Minnesota Department of Education

The Use of Prone Restraint in Minnesota Schools: January 2012 through December 2012

Fiscal Year 2013

Report

To the

Legislature

As required by

Minnesota Statutes

2012 Minnesota Laws, Chapter 146, Section 2, Subdivision 3(v)

COMMISSIONER:

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The Use of Prone Restraint in Minnesota Schools: January 2012 through December 2012

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FY 2013 Report to the Legislature

As required by Minnesota Statutes

2012 Minnesota Laws, Chapter 146, Section 2, Subdivision 3(v)

Cost of Report Preparation

The total cost for the Minnesota Department of Education (MDE) to prepare this report was approximately $26,000.00. Most of these costs involved staff time in compiling and analyzing data, staffing the stakeholder group and preparing the written report. Incidental costs include paper, copying, and other office supplies.

Estimated costs are provided in accordance with Minnesota Statutes 2011, section 3.197, which requires that at the beginning of a report to the legislature, the cost of preparing the report must be provided.

INTRODUCTION

The use of prone restraint in Minnesota schools has sparked considerable political debate in the last several years. Some argue that prone restraint is a necessary tool for preventing harm and ensuring the physical safety of staff and students while others argue that it is only a matter of time before a Minnesota child is seriously injured or killed while in prone restraint, and so conclude that its use should be banned.

In order to better understand the scope of the use of restrictive procedures in educational settings in Minnesota and the potential alternatives to their use, the legislature tasked the Minnesota Department of Education (MDE) with collecting and summarizing data on the use of prone restraint. The initial report provided a summary of prone restraint data from August 2011 through January 2012 and was delivered to the legislature on February 1, 2012. The current report provides that data from January 2012 through December 2012 and, in addition, provides summary data on the use of all reported restrictive procedures in Minnesota during the 2011-2012 school year.

The reporting school districts should be commended for their commitment and candor related to their submission of the required data to MDE. However, it must be noted that there are significant limitations inherent in the data reported. These limitations impact the usefulness of the data for purposes of comparison across years. In specific, data collected to inform the 2012 legislative report was submitted in varying forms by districts and represented only 5.5 months of the school year. The data used to inform the summary of the 2013 report was also initially submitted in varying forms by districts, until statutory language changes required that a form developed by MDE be used. Consequently, data collected and reported after July 1, 2012, represents a consistent reporting format and includes specific data items. In addition to the change in the manner in which data was reported, it is also not yet possible to compare rates of use by either calendar year, fiscal year or school year, since only 18 months of data has thus far been recorded. Data limitations will be further discussed below.

THE STAKEHOLDER GROUP

In order to better understand the opposing opinions, during the 2012 legislative session, the restrictive procedures statute was amended to include a definition of prone restraint[1] and a revised definition of physical holding.[2] Further, the statute limited the use of prone restraint to "children age five or older," but allowed continued use until August 1, 2013,[3] and required districts to report the use of prone restraint on a form provided by MDE.[4] Additionally, the Minnesota Legislature tasked MDE with developing a statewide plan "to reduce districts' use of

[1] Session Laws 2012, Ch. 146, Sec. 1(e).

[2] Session Laws 2012, Ch. 146, Sec. 1(c).

[3] Session Laws 2012, Ch. 146, Sec. 3(a)(7).

[4] Session Laws 2012, Ch. 146, Sec. 3(a)(7)(iv).

restrictive procedures."[5] MDE collected restrictive procedure summary data from the districts (including charter schools) for the 2011-2012 school year and assembled a group of stakeholders to assist MDE with developing a plan.[6] The stakeholder group includes representatives from the legislatively mandated participants, including school districts, school boards, special education directors, intermediate school districts, and advocacy organizations. The stakeholder group convened on five occasions to review the restrictive procedures data and discuss areas where agreement could be achieved on how to reduce the use of restrictive procedures. The meetings included presentations of the restrictive procedures data and small and large group discussions. The plan that was generated by this stakeholder group is attached to this report as Appendix A.

