ETHICALLY GUIDED PROCEDURES OF PHYSICAL AND MECHANICAL RESTRAINT FOR STUDENTS WITH SPECIAL NEEDS

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Introduction

Self-injurious behavior (SIB) can manifest in many topographical forms. Physical harm to oneself may be overtly displayed by hitting, scratching, cutting, ingestion, deprivation, and satiation, among many others. Some of these problem behaviors are maintained by attention, escape, social, sensory, access, and automatic reinforcement. When an individual engages in SIB, methods of restraint may be necessary to assuage and abate problematic behavior. Severe SIB that may cause tissue damage must be addressed immediately by stakeholders in the person's environment by employing drastic response blocking to prevent any further harm to the individual. Additionally, these behaviors may harm others or the environment and impede the development and practice of socially significant and acceptable behaviors for the client. “The intended purpose of physical restraint…in schools is to intervene in a crisis when the behavior of a student poses an immediate or imminent, and significant threat to physical safety" (Bartlett & Ellis, 2021, p. 195).

Behavior analysts must abide by the BACB ® Ethics Code (BACB ® Code). At times, restraint may be a necessary component of therapeutic intervention for the safety or development of a patient. Though the BACB ® Code does not speak specifically to restraint, research, and therapeutic techniques have, presently and historically, been included for maladaptive and developmental behaviors.

The Helen J. Stewart School (Stewart School) is a facility that offers learning and behavioral services for students within the fifth largest school district in the United States, Clark County School District, from the Las Vegas, NV metropolitan area. The students at this facility range from 6 to 22 years of age and are characterized as "nonverbal." The school facilitates functional communication training for all students to build a repertoire of individualized self-management behavior. Developmental diagnosis of the student population consists of Phelan-McDermid Syndrome, Fragile X Syndrome, Williams Syndrome, Down Syndrome, Autism, and other speech, auditory, visual, cognitive, orthopedic, and comorbid disorders. The Stewart School employs special education teachers, behavior analysts, instructional aides, technicians, and psychology and orthopedic specialists to care for their students.

Lindsey Chapter, Special Education Instructional Specialist and Facilitator for the Stewart School addressed the various forms of restraint used within the facility and the procedural guidelines for ethical and legal compliance with district, state, and federal regulations. The restraint procedures and treatments at the Stewart School are treated under the guidance of the student-specific orthopedic specialist only after prescribed by the specific individual's medical doctor. Students at the Stewart School may be treated with physical, mechanical, protective, and other forms of restraint for behavior change or orthopedic correction and facilitation (L. Chapter, personal communication, April 3, 2023). Though many applications can be employed to address SIB, such as time-out, extinction, replacement reinforcement, calming areas, and chemical restraint, the scope of this document broadly discusses the ethical use of physical and mechanical restraint techniques for clients who exhibit behavioral and developmental challenging behaviors in classroom settings in a public school district and the ethical considerations for a behavior analyst operating in tandem with organizations outside the scope of the BACB ® Ethics Code. Literature reviews supporting and opposing restraint procedures with summative implications will also be discussed.

Physical Restraint

Mandated procedures for using restraint and aversive interventions in public school and treatment settings must follow the federal guidelines in the Individuals with Disabilities Education Act. The State of Nevada Department of Education policy related to the use of restraint within a school setting differentiates three categories of restraint for special needs students within the school setting: physical restraint, mechanical restraint, and aversive interventions. *Physical restraint* is defined as physical contact that limits a person's mobility; *mechanical restraint* is defined as the use of devices to restrict or limit a person's mobility; *aversive conditions* are explicitly delineated in the policy to include shock, deprivation, positive and negative punishment procedures, exclusionary time-out, amongst others (State of Nevada Department of Education, 2020, p.10). Physical restraint sometimes referred to as personal restraint, "involves caregivers' physically securing and holding body parts so that problem behavior cannot occur, and caregivers often use it after an episode of problem behavior has begun…[or] an antecedent

