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Professional Practice and Ethical Issues Related to Physical Restraint and Seclusion in Schools

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Abstract
Use of physical restraint and seclusion procedures in schools continues to be controversial, and foster proposals for federal and state legislation and regulation. Despite much discussion about what policies are needed, there has been little discussion about the professional practice issues and the ethical issues related to these practices. The purpose of this report is to present six clusters of professional practice and ethical issues that have not heretofore been specifically identified. To do so, we will examine the codes of professional practice and ethics of organizations representing educators who work with students with severe behavioral challenges. To illustrate these issues, we use real-world case examples from media stories and official reports about problems resulting from restraint and seclusion. Although individuals may disagree regarding decisions about these ethical issues, these questions should be a part of any policy discussion related to professional practice regarding these issues, and they have rarely been addressed in the restraint and seclusion policy debate. In addition, they are also questions that must be examined by all professional educators for them to assure adherence to the professional practice and ethical codes for their field.

Keywords: physical restraint, restraint, seclusion, professional ethics, ethics

Challenging behaviors ranging from noncompliance to extreme disruptive or dangerous behaviors can be a symptom associated with certain disabilities. Such behaviors interfere with students' learning, disrupt the instructional environment, and may pose threats to the safety and well-being of students and adults. In some situations, when these behaviors are so extreme that they threaten the safety of the student or others, educators may use either physical restraint or seclusion to help manage these aggressive or otherwise challenging behaviors and prevent injury. Restraint and seclusion have a long history of use within mental health and correctional settings. However, recent concerns regarding their safety, efficacy, and suitability for use with children, particularly in public schools, has resulted in the introduction of federal legislation in each session of U.S. Congress since 2009 (U.S. House of Representatives, 2015; U.S. Senate Health, Education, Labor & Pensions Committee, 2014).

Prior discussions have debated the merits and risks associated with the use of seclusion and restraint (e.g., National Disability Rights Network, 2009; Ryan & Peterson, 2004, 2012). The purpose of this report is to examine professional practice and ethical considerations associated with these procedures. We describe six clusters of potential ethical issues and policy and practice questions related to each cluster. In addition, to stimulate thought and discussion, we provide real-world examples of situations where restraint or seclusion have been used in school settings derived from media reports. The ethical issues and questions discussed here should become part of the ongoing policy and professional debate on these topics. In addition, these questions should influence ethical decisions of individual staff members regarding their own behavior in situations where the use of these procedures is considered.

Given the lack of consistent state and federal policy or guidelines regarding the use of seclusion and restraint in schools, it is unlikely that there would be consensus regarding professional conduct and ethical issues around this topic. "Ethics is a subject about which honorable people may differ" (Cohen, 2012, p. 7), but each professional who may be involved with restraint or seclusion has the

obligation to engage in careful thought and analysis of the professional and ethical issues related to these procedures. To date, the professional literature has had almost no discussion of these ethical issues.

Definitions

Researchers have found that even the terminology and definitions related to physical restraint and seclusion can vary significantly among existing policies and guidelines (Ryan, Peterson, & Rozalski, 2007). Hence, for this article, we define restraint, seclusion, professional ethics, and foundational ethics as follows:

Restraint

Restraint refers to any method used to restrict an individual's freedom of movement, physical activity, or normal access to his or her body (International Society of Psychiatric- Mental Health Nurses, 1999). Ryan and Peterson (2004) describe three different forms of restraint: ambulatory, mechanical, and chemical. *Ambulatory restraint*, commonly referred to as *physical restraint*, involves care providers using their bodies to restrict the movement of an individual. *Mechanical restraint* means limiting movement with a device or object, and *chemical restraint* refers to the use of medications to calm the individual or restrict the possibility of movement. Although schools have used forms of mechanical restraints with students, for the purposes of this article, the discussion will be primarily focused on physical restraints. Furthermore, momentary physical intervention to avoid imminent danger (e.g., stopping a child from running into the path of an arcing swing) is not considered "physical restraint" for purposes of this discussion.

Seclusion

In seclusion, the student is removed from the environment and placed in confinement alone in a room or area for a period of time in which they are physically prevented from leaving (Council for Children With Behavior Disorders [CCBD], 2009b). Seclusion is differentiated from the accepted behavioral technique of timeout from positive reinforcement (Gast & Nelson, 1977) in terms of location and design of the seclusion setting, length of seclusion, and the purpose for using the procedure.