In addition to the meetings, MDE solicited opinions and ideas from stakeholder group members and others, in a variety of ways, including surveys and numerous requests for written input. It is the intent of MDE that the plan reports on the areas that have general support among stakeholders. In brief, there is general agreement on much of what is needed to reduce the use of restrictive procedures in Minnesota. However, there remains divided opinion on the safety and appropriateness of the use of prone restraint.

As requested by the legislature, the stakeholder group carefully reviewed the current law on restrictive procedures. The stakeholder group's suggestions for changes to the statute are included in Appendix A1. Again, in general there was agreement on the needed changes; however, certain disability advocacy groups noted their opposition to any continued use of prone restraints.[7]

Other members believe that prone restraint is a necessary intervention in some cases. These members believe that a longer period of data collection is necessary, during which time prone restraint should continue to be allowed in order to inform the work of the group. [8] The group

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[5] Session Laws 2012, Ch. 146, Sec. 3(b).

[6] Session Laws 2012, Ch. 146, Sec. 3(b).

[7] Jody Manning, Parent Training and Information Center Coordinator of PACER Center, writing for The ARC Minnesota, the Autism Society of Minnesota, the Minnesota Disability Law Center and PACER Center, states, "We continue to strongly oppose prone restraint as a behavioral intervention and believe it should be discontinued by state law. We support the stakeholder group's other proposed legislative changes to reduce restrictive procedures and support targeted funding toward this goal."

[8] "As special education directors, we want to confirm support for the work of the Restrictive Procedures Committee, including the date of 2017 referenced in the recommended changes to the Restrictive Procedures Statute. We feel strongly that this date enables the work of the stakeholder committee to review baseline data and put into place recommendations to reduce the use of restrictive procedures." - Jill Skarvold, Director of Learner Support Services, Moorhead Public Schools; Melissa Schaller, Director of Special Education, Intermediate School District #917; Dan Naidicz; Director of Special Education, Northeast Metro #916 Intermediate School District; Dolly Lastine, Executive Director of Special Education & Student Services, Intermediate District 287. Connie Hayes, Superintendent of Northeast Metro Intermediate School Districts, writes that NE Metro 916 ". . . is in support of the proposed changes to the statute which was developed by the stakeholder group, including the allowance for the use of prone restraint until August 1, 2017." Deborah Saxhaug, Executive Director of the Minnesota Association for Children's Mental Health, affirms, ". . .the MACMH board met and they are supportive of the changes in the restrictive procedures statute."

believes that there is a need for the group to continue to meet, discuss issues, and develop more detailed recommendations.

DEFINITIONS

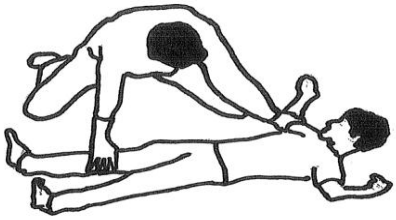
Generally, the term "**restraint**" is used to mean the **use of force to limit another person's movement**, whether by physical contact (physical restraint), with mechanical devices (mechanical restraint), or chemically by the use of drugs (chemical restraint).[9] These types of restraint are commonly referred to as "**restrictive procedures**."

In most states' laws, restrictive procedures can only be used in an **emergency**. In Minnesota, an emergency is defined as "**a situation where immediate intervention is needed to protect a child or other individual from physical injury or to prevent serious property damage**."[10]

The category of **physical restraint**, termed "**physical holding**" in relevant Minnesota law,[11] generally includes several different types of physical holds. Below are generic illustrations of common types of physical holds.

- Basket Hold: An adult holds a child from behind by the wrists with the child's arms crossed in front of the child; this can be done sitting, standing, or lying down.[12]

- Supine Hold: The child's arms and legs are held by at least two adults while child lies on his/her back.



[9] Ferleger, D. (2008). Human services restraint: its past and future. Intellectual and Developmental Disabilities, 46(2), 155.

[10] Minn. Stat. § 125A.0941, Subd. (b) (2011).

