence-based techniques. The vast majority of professionals agree that these techniques are not effective means of changing student behavior and are of no therapeutic or educational use. In fact, seclusion and restraint can escalate a child's arousal, deepen negative behavior patterns, and undermine the child's trust and capacity for learning." *Beyond Seclusion and Restraint: Creating Positive Learning Environments for All Students*, Hearings Before The Senate Comm. On Health, Education, Labor, And Pensions, 112th Congress (2012) (testimony of Daniel Crimmins, Ph.D., Director, Center for Leadership in Disability, Georgia State University) <http://www.help.senate.gov/imo/media/doc/Crimmins.pdf> ; See also *Beyond Seclusion and Restraint*, U.S. Senate Hearings (2012) (testimony of Cyndi Pitonyak, Coordinator of Positive Behavior Interventions and Supports, Montgomery County, Virginia Public Schools for 23 years) <http://www.help.senate.gov/imo/media/doc/Pitonyak1.pdf> ("Restraint and seclusion may be necessary tools in the immediate urgency of an emergency situation when the alternative is serious injury, but restraint and seclusion are not teaching tools. They do not prevent crisis behavior and they do not teach positive alternatives.") Both Dr. Crimmins and Ms. Pitonyak may be considered experts on these issues.

As stated above, the use of aversives is cruel and inhuman. Aversive stimuli have no educational or therapeutic role. They should never be used. To the extent that the proposal suggests the inclusion of aversives in a student's plan, it is wholly inappropriate and dangerous.

Finally, the proposed regulation would permit the inclusion of restraint, seclusion, and aversives in behavioral plans for severe "maladaptive" behaviors. Maladaptive behaviors can include any disruptive behaviors. The use of restraint, seclusion, or aversives for disruptive behavior is completely inappropriate. Restraint and seclusion not only should never be included in a student's individual plan, but they are emergency interventions for imminent threats of physical injury, as the proposed regulations recognize. The proposed new 8 VAC20-671-630 (E) can lead to circumventing this. It would



become an exception that swallows the rule, and allow restraint/seclusion for disruptions and other non-emergencies.

There are some who have argued that parents should be able to consent to the use of restraint, seclusion, or aversives on a routine basis. This is never appropriate. The child is the one who suffers the resulting injury, psychological trauma, and in some cases, death. The child's right to be safe and uninjured must be protected. Moreover, parents often report that they did not understand what they consented to, and that they did not expect the school to use these techniques to the extent they did. Furthermore, for children in more restrictive environments, such as private day and residential schools, there is less opportunity for interaction with the public and less ability to ascertain whether restraint and seclusion are being used as default, routine procedures. Consequently, private schools do not have special circumstances that justify including restraint/seclusion in IEPs. Rather, students in private schools face particular circumstances that warrant strong protection of their rights.

While restraint/seclusion should not be included in any behavioral plan or IEP, this does not prohibit staff from having conversations to plan for crises. While restraint/seclusion should not be included in any behavioral plan or IEP, this does not prohibit staff from planning for crises. Indeed, staff should plan for crises, as this enables them to safely defuse and deescalate situations. Teachers should be taught evidence-based procedures that prevent crises and prevent dangerous behaviors from arising. These practices effectively keep all children and staff safe and avoid restraint and seclusion, according to Senate Testimony by Dr. Michael George of the Centennial School. Dr. George has been an administrator in self-contained day schools for students with disabilities for 26 of his 38 years as an educator. All of the children in his schools were considered in the top 1 percentile for aggression. He is a nationally recognized expert on these issues. *Beyond Seclusion and Restraint*, U.S. Senate Hearings (2012) (testimony of Michael George, Director, Centennial School of Lehigh University; oral testimony in response to questions, beginning at approximately 1 hour, 2 minutes, <http://www.help.senate.gov/hearings/hearing/?id=28ddb0d-5056-9502-5dea-7197eb6434c8>.)

**Recommendation:** Amend proposed 8VAC20-671-630 (Behavior intervention) to make clear that parents must consent to a behavioral intervention plan for their child, including children who are privately placed by their parents rather than placed at public expense.