Ethics

Sturmey (2005) discusses ethics within the context of interventions for individuals with disabilities, describing ethics as a code of professional conduct. The existence of a code of ethics to guide the conduct of members may be a key criterion that differentiates a profession from an occupation (Fiedler & Van Haren, 2009). Professional codes of ethics typically define what members of the profession should do (e.g., be competent in professional practices, maintain integrity and concern for welfare of those served by the profession) and what members should not do, such as engage in illegal or unethical behavior. Other sources that define ethical behavior for professionals are standards of practice or practice guidelines developed by professional organizations or governmental agencies (Sturmey, 2005). Professional codes of ethics may, in some cases, be supported by laws or policies that allow regulatory bodies to sanction, censure, suspend professional licensures or certificates, levy fines, or take other steps as a consequence for behaviors that violate the official standards of practice.

Some professions promote "foundational ethics" that may be determined by the values and cultural practices of a society (Sturmey, 2005). An example of foundational ethics is a societal or cultural belief that society has a responsibility to educate its children; many societies have laws to support that belief, and a foundational ethic among many educators is the basic goal for all students is to learn and succeed. The medical profession adheres to the basic foundational principle of *primum non nocere*, or "first, do no harm" (Yin, 2008). But Yin also points out that physicians cannot operate solely from a perspective of not doing harm because most medical practices are inherently risky. For this reason, ethical decision making in the practice of medicine is also guided by other basic principles, including the principle of beneficence, which requires health care providers to balance benefits of treatment against potential risks or harm.

Ethical Guidance Related to Restraint and Seclusion

For guidance on ethical behavior related to restraint and seclusion, educators and others who work in school settings may look to their professional organizations or to certification or licensure boards, many of which have articulated foundational principles. These are often formalized within codes of ethics or codes of conduct. The Council for Exceptional Children (CEC; 2010) and the Council for Administrators of Special Education (CASE; 2010) call for their members to be highly competent and maintain integrity while exercising professional judgment (CEC, 2010). The National Association of School Psychologists (2010) expects members to engage only in professional practices that maintain the dignity of all individuals. Some members of the Division of School Psychology of the American Psychological Association have called for more specific ethical practice guidelines for school psychologists specifically related to restraint and seclusion but have not stipulated what these guidelines should include (Yankouski, Masserelli, & Lee, 2012).

Some professional groups have adopted specific positions on the use of restraint and seclusion. These positions range from calls for bans on the use of restraint and se-

clusion (e.g., The Alliance to Prevent Restraint, Aversive Interventions, and Seclusion [APRAIS], 2005), to support for restraint and seclusion on the grounds that these are a legitimate part of a comprehensive behavior intervention program (Association of Professional Behavior Analysts [APBA], 2009) or that the procedures are necessary for school safety (American Association of School Administrators, 2012). The Autism National Committee (1999) opposes using physical restraints and seclusion at any time, viewing these procedures as restricting the civil and human rights of people with disabilities and arguing that the use of physical restraint is a failure in treatment. APBA (2009) and the Association for Behavior Analysis International (ABAI; Vollmer et al., 2011) have each adopted official positions in support of restraint and seclusion as professional tools that can be therapeutic or protective for children who exhibit challenging behaviors. Both organizations differentiate between misuse of restraint and seclusion and correct and ethical use of the procedures for safe management of dangerous behaviors. Both stipulate that restraint and seclusion should only be used as part of a comprehensive intervention plan, with careful monitoring and oversight.

The Autism Society (2013) supports federal legislation intended to protect students from misuse of restraint and seclusion, and call for restraint to be used only in situations of imminent danger of injury and carried out by trained staff. The American Association of School Administrators (Pudelski, 2012) opposes legislation that prohibits restraint or seclusion, taking the stance that these techniques are necessary to maintain some students in public school; without them, these students would be relegated to more restrictive settings. The National School Boards Association (Resnick, 2012) argues that state and local school boards should establish their own policies, opposing federal legislation to ban or restrict use of restraint and seclusion.