[11] Minn. Stat. § 125A.0941, Subd. (c) (2011).

[12] Seibert, C.F. (2012). Restraint-related fatalities in mental health facilities: Report of two cases. Retrieved from http://charlydmiller.com/LIB02/2000ramhf.html.

- Prone Hold: The child's arms and legs are held by at least two adults while child lies on his/her front in a face-down or face-to-the-side position.

REGULATORY HISTORY OF RESTRAINT IN MINNESOTA

The legality, morality, and efficacy of using seclusion[13] or restraint on individuals with disabilities have been debated in the United States for decades.[14] School districts have both practical and legal responsibilities to ensure a safe working and learning environment for their staff and all students, and these responsibilities provide a legitimate basis of support for the use of restraint in appropriate circumstances. At the same time, concerns exist that these procedures are subject to misapplication and abuse, placing students at equal or greater risk than their problem behavior(s) pose to themselves or others. These documented[15] concerns include the following:

- Restraint procedures are inappropriately implemented as "treatments" or "behavioral interventions" rather than as safety procedures;
- Restraint is inappropriately used as punishment for noncompliance rather than for safety or harm prevention;
- The use of restraints causes more physical harm to the student and staff involved than does the initiating problem behavior;
- Inadequate training in the appropriate use of restraint increases the risk of harm to all involved;
- Use of restraint inadvertently reinforces the triggering behavior; and
- Restraint is implemented independent of comprehensive, function-based behavioral intervention plans, which is contraindicated as an effective teaching strategy.

Regulation of Restraint in DHS Facilities

Within state government, the Minnesota Department of Human Services (DHS) historically had responsibility for children with disabilities, the majority of whom were not allowed in the nation's

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[13] Minnesota's restrictive procedures statute defines seclusion as "confining a child alone in a room from which egress is barred. Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion." Minn. Stat. § 125A.094(f) (2011).

[14] Ferleger, D. (2008). Human services restraint: its past and future. Intellectual and Developmental Disabilities, 46(2), 155.

[15] Horner, R., and Sugai, G. (2009, April 29). Considerations for seclusion and restraint use in school-wide positive behavior supports. Retrieved from http://www.pbis.org/seclusion/restraint/default.aspx.

public schools.[16] Rules governing the use of restrictive procedures in facilities licensed by DHS, commonly referred to as "Rule 40" and first authorized by the legislature in 1982, were initially promulgated in June 1987 as published at Minnesota Rules 9525.2700-9525.2810.[17] Though they have been refined over time,[18] these authorities have been relatively settled and enforced for over 20 years. As a result DHS has had a much longer history of addressing the use of restraints than has the state's public education system.[19]

Rule 40 is lengthier and more detailed than the statutes governing the use of restrictive procedures in the public education system, in part, because Rule 40 addresses the use of what is termed "controlled procedures" in situations that do not constitute an emergency.[20] Rule 40 differs most significantly from the comparable education statutes in the following ways:

- Provides a more comprehensive description of actions and procedures that are exempt from the restrictions of the rule;[21]
- Provides a more comprehensive list of "permitted but controlled procedures" such as mechanical restraint;[22] and
- Provides that even when "controlled procedures" are part of an individual's service plan, "[t]he person's primary care physician must be consulted to determine whether implementing the procedure is medically contraindicated."[23] The doctor's report must be completed 90 days before the initial development of a plan that includes a controlled procedure.[24]

In 2011, DHS entered into a settlement agreement enforced by the federal court in Minnesota regarding the inappropriate use of aversive and deprivation procedures, including the improper use of seclusion and restraint techniques. The settlement arose from a class action lawsuit involving residents' claims of abuse suffered at Minnesota Extended Treatment Options (METO), a former[25] DHS-licensed facility for developmentally disabled adults located in Cambridge, Minnesota. Pursuant to the settlement in the METO case (METO Settlement), the programmatic use of prone restraint, among many other types of restraint, are not allowed in similar DHS-licensed facilities serving residents with developmental disabilities for the purpose

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[16] Granquist, L. (2011, March 11). Educable children. Retrieved from http://www.accesspress.org/2011/03/educable-children.