intervention in situations where problem behavior is highly likely to occur" (Fisher et al., 2021, p. 305). This intervention would be employed for a person engaged in SIB or destructive behavior to the environment or other persons, decreasing the risk of injurious behavior immediately. "One form of physical restraint, called a basket-hold time-out, involves confining the student in a chair or placing the student face down on the floor while restraining the student's arms. This form of physical restraint protects the student or others" (Magee & Ellis, 2001, p. 501). "Research findings on the basket-hold…indicate that it is effective in treating disruptive behavior" (Grace, Kahng, & Fisher, 1994 as cited by Magee & Ellis, 2001), but should be used sparingly and only if the student is in immediate danger of harming himself or others.

To clarify this type of restraint that may be intimidating to novice teachers and healthcare providers, Jennifer Geissinger, Assistant Principal and Special Education Specialist in the Clark County School District provided the following hypothetical scenario implementing the current ethical procedures for addressing the use of physical restraint in the classroom:

> If a student in the classroom begins to display SIB, such as banging their head into the desk, a split-second risk assessment would determine immediate intervention that should be administered to protect the student. The teacher could begin by placing a blanket, pillow, or other absorbing textured device on the desk to prevent tissue damage from the resulting force of the student's head making contact with the hard surface. The teacher will administer physical restraint if that action is unavailable to protect the student. An example would be utilizing a basket-hold (arms around the student), limiting the access of the head to a hard surface but not holding the neck or head directly. Additionally, the teacher must protect their head from damage if the student continues to display the problem behavior. After either intervention (blanket protection or physical restraint), and the level of risk to the student is controlled and does not show probable harm to themselves or the environment, communication must be made to an attending administrator, nurse, parent, and other stakeholders. In addition to the attending teacher, an instructional aide would facilitate any intervention or communication required for the scenario if present. Also, all responsible parties must complete a Clark County School District 624 (appendix a) within 24 hours. This document contains antecedent conditions, environmental conditions, parties present, and the duration of the crisis response. If the behavior is not isolated, IEP revision, an FBA, and BIP will be implemented (J. Geissinger, personal communication, April 24, 2023).

In addition to the external application of physical restraint, a person who exhibits stereotypic behavior and SIB may physically restrain themselves (self-restraint) in the same topographical form and function as physical or mechanical restraint. Cooper et al. (2020) discuss the classification of self-restraint

(e.g., sitting on one's own hands) as either a substitute for SIB or can act as positive reinforcement, recommending further research of the behavior. Additionally, an essential distinction between restraint and response blocking should be stated. "Physical restraint restricts or limits an individual's movement, unlike response blocking, which only prevents the response. Results of several studies have shown that numerous variations of physical restraint effectively reduce problem behavior" (Cooper et al., 2020, p. 354).

Mechanical restraint

In addition to physical and protective restraint, "mechanical restraint involves securing limbs and body parts with devices designed for this purpose, such as four-point restraints, arm splints, and straight jackets…to stop ongoing episodes of problem behavior, but they can also use it as a proactive, antecedent intervention" (Fisher et al., 2021, p. 305).

Head trauma can be a common form of SIB for individuals within special needs populations. Deshais et al. (2015) conducted a multielement design with 10 participants and measured target behavior responses correlated with bare arms, empty splints, or stays. The study incorporated the least restrictive fading to observe a decrease in the target behavior. "The goal of the current study was 3-fold: (a) to extend previous research on RRA [rapid restraint analysis] by reporting RRA results for 10 participants and investigating post-RRA outcomes, (b) to investigate whether the RRA might have the potential to eliminate the need for restraint fading altogether for some individuals, and (C) to investigate whether the RRA might help to identify a starting point for restraint fading for individuals for whom fading is necessary" (p.845). The research is a valuable source of information that depicts the specific and unique intervention plans associated with each of the 10 participants. The treatment variations provide good examples of efficacious restraint procedures in future studies or therapeutic usage.