**Rationale:** All children in private or public schools should receive effective positive behavior supports that are part of a comprehensive, professionally-developed plan of evidence-based positive behavioral accommodations, supports, and interventions. Functional Behavioral Assessments (FBA) and Behavioral Intervention Plans (BIP) are critical tools for identifying behaviors that interfere with the ability to learn and participate in the general curriculum, and then address those behaviors with comprehensive supports and accommodations. The parents of all students should give fully informed consent to their child's behavioral intervention plan. Nonetheless, restraint, seclusion, and aversives should never be included in any behavior management plan, for the reasons stated above. Our comment pertains only to positive behavioral intervention plans based on evidence-based practices.

**Recommendation:** In proposed 8 VAC20-671-650 (Prohibitions), add a clause prohibiting the use of restraint or seclusion that prevents a child from communicating distress or danger.

**Rationale:** It is vital that children and youth be able at all times to communicate if they are unable to breathe or are in medical distress. The GAO documented at least four cases in which verbal children

who died or were injured in restraint told staff that they could not breathe. Yet, many children with disabilities cannot speak or have difficulty doing so. A Gallaudet University survey of 37,500 deaf and hard of hearing students found that 40% used sign language as their primary method of communication. Many children with autism, intellectual disabilities, and physical disabilities also have communications impairments; a number may be nonverbal or unable to speak. Some popular estimates report that up to 25 percent of children with autism cannot speak. These, and other children, may need augmentative communication devices, which can range from simple symbol cards to dynamic computerized devices which “speak” for a child, or sign language.

To ensure that students who cannot speak can communicate medical distress, a number of states prohibit restraint and seclusion from impairing communication in their primary language. These include Colorado, Iowa, Maryland, Minnesota, and Kansas. J. Butler, *How Safe Is The Schoolhouse, An Analysis Of State Seclusion And Restraint Laws & Policies* 45-46 (Autism National Committee 2013), <http://www.autcom.org/pdf/HowSafeSchoolhouse.pdf> The Department of Education has likewise concluded that restraint should not be used if it interferes with the ability to communicate. U.S. Dept. of Ed., *Restraint and Seclusion: A Resource Document* 16 (2012) <http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf>

**Recommendation:** In 8 VAC 20-671-660, new B. 7, state that parents must receive oral or other notification within 24 hours, followed by a written report within 2 days including the information required in the B.8. documentation, including the date, time, staff involved, justification for restraint/seclusion, less restrictive interventions that were unsuccessfully attempted prior to using restraint/seclusion, duration and description of the methods of restraint used. The written notification should also include a description of the behavioral antecedents that occurred before the child engaged in dangerous behavior that led to emergency use of restraint/seclusion.

**Rationale:** As worded, the regulation only requires some communication within 24 hours of when restraint and seclusion are used. In some cases, oral or email notice may not be received (message left on answering machine; old email address, etc.). Given the dangers of restraint and seclusion, including the need for parents to seek medical care for concussions, hidden internal injuries, other injuries, and trauma, parents must receive actual notice. Requiring written follow-up will ensure that parents receive the notice. The elements cited above are often included in state regulations requiring written follow up. They help parents and staff understand why the incident occurred and the circumstances surrounding the use of restraint or seclusion. These elements will not pose any additional burden, as they must already be documented in the child’s records under B.8. The only different element would be describing the behavioral antecedent, which is important for learning how to prevent such episodes in the future. Generally, some states mandate written follow up within 24 hours but do not require much information in the follow up report. Other states allow more time and require the kind of information listed above, which is very useful for planning to prevent restraint/seclusion in the future and for protecting children. The Department of Education has emphasized the need for quick, effective communication with parents when a child is restrained or secluded. U.S. Dept. of Ed., *Restraint and Seclusion: A Resource Document* 21 (2012) <http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf>

**Recommendation:** Add a new provision requiring that after each use of restraint or seclusion, the school shall convene a debriefing or review meeting to review the incident, consider relevant information, plan to prevent and reduce reoccurrence of the use of physical restraint and seclusion and recommend appropriate positive behavioral interventions and support.