[17] 11 Minn. Reg. 1355; 11 Minn. Reg. 2408.

[18] 17 Minn. Reg. 2085; 18 Minn. Reg. 1141.

[19] Feder, N. L. Congressional Research Service. (2009). The use of seclusion and restraint in public schools: The legal issues (7-5700), 8.

[20] Minn. R. 9525.2750.

[21] Minn. R. 9525.2720.

[22] Minn. R. 9525.2740.

[23] Minn. R. 9525.2750, H.1.

[24] Minn. R. 9525.2760,1.B.

[25] METO closed on June 30, 2011, and has been replaced at the same location by the Minnesota Specialty Health System – Cambridge, a new DHS-licensed facility.

of changing behavior through punishment. This prohibition is based, in relevant part, on the recognition that "asphyxiation is a risk factor" for the use of prone restraint.[26]

As part of the METO Settlement, DHS is currently undertaking a rulemaking process to amend Minnesota Rules, Parts 9525.2700 to 9525.2810, to reflect best practices regarding the use of aversive and deprivation procedures in facilities that serve persons with developmental disabilities, including through the use of positive behavioral approaches and the elimination of particular restraint practices. DHS commenced the formal process by publishing a Request for Comments Notice in the State Register on January 30, 2012.[27] DHS also convened a Rule 40 Advisory Committee in January of 2012. The Advisory Committee will meet for a final review of the recommendations on February 8, 2013. DHS anticipates making the recommendations public by the end of February 2013. Some of the high-level Rule 40 Advisory Committee recommendations are in some of this session's proposed legislation in Minnesota Statutes, Chapter 245D. Chapter 245D applies to some home and community-based waiver services. DHS will continue to move forward with additional rulemaking, repeal of current Rule 40, development of positive practices manual, and an implementation plan.

Regulation of Restraint in Minnesota Schools

As deinstitutionalization moved people with disabilities into their communities in the 1970s, the controversy over the use of restraints shifted from DHS-licensed institutions to community-based settings and eventually to schools. In 1975, Congress passed the Education for All Handicapped Children Act, renamed the Individuals with Disabilities Education Act (IDEA) in 1990; and the most recent amendments were passed by Congress in December 2004, with final regulations published in August 2006. IDEA mandates that all children be provided the right to a "free appropriate public education,"[28] and requires that children with disabilities be educated in the "least restrictive environment."[29] Under IDEA, students eligible for special education began being mainstreamed into general education classrooms in typical school environments. A small fraction of those students brought with them challenging behavioral problems which were disruptive and, at times, dangerous to themselves and/or others. Accordingly, schools began to implement various forms of physical restraint as a "disciplinary management practice"[30] and to ensure staff and student safety.

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[26] METO Settlement, Case 0:09-cv-01775-DWF-FLN, Doc. 104-1, Attachment A, p. 5 (2011). Retrieved at http://www.johnson-condon.com/documents/SettlementAgreementAttachmentA.pdf.

[27] 36 Minn. Reg. 878.

[28] 34 C.F.R. § 300.17.

[29] 34 C.F.R. §§ 300.114 - 300.120.

[30] Vital, C., Kajs, L. and Alaniz, R. (2005). Strengthening policies and practices in the use and prevention of physical restraint in schools. C. Hooker (Ed.) West's Education Law Reporter. Thompson West.

In 1993, the Minnesota Department of Education (MDE) promulgated its first rule regulating the use of restrictive procedures for children with disabilities.[31] Known as the "behavior intervention rule," the MDE rule was closely modeled on DHS's Rule 40.

The MDE rule proved controversial from the outset. As part of a legislatively mandated task force charged with reviewing many of the state's special education rules, the rule was first revised in 1995[32] in several relevant respects: (1) language was added to encourage the use of positive approaches to behavioral interventions; (2) definitions were included; and (3) regulated interventions were categorized as either prohibited procedures, which were disallowed, or conditional procedures, which could only be used if included in a special education child's Individual Education Plan (IEP) or in an emergency situation.[33] At the time, prone restraint was not specifically prohibited in Minnesota Rules, Chapter 3525, so it was considered a conditional procedure.