Morgan et al. (2015) conducted research with a young autistic boy and the use of an arm-splint belt to reduce maladaptive behavior. The initial intervention for this study observed the effects of canvas arm splints with metal stays used with an autistic child to decrease SIB. The problem behavior was defined as hand-to-head and access to tangibles was hypothesized as a motivator for the behavior. A

multielement research design was employed for the restraining conditions. The article describes the interventions as being practical, though not formalized in data collection for the appropriate use of arm splints, stays, and belt fading to prevent SIB. The observations were collected to contribute to a better understanding of contemporary techniques of restraint utilized with special needs populations. The young participant's parents “approved of the belt, largely because it eliminated self-injury but enabled activities of daily living” (Morgan et al., 2015, p. 260).

In addition to physical and self-restraint, protective or preventative restraint may be employed to prevent future problem behavior. Banda et al. (2017) conducted research with a 14-year-old boy diagnosed with Autism and Tourette's who displayed SIB by hitting his head and face with his fist at a high rate of frequency. To control the intensity of SIB, the student was required to wear boxing gloves and headgear to prevent harming himself while hitting his face and head with a closed fist. During the concluding phases of the intervention, the student was no longer required to wear hand and head safety gear, and the intervention had faded and was not required during the maintenance probe phase.

As shown in the literature, restraint can be an effective tool to prevent SIB and harm to others or the environment if utilized ethically and under the least invasive conditions for the least amount of time. However, "[r]esearchers have not sufficiently explored the contribution of physical contact or restraint to the efficacy of other procedures" (Cooper et al., 2020, p.354). In addition to the support of efficacious restraint practice, a plethora of restraint-related research can be found in the *Journal of Applied Behavior Analysis, Behavioral Interventions*, and other peer-reviewed psychological, educational, and unique needs-related journals.

Counterpoint

Thus far, the discussion has presented the efficacious use of restraint to address problem behavior and their replacement. Due to the stigma associated with restraint procedures, many texts, documents, and informational platforms avoid using and discussing restraint altogether. The use of restraint can be aversive, overused, and stigmatized as a harmful course of action that should always be avoided in the public eye.

Trader et al. conducted a peer-reviewed qualitative research study in 2017 to survey restraint procedures used throughout the United States and recommended:

> As a nation and as a field, we are using restraint and seclusion excessively and often in non-emergency situations. This represents a failure to our students, a failure to our families, and a failure to the dedicated faculty and staff in our schools. Although implementing a ban on all restraint and seclusion may be tempting, a policy that limits the use of existing practices must be accompanied by practical, evidence-based strategies for meeting the needs of students, families, and staff in all likely conditions (p. 84).

Additionally, Maggee and Ellis (2001) observed the effects of physical restraint in managing severely disruptive classroom behavior, commenting that "[r]esults for both participants also showed the detrimental effects of using physical restraint when this common classroom intervention is applied without regard for the function of problem behavior" (p. 504).

Bartlett and Ellis (2021) conducted a qualitative study on the Canadian school system's restraint, seclusion, and time-out procedures. Thematic trends from the research revealed disparities and inconsistencies related to aversive interventions in the classroom across the nation. *Physical*, *personal*, *manual*, *self*, *preventative*, and *protective* restraint descriptors may be used circumstantially, interchangeably, or synonymous, depending on the context. Additionally, the research addresses when these treatments are sanctioned or warranted. Like defining a behavioral objective and target behavior, the authors state that ambiguity and lack of articulation related to physical restraint and other aversive conditions must be succinctly and precisely defined. *Physical, imminent, immediate, appropriate, danger, exceptional circumstances, last resort, risk,* and *crisis* are a few of the main themes the authors identified needing specific definitions to impact the application of interventions across settings and participants. Though this research was conducted in Canada, similar policy concerns exist in the United States. "The Ohio Department of Education should establish an effective system for reporting and investigation of incidents of restraint and seclusion that violate the rule" (Gray, 2016, p.9). Much like the concerns addressed by Bartlett and Ellis (2020), the lack of consistent procedures and definitions will continue to promote the negativity of restraint and aversive interventions in the court of public opinion. The inconsistencies within behavioral management and institutions of student learning are creating an