Some groups take a middle ground, offering practice guidelines to define parameters for use of the procedures. For example, CCBD neither opposes nor endorses the use of restraint and seclusion but instead offers practice guidelines that should be followed if the procedures are used (CCBD, 2009a, 2009b). APBA (2009) and ABAI (Vollmer et al., 2011) also offer practice guidelines, all in an effort to better balance the benefit-risk equation, articulate guiding principles that should drive decision making about any intervention, delineate circumstances under which restraint and seclusion may be indicated, and describe procedures that should be followed to minimize risk.

Ethical Issues Related to Restraint and Seclusion

Using pertinent elements from the previously described professional codes of ethics, professional practices, or position statements, we identified six clusters of important professional/ethical issues related to the use of seclusion and restraint in schools. These are (a) potential for death or injury, (b) failure to use the least intrusive intervention and evidence-based practices, (c) inappropriate restrictions on liberty and removal from access to education, (d) repeated use of restraint or seclusion as the failure of programming, (e) disproportionate use with certain critical groups, and (e) insufficient training, supervision, and monitoring. We use examples from media reports regarding restraint and seclusion to illustrate each issue. In addition, we pose questions to stimulate further professional discussion regarding ethical issues. Although the media reports are from reputable sources, we recognize that situations that end up in the media are sometimes sensationalized. Nevertheless, these are actual examples that should provoke professional practice questions regarding the use of seclusion and restraint.

We acknowledge that policies and procedures can be violated, misapplied, or abused. It would be convenient to dismiss these media cases as being isolated instances of violations of procedures or outright abuse, but the volume of such cases in media and official reports appears to indicate that the problem is not simply one of a few rogue educators violating clear or commonly understood guidelines.

Issue 1: Potential for Death or Injury

Restraint and seclusion have been associated with instances of child death, and adult injuries. In 2012, the *New York Daily News* wrote about 16-year-old Corey Foster who died during a restraint in a school for students with emotional and developmental disabilities (Wills & Jacobs, 2012). The student apparently became aggressive following a basketball game during which he attacked a staff member. School staff subdued the youth with an eight-person prone restraint. During the restraint, Corey suffered cardiac arrest. Corey's case, and many of the others highlighted later in this manuscript, illustrates the fact that use of seclusion or restraint can result in injury or even death. The Child Welfare League of America (2004) estimated that between 8 and 10 children in the United States die each year due to restraint, and numerous others suffer injuries ranging from broken bones to bites. A U.S. Government Accountability Office (GAO; 2009) report spoke to the difficulty of determining precisely how many children and youth die each year from restraints or seclusion. The authors of the report described finding "hundreds of cases of alleged abuse and death" (GAO, 2009, p. 2) from restraint and seclusion, although they were unable to verify an exact number due to the lack of any centralized or consistent reporting requirement for this type of monitoring. The leading reason cited by opponents of physical restraint is the potential for injury and death (APRAIS, 2005), with most deaths caused by asphyxiation, aspiration, and massive release of catecholamines leading to cardiac arrhythmias (Mohr, Petti, & Mohr, 2003).

In addition, many have speculated that use of these procedures may themselves cause psychological trauma, particularly for students who may have been abused or neglected (APRAIS, 2005). Even if no physical injuries result from restraint or seclusion, it may be much less clear about whether there may also be psychological injuries, and if so, what the nature, extent, and duration of such damages might be.

Similar to the physician's ethical principal to "do no harm," educators must consider the potential benefit of implementing seclusion or restraint versus potential risk of injury or death. CEC's (2010) Ethical Principles for Special Education Professionals states that members are committed to "neither engaging in nor tolerating any practice that harms individuals with exceptionalities," but also to maintain the official stance that physical restraint may be needed as an emergency procedure (CEC, 2009). The potential for serious injury or death due to asphyxiation during restraints has led to calls to ban prone and supine restraints that can inhibit an individual's breathing (CCBD, 2009a, 2009b), and many leading crisis management training programs no longer include training in prone restraints (Couvillon, Peterson, Ryan, Scheuermann, & Stegall, 2010). Although seated restraints, sometimes called a "basket hold," have been promoted as a safer alternative to prone and supine restraints, these types of restraints have also been associated with a number of child deaths and injuries (Kliewer, 2002).