RECENT REGULATORY DEVELOPMENTS

Federal Developments

In 1998, the Hartford Courant published an investigative report[34] on the nationwide extent of restraint and seclusion, identifying at least 142 deaths due to the use of seclusion and restraint in psychiatric hospitals and other licensed facilities over a decade. That same year, a commissioned report from the Harvard Center for Risk Analysis estimated that between 50 to 150 individuals died each year as a result of improper restraint and seclusion, and that children were at especially high risk for death and serious injury. These publications led to increased public awareness of the use of restraint and seclusion, which led to Congressional examination of the issue.

In May 2009, the Education and Labor Committee of the United States House of Representatives held hearings that examined the misapplication of seclusion and restraint techniques in schools. At the same time, the United States Government Accountability Office released a report, "*Seclusions and Restraints: Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers*" (GAO Report),[35] which uncovered allegations of abuse and potentially deadly misapplication of seclusion and restraint techniques in schools. This document confirmed the existence of "no federal regulations related to seclusions and

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[31] Minn. R. 3525.2925.

[32] Minnesota Rules 3525.2925 was actually repealed in 1995; its content was reenacted as divided between Minnesota Rules 3525.0850 and Minnesota Rules 3525.2900. See 19 Minn. Reg. 2432.

[33] Minn. R. 3525.2900, subp. 5(A)(1).

[34] Weiss, E.M. (1998, October 11). Deadly restraint: a Hartford Courant investigative report. Retrieved from http://www.charlydmiller.com/LIB05/1998hartforddata.html.

[35] Kutz, G. Government Accountability Office, Forensic Audits and Special Investigations, (2009). Seclusions and restraints selected cases of death and abuse at public and private schools and treatment centers (GAO-09-719T). Retrieved from http://www.gao.gov/assets/130/122526.pdf.

restraints in public and private schools and widely divergent laws at the state level."[36] At the time, 19 states[37] had "no laws or regulations related to the use of seclusions or restraints in schools"[38] while 8 states[39] specifically prohibited the use of "prone restraints or restraints that impede a child's ability to breathe."[40]

On July 31, 2009, United States Department of Education Secretary Arne Duncan sent a letter (the Duncan Letter) to all Chief State School Officers encouraging each state to review and revise their policies and guidelines regarding the use of restraint and seclusion in schools to better ensure the safety of students. The Duncan Letter[41] and growing public interest in the issue motivated several states to enact legislation or policy guidance pertaining to the topic.

The Keeping All Students Safe Act (S. 2020), legislation aimed at regulating restraint and seclusion on the federal level, was introduced in the United States Senate by Senator Tom Harkin on December 16, 2011,[42] and the bill was referred to the Committee on Health Education Labor and Pensions.[43] The committee held a hearing on July 12, 2012, which focused on the potential positive alternates to restraint and seclusion.[44] Additionally, in 2011 the Substance Abuse and Mental Health Administration released a white paper titled, *The Business Case for Preventing and Reducing Restraint and Seclusion Use.* [45] This paper concludes, "Successfully reducing or preventing seclusion and restraint requires leadership commitment, resource allocation, and new tools for staff. Substantial savings can result from effectively changing the organizational culture to reduce and prevent the use of restraint and seclusion."[46]

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[36] *Id.*, at 3.

[37] Arizona, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, New Jersey, North Dakota, Oklahoma, South Carolina, South Dakota, Vermont, Wisconsin and Wyoming.

[38] Kutz, G., *Supra.* note 35 at 4.

[39] Colorado, Connecticut, Iowa, Massachusetts, Pennsylvania, Rhode Island, Tennessee, and Washington.

[40] Kutz, G., *Supra.* note 38 at pp. 4, 9.