environment of negativity for restraint intervention in areas where they may be helpful and warranted to benefit a student or patient. In addition, the need for more consistency in terminology, procedures, and guidelines for recourse is skewed within states, districts, and nations.

Outside North America, United Nations policies have been scrutinized for similarities to the aforementioned qualitative investigations:

> Draconian practices such as seclusion and physical or chemical restraint frequently occur in psychiatric detention. They are often used too hastily to prevent anticipated aggression instead of de-escalation techniques, to control or punish, or merely for staff convenience... any inclusion of restraint and seclusion in mental health legislation prior to a complete ban on coercion must be severely curtailed. It must be permissible only in an emergency for the shortest period of time commensurate with any risk. Other procedural protections required are swift and regular reviews of restraint after commencement (Davidson, 2020, p. 171).

This commentary speaks to the importance of creating and implementing restraint if it is to be used ethically and consistently with persons with disabilities. Additionally, the article attests that "restraint lacks any therapeutic justification…[and estimates] 25—47% incidence of post-traumatic stress disorder aver intervention" results (Davidson, 2020, p. 171).

Early physical science, medical science, and social science constantly evolved to provide better solutions to problems. As in every scientific field, early discovery and invention have led to disastrous and catastrophic experiments that may stigmatize the specific field for many years. The behavioral sciences have withstood and evolved from primitive electric shock, insulin, and institutionalized treatment by sound scientific design and implementation to improve on the folly of the past. This research reminds behavioral science to *be better* and continue to search for meaningful treatments that are systematic, less intrusive, and generalize to all humans across the globe.

Implications and Discussion

When a Board Certified Behavior Analyst (BCBA) considers employment with a school or organization outside the BACB ®, ethically sound procedures must be addressed. Though a BCBA is beholden to the BACB ® Code, problem-solving solutions must be employed if procedural recommendations conflict. Brodhead et al. (2018) recommend that behavior analysts "evaluate…the extent to which the organization expects employees to engage in ethical conduct, and actively supports

those expectations, should be an important consideration" (p. 165). The author clarifies the positions by stating, "Behavior analysts are accountable for disciplinary action from the BACB ®, but the organization is not" (Brodhead et al., 2018, p. 165).

Fortunately, for behavior analysts, each state mandates specific ethical guidelines for assessment and intervention for SIB and restraint procedures within the school and clinical settings, many of which are congruent standard practices in alignment with federal guidelines. Dr. Brian Iwata, an international authority on SIB, discusses the protocols and procedures that detail the scope of SIB and standard practice and procedures for assessing, documenting, and recommending implementation for treatment (Autism Center for Excellence, 2015). In the interview, Iwata discusses how applied behavior analysts incorporate risk assessment, a functional behavior assessment (appendix b,c), functional analysis, behavioral intervention, guardian consent, and review board permission must approve the treatment techniques before administering those treatments to the patient. Intrusive procedures, like restraint, must be implemented from least to most restrictive for the client's comfort. Additionally, plans for replacement behavior must be implemented, and protocols for fading the restraint intervention must be administered at the appropriate time, ensuring "that practitioners implement the least restrictive procedures possible while the safety of individuals with SIB is maintained" (Deshais et al., 2015, p. 858).