In addition to calls for safer versions of physical restraints, CCBD and others have called for improving safety monitoring during restraints. One such safety issue is to have all appropriate educators trained in cardiopulmonary resuscitation (CPR). Another is to ensure the availability of a portable automatic electronic defibrillator (AED). Relatively easy-to-use methods are available for monitoring signs of physiological danger during restraints (Masters & Wandless, 2005), including use of a pulse oximeter to monitor blood oxygen levels, frequently checking the student's vital functions, and involving more than one adult to conduct the restraint, with at least one adult specifically responsible for monitoring the student's well-being (CCBD, 2009a, 2009b). Couvillon and colleagues (2010) reviewed crisis intervention training programs and found that the all restraint-training programs reviewed provided varying degrees of training in monitoring students' physical states and symptoms of physical distress during restraint, but none reported training in use of pulse oximetry or AED. To our knowledge, no studies have assessed the prevalence of safety-monitoring procedures, fidelity of use of such procedures during restraints, or laws or policies requiring use of monitoring devices during restraints. According to the National Conference of State Legislators (2010), 16 states have laws requiring or encouraging placement of AEDs in schools, partially as a result of student deaths during athletic activities, but these laws do not specifically mention restraint or seclusion.

Most professional practice guidelines for restraint and seclusion urge parental consent for use of the procedures. In 2008, *CNN* reported on Jonathan King, a 13-year-old boy who hung himself in a seclusion room with the cord a teacher gave him to hold up his pants (Franz, 2008). According to reports, the boy had been repeatedly placed in seclusion; however, Jonathan's parents were unaware of the use of seclusion with their son. School staff had only informed the family that Jonathan was placed in "timeout" for misbehaving. The 2009 GAO report identified 10 verified cases of abuse or death from restraint or seclusion and concluded that one common theme across these cases was that parents did not give consent for the procedures to be used.

These issues and examples raise a number of ethical questions. The first and most critical question is whether it is ethical for educators and others who work with children to use *any* procedure that has demonstrated potential for death or injury to a child or youth. Professional organizations such as CCBD, APBA, and ABAI all stipulate that informed parental/guardian consent is essential, which raises the question of whether parents/guardians are fully informed of the potential myriad of problems, including death (e.g., cardiac arrhythmias, asphyxiation, aspiration) or injury (e.g., broken bones, bruises, scratches, rug burns) that can arise during a restraint. Would requiring the use of safety mechanisms during restraints sufficiently offset the risk? Is it sufficient that restraints that are known to be dangerous are no longer included in training programs, or might evidence eventually substantiate that those dangers can also apply to other forms of restraint, such as basket holds? Finally, is it ethical to use risky procedures when virtually no research exists regarding the full extent of those risks? Is it ethical to assume that certain forms of restraint are safer, without research to support that assumption?

Issue 2: Failure to Use the Least Intrusive Intervention

Often, restraint and seclusion result from a failure to use techniques that may have prevented the behaviors that eventually led to restraint or seclusion, or failure to use effective early interventions at the first sign of inappropriate behaviors. One case that illustrates this principle is that of 7-year-old Angellika Arndt, who died following a 98-min prone floor restraint performed at a mental health day-treatment facility (Reynolds, 2006). The restraint was performed by staff members, initiated because Angellika was blowing bubbles in her milk during lunch period. School staff initially elected to implement a seclusion timeout where Angellika fell asleep after be-

ing placed in the room. Following further noncompliance to staff requests to sit on a chair in the seclusion room, she became agitated at which time staff members physically restrained her in the chair. These actions further escalated Angellika's behavior, which led to staff placing her in a prone floor restraint that continued for 98 min. During the restraint, the child vomited and lost control of her bodily functions. The autopsy from the medical examiner ruled Angellika's death resulted from complications of chest compression asphyxia (suffocation) and cardiopulmonary arrest.