[41] Duncan, A. U.S. Department of Education, (2009). Key policy letters signed by the education secretary or deputy secretary. Retrieved from http://ed.gov/policy/elsec/guid/secletter/090731.html.

[42] U.S. S. Comm. on Health Educ. Labor and Pensions website: http://www.help.senate.gov/newsroom/press/release/?id=872072ab-8049-4df7-b224-ac7001f77665.

[43] Libr. of Cong. website: http://thomas.loc.gov/cgi-bin/bdquery/D?d112:47:./temp/~bdmXB8::|/home/LegislativeData.php?n=BSS;c=112|.

[44] U.S. S. Comm. on Health Educ. Labor and Pensions website: http://www.help.senate.gov/hearings/hearing/?id=28ddbd0d-5056-9502-5dea-7197eb6434c8.

[45] Substance Abuse and Mental Health Services Administration. *The Business Case for Preventing and Reducing Restraint and Seclusion Use*. HHS Publication No. (SMA) 11-4632. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

[46] *Id.,at 4.*

In May 2012 the United States Department of Education published a report titled, *Restraint and Seclusion: Resource Document.*[47] The report articulated 15 principles that states and stakeholders could look to "when developing or revising policies and procedures on the use of restraint and seclusion"[48] stressing as the first principle that "[e]very effort should be made to prevent the need for the use of restraint and for the use of seclusion."[49] The majority of the 15 principles mirror those already in Minnesota statute but diverge in recommending that "… prone restraint or other restraints that restrict breathing should never be used…"[50] and in recommending that "[p]olicies restricting the use of restraint and seclusion should apply to all children, not just children with disabilities."[51]

Minnesota Developments

In 2008 the Minnesota Legislature charged an existing Special Education Task Force with recommending revisions to state rules regulating the use of aversive and deprivation procedures in schools.[52] The Task Force was made up of special education providers, advocates, regulators, lawyers, teachers, school officials, and consumers of special education services, and was convened by the Bureau of Mediation Services. During the 2008 legislative session, the convener filed a Task Force report[53] indicating that the group was unable to make final recommendations to amend the state rules given other ongoing rule processes and a lack of consensus, which was later evidenced by the filing of a non-majority report from a segment of the Task Force.

Between the 2008 and 2009 legislative sessions, the National Alliance on Mental Illness - Minnesota (NAMI) convened a group of stakeholders to continue working to update Minnesota's statutes and rules on seclusion and restraint in schools. With assistance from this group of experts, which included parent representatives, advocacy organizations, and special education professionals, a consensus-based draft of legislative language was eventually submitted for consideration and action.

The 2009 Minnesota Legislature repealed the state's existing behavior intervention rule[54] and replaced it with the consensus-based legislative language, enacted as Minnesota Statutes Sections 125A.094, 125A.0941 and 125A.0942.[55] The statutes, which were made effective on

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[47] U.S. Dept. of Educ. *Restraint and Seclusion: Resource Document* (May 15, 2012). Retrieved from website: http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf.

[48] *Id.,* at iii.

[49] *Id.,* at 12.

[50] *Id*., at 16

[51] *Id.,* at 12.

[52] The Task Force was originally established in 2007 and directed to examine state and federal special education law for the purpose of identifying where state law exceeded federal mandates. See 2007 Minn. Laws, Chapter 146, Article 3, Section 23.

[53] The Task Force report is available at http://www.docstoc.com/docs/82037224/Mindy-Greiling-house.

[54] The behavior intervention rule was then numbered Minn. R. 3525.2900, Subpart 5.

[55] 2009 Minn. Laws, Chapter 96, Article 3.

August 1, 2011, revamped the use of seclusion and restraint in public schools and reflected stakeholder compromise and agreement on definitions, a required plan, procedures, conditions, documentation, prohibitions, staff training requirements and the promotion of positive behavior interventions and supports.[56] This legislation specifically prohibited the use of "physical holding that restricts or impairs a child's ability to breathe"[57] but included no definitions specifying whether that limitation barred the use of prone restraint in all instances.