Though research for the promotion, reduction, or absence of physical, mechanical, and self-restraint procedures have been documented, limited literature recommends restraint techniques being included as an early treatment intervention for any client. In addition to implementing restrictive procedures, legal guardian consent must be attained before physical, mechanical, or aversive treatment can be administered. The BACB ® Ethics Code 2.15 states:

> Behavior analysts select, design, and implement behavior-change interventions (including the selection and use of consequences), focusing on minimizing the risk of harm to the client and stakeholders. They recommend and implement restrictive or punishment-based procedures only after demonstrating that desired results have not been obtained using less intrusive means or when an existing intervention team determines that the risk of harm to the client outweighs the risk associated with the behavior-change intervention (p. 12).

As previously mentioned, the BACB ® Ethics Code does not mention " restraint " in the document. The Code advises an analyst should:

> [R]ecommend and implement restrictive or punishment-based procedures only after demonstrating that desired results have not been obtained using less intrusive means or when it is determined by an existing intervention team that the risk of harm to the client outweighs the risk associated with the behavior-change intervention (p.12).

Utilizing the least-to-most intrusive restraint coupled with differentiated reinforcement interventions that require equal or less effort is a standard recommendation for any aversive treatment. In cases where a person is an immediate harm to themselves or others, blocking those responses is paramount and necessary for the safety and survival of persons in a civilized society. Though aversive, if administered strategically, restraint may be a helpful tool that addresses a problem behavior that proves beneficial. Another critical issue within schools, clinics, and other therapeutic environments lies within the lexicon and taxonomy of classified descriptors for restraint and aversive procedures. As stated previously, physical, personal, self, mechanical, chemical, manual, and automatic are terms used to describe the different types of restraint. In the literature, some of these terms are synonymous with each other, and in many cases, they describe similar behaviors associated with aversive techniques. In order to provide the best care available, patients and practitioners of behavioral science would benefit significantly by defining and clarifying intervention techniques and the criteria for ethical usage.

Conclusion and Reflection

For the novice analyst who is unsure and less confident intervening with physical and mechanical restraint, reviewing the literature and becoming aware of the ethical procedures, current research, and therapeutic trends may help to assuage a tentative disposition. An integral aim of this document is to balance the aversive stigma associated with restraint for introductory or novice analysts. Due to the seriousness of restraint intervention, school and clinical settings share similar procedural responsibilities and approaches to providing ethical care for the student or patient and training for the therapist.

Like many districts nationwide, the Stewart School, mentioned in the introductory pages of this document, trains all staff in the legal and therapeutic protocols and procedures for administering restraint

if a student is in imminent harm to themselves or others. STAR and LINKS Teams supplement additional behavioral support, onsite Board Certified Behavior Analysts, orthopedic therapists, and special education instructional facilitators who provide ongoing, current, and practical guidance for all staff for the Stewart School. A competent network of professionals should be resourced for novice and veteran BCBA alike. Collaboration with colleagues, clients, parents, and stakeholders (Behavior Analyst Certification Board, 2020, p. 11) is required to provide our students and clients with the most effective and meaningful service. Additionally, the analyst should research, carefully prepare, monitor, and revise any intervention plan to ensure integrity and positive results for the patient.

Lastly, the novice analyst needs to revisit the BACB ® Ethics Code, which recommends an eleven-step process if an analyst may find themselves in a compromising situation:

> Behavior analysts will likely encounter complex and multifaceted ethical dilemmas. Behavior analysts should identify problems and solutions with care and deliberation when faced with such a dilemma. In resolving an ethical dilemma, behavior analysts should follow the spirit and letter of the Code's core principles and specific standards. Behavior analysts should address ethical dilemmas through a structured decision-making process that considers the full context of the situation and the function of relevant ethics standards (p. 5).