Angelikka's case highlights a number of professional/ethical issues, including the failure of the staff to use a hierarchal behavior management plan of less intrusive interventions prior to utilizing high risk interventions, such as seclusion and restraint. This tragic sequence of events, apparently initiated as a result of minor noncompliance, potentially could have been avoided through the use of a number of less intrusive techniques to respond to the bubble- blowing behavior. Furthermore, if bubble-blowing behavior led to the seclusion timeout, that response raises questions about the staff's knowledge of developmentally appropriate techniques for managing such behavior. The fields of positive behavior interventions and supports and applied behavioral analysis offer a substantial collection of evidence-based interventions for preventing or managing challenging behaviors. These interventions include functional assessment and functional analysis (Hanley, Iwata, & McCord, 2003); antecedent interventions such as offering choices (Kern, Vorndran, & Hilt, 1998), providing stimulus prompts (Phillips & Vollmer, 2012), altering schedules and routines through interventions such as behavioral momentum (Nevin & Shahan, 2011), manipulating stimuli thought to influence motivating operations (Vollmer & Iwata, 1991) through techniques such as presession access to reinforcement (O'Reilly et al., 2009), establishing communicative skills through functional communication training (Carr & Durand, 1985), reinforcement interventions to strengthen prosocial alternatives to challenging behaviors, behavior reductive procedures such as timeout or response cost procedures, and finally, response interruption or redirection.

Reliance on evidence-based practices is a common theme in professional codes of ethics of special educators and related service professions, and the techniques listed above meet that expectation. However, Day (2002) and Ryan and Peterson (2004, 2012) concluded that there is little empirical evidence to support the efficacy of restraint for any purpose, therapeutic or otherwise.

Given that safe and proven methods exist for prevention and early intervention in challenging behaviors, it seems that ethical practice would require that all professionals who interact with children who exhibit challenging behaviors be competent in the use of these techniques; in fact, competence in one's field is a foundational ethical principle articulated by many professional organizations, including CEC and CASE. This begs the question of whether general educators and support staff, and even special education professionals who work with these students, are knowledgeable about and skilled in use of these preventive techniques. Also, is it potentially contrary to the ethical principle of reliance on proven practices to use interventions, such as restraint and seclusion, for which little to no data exist to document efficacy?

Issue 3: Inappropriate Restrictions on Liberty and Removal From Access to Education

Some of the media cases we reviewed reflect an important theme in the debate over restraint and seclusion, which is whether these procedures pose potential violations to basic human, constitutional, and civil rights. A 2008 *CBS* news report provided details of how a sixth-grade student with attention-deficit/hyperactivity disorder named Chris was continuously thrown into a dark closet on numerous occasions at California's Mendenhall Middle School (Werner, 2008). The student claimed his teacher would put him in the closet by twisting his arm behind his back and shoving him into the confined space, which served as a seclusion room. Chris purported he was placed in the "Quiet Room" a lot, including once for an entire school day, and was kept from escaping by staff members who either sat on the other side of the door or by placing a chair up against the door.

Most courts have not objected to the use of physical restraint and seclusion in school settings unless there is an egregious violation of those students' rights (e.g., *CN v. Willmar Pub. Sch.*, 2010). However, the Courts ruled in *Wyatt v. Stickney* that patients in mental health settings have a "constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition" (*Wyatt v. Stickney*, 1971). Decisions about the restriction on a person's freedom of movement or their confinement have hinged on that person being provided appropriate treatment for the conditions causing their behavior. It is much less clear what the criteria are for educational treatment in the schools.

A related human and civil rights issue is the fact that restraints and seclusion may result in students being removed from the educational environment for significant amounts of time. In 2008, *CNN*'s investigation of seclusion rooms highlighted Isabel Loeffler, an 8-year-old girl with autism who was placed in timeout and left alone for 3 hr for failing to finish her reading assignment (Crumb, 2008). Although no data exist to substantiate the average duration of restraints or seclusions, numerous examples of inappropriately long restraints or seclusions appear in media stories and advocacy/government reports (GAO, 2009). This is a serious concern, especially for students with special needs who are typically already per-

forming grade level academically, and whose academic deficits may be a contributing factor to their challenging behaviors (Sutherland & Wehby, 2001).

Education is a basic right of children, declared by the United Nations (1959), UNICEF (n.d.), and Individuals With Disabilities Education Act, which established the right of children with disabilities to a Free Appropriate Public Education (FAPE). Certainly, best-practice guidelines for restraint and seclusion call for brief and limited applications, for use only as part of a multi-component intervention package that includes function-based reinforcement contingencies and team-based decision making about criteria for use of restraint and seclusion (e.g., APBA, 2009; CCBD, 2009a, 2009b; Vollmer et al., 2011).