**Rationale:** A debriefing is a meeting that occurs after an incident of restraint or seclusion. Debriefings are one of the six “core strategies” for decreasing the use of seclusion and restraint, according to the National Association of State Mental Health Program Directors (NASMHPD). Kevin Ann Huckshorn, Six Core Strategies To Reduce The Use Of Seclusion And Restraint As A Planning Tool (The National Association of State Mental Health Program Directors 2005). Debriefings help reduce and eliminate seclusion and restraint by analyzing the event, how it could be avoided, and by planning for and implementing positive approaches. *Medicaid Program; Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under Age 21; Interim Final Rule*, 66 FED. REG. 7148, 7152 (Jan. 22, 2001).

**Recommendation:** Add a new provision requiring the collection and reporting to the Virginia Department of Education the following data each year: the total number of incidents in which restraint or seclusion were imposed upon a student; and the total number of incidents in which restraint or seclusion resulted in injury to students or school personnel.

**Rationale:** Data collection will enable better informed decision-making. It will enable administrators to analyze trends within the school to ensure restraints and seclusion are used very rarely and to examine ways in which positive programs can be fully implemented. Data collection will ensure that schools follow the requirements of the regulation and provide important sunshine. Florida required data collection of its public schools in 2010 and the Orlando area school district virtually eliminated seclusion and cut its restraint use by nearly 2/3.

**Recommendation:** Adopt definitions of mechanical and pharmacological restraint. (A) Define Mechanical Restraint to mean the use of devices as a means of restricting a student's freedom of movement, and does not mean does not mean devices used by trained school personnel, or used by a student, for the specific and approved therapeutic or safety purposes for which such devices were designed and, if applicable, prescribed, including-- (1) restraints for medical immobilization; (2) adaptive devices or mechanical supports used to allow greater freedom of mobility than would be possible without the use of such devices or mechanical supports; or (3) vehicle safety restraints when used as intended during the transport of a student in a moving vehicle. (B) Define Pharmacological Restraint as a drug or medication used on a student to control behavior or restrict freedom of movement that is not--(1) prescribed by a licensed physician, or other qualified health professional acting under the scope of the professional's authority under Virginia law, for the standard treatment of a student's medical or psychiatric condition; and (2) administered as prescribed by the licensed physician or other qualified health professional acting under the scope of the professional's authority under Virginia law.

**Rationale:** We applaud the regulations for banning dangerous mechanical and pharmacological (chemical) restraints. Children have been traumatized, injured and killed by these restraints. Children have been placed in mechanical restraints and then locked alone in seclusion rooms—highly dangerous situations. In one situation, an Alabama second grader was found in a bathroom hanging from a restraint chair, having wet herself. The dangers of chemical restraint have been known since they were documented by the Hartford Courant in 1998. The proposed VDOE regulations do not appear to define mechanical and pharmacological restraint. We would suggest the definitions used in the Keeping All Students Safe Act, introduced by Senator Tom Harkin (S.2020, 112th Congress, introduced 12/16/11), <http://hdl.loc.gov/loc.uscongress/legislation.112s2020>. These definitions are very useful because they also appropriately clarify the circumstances under which devices and pharmacological agents are, and are not, restraints.

**Recommendation: Retain the current draft 8VAC20-671-620 (Student Conduct) requiring private schools to have policies to prevent disability harassment and procedures for enforcement.**

**Rationale:** Harassment of students on the basis of disability is a serious problem and every school must address it and prevent it. The only studies about a connection between bullying and developmental disabilities have determined that children with disabilities were 2-3 times more likely to be bullied than their nondisabled peers. One study found that 60 percent of students with disabilities reported being regularly bullied compared with 25 percent of all students.

<http://www.pacer.org/bullying/resources/students-with-disabilities/> Disability harassment also violates Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. For this reason, the proposed language should be retained.