Training, research, collaboration, and education provide a foundation for a therapist to make rational decisions, provide efficacious care, and improve the lives of clients as well as protect themselves. Behavior analysis exists to find empirically based solutions to problems of the human condition and reject harmful practices. Research shows that if restraint is to be used as an intervention, strategic planning must be in place to account for all variables and include the proper supervision, monitoring, evaluation, and timeline to protect the integrity of the client and the therapist. The physical limitation of mobility for myself evokes constrictive ideation of human function. As a novice practitioner that may have to employ physical restraint in an emergency or mediate and monitor the use of physical and protective restraints, this author better understands the scope, specific practice, limitations, and usage of the intervention. Also, administering basket-holds or other extreme response-blocking techniques to prevent a patient from harming themselves or others requires the therapist to know as much as possible about the proper techniques to prevent harm to themselves or others.

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Appendix A

Clark County School District CCF-624 Reporting Document

Clark County School District CCF-624 Rev 10/16

Notice of Use of Physical Restraint, Mechanical Restraint, or Aversive Intervention

Student Name_____ Grade Level_____ Gender_____ Race/Ethnic Code_____ *(see below)*

Student Eligibility Category _____ Incident Date_____ Time ____:____ AM / PM

School Name _____ Phone Number _____ Zone _____

Name of Person Completing Report_____ Title _____

Names and Titles of Person(s) who used restraint or aversive intervention _____

Type of Report

☐ Physical Restraint ☐ Mechanical Restraint ☐ Aversive Intervention

Reason for Restraint/Intervention

☐ Protect Physical Safety of Student ☐ Protect Physical Safety of Others

☐ Protect against Severe Property Damage Other _____

Description of Incident: _____

Duration of Restraint/Aversive: _____

Site Administrator Report *(Please complete all items)*

☐ Verified of account of incident

☐ Verified accuracy of written report ☐ Determine need for personnel action

☐ Yes ☐ No Emergency condition existed ☐ Report sent to distribution *(see below)*

Site Administrator's Signature_____ Position/Title _____ Date _____

Parent Notification

Method(s) by which parent was informed of incident_____ Date_____

Person responsible for notifying parent_____ Date _____

Copy of form and summary of statute (*page 2 of this form – available at graphics.ccsd.net*) sent to parent Date_____

Notice to Parents

If you have any concerns or questions regarding the information contained in this report, please be advised that your options include, but are not limited to:

- Contacting/meeting with the staff member(s) involved in the incident
- Contacting/meeting with the administrator(s) involved in the incident
- Contacting the Student Services Division at 799-1020
- Contacting your student's school to convene an Individualized Education Program (IEP) meeting
- Completing a Clark County School District Public Concern Form (CCF-660). This form can be obtained at any school site or from the Edward A. Greer Education Center at 2832 East Flamingo Road, Las Vegas, Nevada 89121

Please see page two of this form for a summary of the statutes describing the permissible and non-permissible use of physical and mechanical restraints, and the use of aversive interventions on students with disabilities.

District Action to be Completed After Initial Report and Notification

Board of Trustees/Designee Action: *(check all that apply)* Board or Designee Action Date:_____

☐ Denial of rights determination made

☐ No denial of rights determined

☐ Factual report forwarded to NDE

☐ Corrective action plan forwarded to NDE (within 30 days)

☐ Other_____

Ethnic Codes: ***A*** - *Asian* ***B*** - *Black/African Am.* ***C*** - *White* ***H*** - *Hispanic/Latino* ***I*** - *Am. Indian* ***M*** - *Multiracial* ***T*** - *Native Hawaiian/Pacific Islander*

Distribution: Original - Confidential Folder 2nd Copy - Associate Superintendent 3rd Copy - Parent 4th Copy - Cumulative File 5th Copy - IEP Team

This form must be faxed to Compliance and Monitoring within 24 hours of the incident (Fax Number 702-799-1066)

CCSD CLARK COUNTY SCHOOL DISTRICT

A Summary of Nevada Revised Statutes (NRS) 388.471-5315

This summary is intended to assist parents and school staff in understanding procedural requirements for compliance with NRS 388.521-5315.