Issue 4: Repeated Use of a Potentially Dangerous and Ineffective Intervention

A 2009 *Texas Tribune* article investigating the use of restraints in schools posted photographs of 20-year-old Jenifer Howson, a student with intellectual disabilities who suffered contusions over most of her body, including the face, limbs, and back from being restrained dozens of times while in a public school (Ramshaw, 2009). Jenifer's case highlights an important concern for advocacy groups that question why an intrusive intervention such as restraint is used repeatedly. Certainly, ongoing use of any behaviorreductive intervention is an indicator that the intervention is not working because its purpose is to change the behavior in such a way as to no longer need the behavior intervention. The President's New Freedom Commission on Mental Health (2003) stated that high rates of restraint should be viewed "as evidence of treatment failure" (p. 45). Reports from advocacy and professional organizations state that repeated use of restraint or seclusion constitutes a failure of educational programming (CCBD, 2009a; National Disability Rights Network, 2009). According to the CCBD statement on restraint,

> Repeated use of physical restraints for any one student or … across different students should be viewed as the failure of educational programming and the likelihood that … interventions for the students are inadequate and should be modified. (CCBD, 2009a, pp. 14–15)

Uncorrected failure of educational programming raises questions about potential violation of educational rights for children with disabilities.

These issues raise numerous relevant questions. First, if confinement of a child or youth for extended amounts of time constitutes inappropriate restrictions on liberty, what is the threshold for such a violation? At what point does a restraint or seclusion become an inappropriate restriction on liberty? Also, does the use of methods that potentially interfere with significant amounts of instructional time pose a violation of children's basic right to an education? How long a time in seclusion is too long, thus interfering with the child's right to an education? How many instances of restraint or seclusion should trigger a review of potential violation of the child's right to an education or before it is considered "repeated use" and, thus, potentially a failure of programming? Finally, should these questions be answered locally, perhaps by students' Individualized Educational Planning teams, or should criteria be defined in policy or law?

Issue 5: Disproportionate Use With Certain Critical Groups

Recent data demonstrate the disproportionate use of restraint and seclusion with students who belong to certain minority groups, or those who are disabled according to civil rights data published by the U.S. Department of Education (2012). In a sample of 38,792 students, students with disabilities comprised 12% of the reporting sample; of those students who were restrained, 69% were students with disabilities. In one part of the survey (n = 25,053), just over half the population were White, 24% were Hispanic, and 18% were African American. However, 42% of students in the sample who had been secluded were Hispanic. Mechanical restraints were also disproportionately applied to minority students. African American students comprised 21% of the sample, yet 44% of the population who had been subjected to mechanical restraints.

Evidence clearly indicates that most school disciplinary procedures are disproportionately applied to minority students and students with disabilities (Council of State Governments Justice Center, 2011; Skiba, Michael, Nardo, & Peterson, 2002). Although the causes of these disproportionalities are elusive, many believe that this represents civil rights violations (Advancement Project, n.d.; American Civil Liberties Union, n.d.). If the thesis that disproportionate use of a procedure constitutes a civil rights violation is accepted, then it also stands that the long term disproportionate use of these procedures, given the fact that they entail serious risks, should also be considered ethically unacceptable.

Disproportionality has been the basis for calls from many groups for reforming school discipline practices and recently was the basis of a "Letter to Colleagues" from the U.S. Office of Justice & U.S. Department of Education (2014). Reforming restraint and seclusion practices may be needed for the same reasons, and the "Guiding Principles" set out by the U.S. Department of Education (2014) may also be useful in reforming the use of physical restraint and seclusion. Treatment decisions should not be made on the basis of the groups to which the student belongs, and continued disproportionate application of restraint and seclusion procedures with certain groups should raise questions about the overall efficacy of education practices for those groups.

Issue 6: Insufficient Professional Training, Supervision, and Monitoring

The GAO (2009) report on the use of seclusion and restraint in schools found that teachers and staff involved in restraints that resulted in injuries or death often had insufficient or no training in the procedures. This is not surprising given that it is widely acknowledged that more students with mental, emotional, and behavioral disorders than ever before are being served in public school settings (National Research Council & Institute of Medicine, 2009). Most students with significant behavioral disabilities spend all or part of their day in general education settings (U.S. Department of Education, 2011). These facts suggest that many students who exhibit challenging behaviors may be taught by individuals with less than extensive, advanced training in the sophisticated techniques known to effectively mediate severe challenging behaviors. Furthermore, ineffective programming may act as antecedent conditions for challenging behaviors (Couvillon et al., 2010). At the same time, many educators who work with students who exhibit challenging behaviors receive training in crisis management programs. Lacking knowledge of, or skills in, other, more effective intervention strategies, it is conceivable that educators may rely on the tools in which they have been trained (e.g., restraint and seclusion), and may apply those interventions to control challenging behaviors, even before the behaviors escalate to the point of an emergency or real threat to safety.