Aversive Interventions

The use of aversive interventions as enumerated in NRS 388.473 (1-10) on a student with a disability, is prohibited, and constitutes a violation of NRS 388.471-51. Aversive interventions mean any of the following actions if the action is used to punish a student with a disability or to eliminate, reduce or discourage maladaptive behavior of a student with a disability:

1) The use of noxious odors and tastes; 2) The use of water and other mists or sprays; 3) The use of blasts of air; 4) The use of corporal punishment; 5) The use of verbal and mental abuse; 6) The use of electric shock; 7) The administration of chemical restraint to a person; 8) The placement of a person alone in a room where release from the room is prohibited by a mechanism, including, without limitation, a lock, device or object positioned to hold the door closed or otherwise prevent the person from leaving the room; 9) Requiring a person to perform exercise under forced conditions if the: (a) Person is required to perform the exercise because he exhibited a behavior that is related to his disability; (b) Exercise is harmful to the health of the person because of his disability; or (c) Nature of the person's disability prevents him from engaging in the exercise; or 10) The deprivation of necessities needed to sustain the health of a person, regardless of the length of the deprivation, including, without limitation, the denial or unreasonable delay in the provision of: (a) Food or liquid at a time when it is customarily served; or (b) Medication.

Physical and/or Mechanical Restraints

The use of physical and/or mechanical restraints on a student with a disability is generally prohibited. However, there are specific circumstances in which such restraint is "permissible," depending on the type of restraint used and the conditions surrounding its use. NRS 388.471 – 388.515 identifies those conditions in which restraints are permitted:

1. **Permissible use of restraints**, as defined in sections NRS 388.501 (1)(a-c) and NRS 388.503, do not constitute a violation of NRS 388.471-515. Additionally, emergency use of physical and/or mechanical restraint(s) is allowed, as long as all required criteria are met under NRS 388.501 (1)(a-c) and NRS 388.501 (2)(a-c).

(a) **Required criteria for permissible use of a physical restraint:**

- The restraint was used to assist a student to complete task or response, and either the student did not resist the application of physical restraint, or the student's resistance was minimal in intensity and duration or
- The restraint was used to escort or carry a student to safety due to danger in present location or
- The restraint was used to conduct necessary medical examinations or treatments on a student

(b) **Required criteria for permissible use of a mechanical restraint:**

- The restraint was used to treat the medical needs of a student or
- The restraint was used to protect a student who is known to be at risk of injury to self due to lack of coordination or frequent loss of consciousness or
- The restraint was used to provide proper body alignment to a student or
- The restraint was used to position a student who has physical disabilities in a manner prescribed in the student's Individualized Educational Program (IEP)

(c) **Required criteria for use of a physical restraint in an emergency situation:**

The restraint must have been used because an emergency existed that necessitated use of physical restraint due to immediate threat of physical injury to self, others and/or to protect against immediate threat of severe property damage

and

The restraint must have been used only for the period that was necessary to contain the behavior of the student so that the student was no longer an immediate threat of causing physical injury to self, others and/or causing severe property damage

and

The restraint must have been used in a way such that the use of force in the application of physical restraint did not exceed the force that was reasonable and necessary under the circumstances precipitating the use of physical restraint.

(d) **Required criteria for use of a mechanical restraint in an emergency situation:**

The restraint must have been used only due to immediate threat of physical injury to self

and

A medical order authorizing the use of mechanical restraint was obtained from the student's treating physician and written into the student's IEP

and

The physician who signed the order or the attending physician examined the student as soon as practicable

and

The mechanical restraint was applied by a member of the staff of the school who is trained and qualified to apply mechanical restraint

and

The student was given the opportunity to move and exercise restrained body parts at least 10 minutes for every 60 minutes of restraint unless otherwise prescribed by the physician who signed the order

and

A member of the staff of the school lessened or discontinued the restraint every 15 minutes to determine if the student would stop or control inappropriate behavior without the use of restraint

and

The record of the student contains a notation that includes the time of day that the restraint was lessened or discontinued, the response of the student, and the response of the member of the staff of the school who applied the mechanical restraint

and

A member of the staff of the school continuously monitored the student during the time that mechanical restraint was used on the student

and

The mechanical restraint was used only for the period that was necessary to contain the behavior of the student so that the student was no longer an immediate threat of causing physical injury to self.

2. **Non-permissible use of restraints** is any other use of physical and/or mechanical restraint which does not meet the criteria of the four categories, (1) (a-d) described above, and does constitute a violation of NRS 388.513.

District Requirements for Notice

Within one working day of the use of a physical or mechanical restraint in an emergency situation, the use must be reported to the student's cumulative record and confidential file. A report must also be sent to the student's Individualized Educational Program (IEP) Team, the student's parent or guardian, and the Board of Trustees/ designee of the school district.

If the Board of Trustees or designee determines that the emergency use was a "denial of rights," this determination must also be reported to the student's confidential file and cumulative record and the Department pursuant to NRS 388.513. [Note: The Open Meeting Law applies to Board of Trustees' meetings. Additionally, notice of the meeting must be provided 21 days before the meeting date.]

Within 24 hours of the occurrence of a violation, or as soon thereafter as the violation is discovered, the use of an aversive intervention or a non-permissible physical and/or mechanical restraint must be reported to the Board of Trustees/designee of the school district.

The non-emergency use of a permissible restraint pursuant to NRS 388.499 and 388.503 need not be reported.

Appendix B

CCSD Functional Behavior Assessment, Indirect Assessment

CCSD CLARK COUNTY SCHOOL DISTRICT

Clark County School District

Functional Behavior Assessment

Indirect Assessment

Student Name	Student Number	DOB
Case Manager	Date	School

Per NAC 388.386 Summarize information related to the problem behavior. Information **MUST** include; health history, previous problem behaviors and previous interventions.

Source	Information Sought	Information Gathered Pertinent to Problem Behavior
	Health History/ Medical Evaluation	Medication: Sleep Cycles: Diet: Other:
	Multidisciplinary Team Report (MDT)/ Psychological Evaluation	
	Teacher/Parent/Student Interview	
	Attendance/Enrollment History	
	Previous IEP	
	Community Agency Report	
	Previous Services and Interventions	Identify previous interventions and effectiveness

Common Sources (not an exhaustive list):

Parent Interview	*Teacher Interview*	*Student Interview*
School Nurse Report	*Attendance Records*	*Psychological Report*
Mental Health Report	*Enrollment History*	*Discipline Records*
Cumulative Folder Review	*Confidential Folder Review*	*Previous Behavior Intervention Plan*

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Appendix C

CCSD Functional Behavior Assessment Results Summary

CCSD CLARK COUNTY SCHOOL DISTRICT

Clark County School District

Functional Behavior Assessment Results Summary

Student Name	Student Number	DOB
Case Manager	Date	School

Problem Behavior	
Define Behavior:	
Setting: *(include place & time behavior is most likely to occur)*	
Antecedent: *(events that immediately precede/trigger the behavior)*	
Consequence: *(events that occur after the behavior and reinforces the behavior)*	
Setting Event: *(events that make an antecedent more likely to trigger the behavior. ex. sleep/hunger/Mondays/etc.)*	
Function: *(attention, avoidance, access to a tangible, or automatic)*	

Summary of Indirect Assessment	
Health Factors: *(Medical/Sleep/Medicine/Diet/etc.)*	
Attendance/Enrollment History	
Previous Interventions / IEPs/ BIPs / Discipline	
Parent/Student/Teacher Interviews	

Summary of Direct Assessments:	
Frequency Data	
Duration Data	
Intensity Data	

Functional Behavior Assessment Summary (Hypothesis Statement)
When_____ *(write the antecedent)*
He/she will_____ *(define the problem behavior)*
In order to_____ *(write function)*
This is more likely to occur if_____ *(write setting event, if known)*

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