Intervention research documents effective strategies for managing extreme challenging behaviors, including the techniques described previously. Also, many professional organizations state that restraint and seclusion should be considered emergency procedures, used only in cases of clear and imminent danger (APRAIS, 2005; CCBD, 2009a, 2009b). Reallife interpretation of student behaviors from moment to moment requires extensive knowledge of challenging behaviors, experience with individuals who exhibit challenging behaviors to better understand the trajectory of those behaviors, knowledge of a comprehensive array of strategies to prevent or redirect these behaviors, and the ability to engage in swift decision making about whether precipitating conditions meet threshold criteria for an emergency.

A 2012 article in the *Palm Beach Post* told the story of a mother who was suing the Palm Beach County School District because it failed to ensure the safety and security of her 10-year-old son from its employees who applied a prone restraint to control him (Ross & Schultz, 2012). A number of witnesses reported seeing the child restrained by having his arms held tightly behind his back. Aside from the questions of what level of staff training is appropriate, there are significant concerns regarding the level of supervision and oversight provided in schools regarding restraint and seclusion. In hospitals, review boards routinely examine specific medical interventions provided, reviewing for appropriateness and concordance with scientific and professional standards. Moreover, incidents in which patients die or become more ill during treatment typically receive special procedural oversight and evaluation. In law enforcement, incidents involving the use of weapons or deadly force typically receive special analysis and review to determine whether appropriate procedures were followed. Unfortunately, there is little evidence that any similar mechanism exists for procedural review of restraint or seclusion in school settings in spite of the call for such oversight by professional organizations (e.g., CCBD, 2009a).

These issues raise a number of potential ethical questions. Do current restraint and seclusion training and implementation procedures reflect professional ethical guidelines and standards of practice? Is it ethical practice to place children and youth with significant behavioral challenges in general education settings where personnel have not been trained in evidence-based preventive or early intervention techniques? A foundational ethical principle of many professional organizations is member competence, skill, and professional judgment. Does research suggest that competence in using physical restraints is achieved by completing a training program in which one demonstrates use of restraints in a controlled setting? Does demonstrated competence in applying restraint and seclusion procedures during training constitute a sufficient criterion for real-world use of these procedures? Other potential ethical questions relate to relying on budget limitations to plan staff training or minimum safety standards for restraint and seclusion and allowing a practice that has the potential to result in death or injury to students to remain unregulated by federal law.

Finally, one key argument in favor of restraint and seclusion is that the techniques are needed to ensure a safe environment. Safety must be a driving concern, but perhaps technology has not evolved to sufficiently meet that need. Thus, is it ethical to use a potentially risky practice simply because we do not yet have a better solution?

Conclusion

We identified six clusters of important professional/ethical issues related to the use of seclusion and restraint in schools and associated ethical questions. In each cluster, there exist multiple, complex, and often interrelated issues. If completely effective behavioral programming could be provided, with excellent training of staff and appropriate resources provided, these techniques would likely rarely (if ever) be needed. But because the "real world" does not often operate under these circumstances, we are left with potential issues that have not yet been adequately addressed in the debate over use of restraint and seclusion.

Educators must manage challenging behaviors by selecting effective interventions. But because even the best plans may not prevent all behavioral crises, staff members should have high levels of expertise and experience in making quick decisions regarding the least intrusive response required to maintain safety and to follow safety precautions during any response. Furthermore, educators must also insist on adequate resources, appropriate staffing, and sufficient training in preventive techniques.

Honorable professionals may differ on ethical issues, yet we all seek to provide maximum benefit and minimize risks to our clients. We hope that our discussion here will assist educators and other school personnel to carefully consider their policies, and their decisions on these topics, but we also believe that thought and analysis by each individual professional is needed for all of us to maximize our "beneficence" to our students. Furthermore, we encourage professional groups to consider these issues as the basis for a call-to-action for more comprehensive, robust training for all personnel who work closely with students who exhibit challenging behaviors.

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