Before the 2009 legislation became effective, a Special Session of the 2011 Minnesota Legislature amended Minnesota Statute, Section 125A.0942 to address the use of prone restraint. The amendment specifically allowed the use of prone restraint within schools until August 1, 2012, if all of the following statutorily defined criteria were met.[58]

1. Prior to using prone restraint, the district must review "any known medical or psychological limitations that contraindicate the use of prone restraints" for a specific child.[59]
2. It can be used only in an emergency, defined as a situation when "immediate intervention is needed to protect a child or other individual from physical injury or to prevent serious property damage."[60]
3. It is used in a manner that does not restrict or impair a child's ability to breathe.[61]
4. Prone restraint is only used by personnel with required credentials who have completed required training.[62]
5. The district has provided to MDE a list of staff that has had specific training on the use of prone restraints.[63]
6. It is used only when prone restraint is the least intrusive intervention that effectively responds to the emergency.[64]
7. It ends "when the threat of harm ends and the staff determines that the child can safely return to the classroom or activity."[65]
8. Staff must directly observe the child while in prone restraint.[66]

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[56] Minn. Stat. §§ 125A.0940 - .0942 (2009).

[57] Minn. Stat. § 125A.0942, Subd. 4(9) (2009).

[58] Minn. Stat. § 125A.0942, Subd. 3(7) (2011).

[59] Minn. Stat. § 125A.0942, Subd. 3(7)(v) (2011).

[60] Minn. Stat. § 125A.0941(b) (2011).

[61] Minn. Stat. § 125A.0942, Subd. 4(9) (2011).

[62] Minn. Stat. § 125A.0942, Subd. 2(a) (2011).

[63] Minn. Stat. § 125A.0942, Subd. 1 (2011).

[64] Minn. Stat. § 125A.0942, Subd. 3(1) (2011).

[65] Minn. Stat. § 125A.0942, Subd. 3(2) (2011).

[66] Minn. Stat. § 125A.0942, Subd. 3(3) (2011).

9. Staff completes required documentation every time it is used, noting why a less restrictive measure failed or was determined by staff to be inappropriate or impractical and the time the prone restraint began and ended.[67]

10. The school makes reasonable efforts to notify the parent on the same day prone restraint is used on the child, or at least sends notice of its use within two days.[68]

11. Each incident of the use of prone restraint is reported to MDE within five working days, on either an MDE or a district's documentation form.[69]

12. If, within 30 days, a child is subject to a total of two instances of prone restraint or other combination constituting two instances of restrictive procedures, the district must convene the IEP Team to:

    a) "conduct or review a functional behavioral analysis, review data, consider developing additional or revised positive behavioral interventions and supports, consider actions to reduce the use of restrictive procedures, and modify the individualized education program or behavior intervention plan as appropriate;" and

    b) "review any known medical or psychological limitations that contraindicate the use of a restrictive procedure, consider whether to prohibit that restrictive procedure, and document any prohibition in the individualized education program or behavior intervention plan."[70]

13. Schools must maintain and make publicly accessible a restrictive procedures plan that: includes prone restraint; defines a monitoring and review process related to its use which includes post-use debriefings and an oversight committee; and describes and documents required staff training.[71]

The 2011 legislation did not "create" the use of prone restraint in Minnesota. School districts utilized various forms of restrictive procedures, including prone restraint, prior to the 2011 enactment as allowed by earlier forms of the behavior intervention rule. Pursuant to Minnesota Statutes, Section 125A.0942, Subdivision 3(4), districts are required to maintain documentation regarding their use of all restrictive procedures but were not legally required to report to MDE any data concerning the use of any type of restrictive procedures prior to August 1, 2011. As a result, MDE is unable to quantify how often and in what circumstances prone restraint was utilized by districts prior to that date.

MDE submitted a report to the Minnesota Legislature on February 1, 2012, detailing the results of data collected on the use of prone restraint during the 2011-2012 school year. MDE made important disclaimers about the quality of the data presented, which included the short reporting window, the lack of information about the use of other non-prone physical holding and

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[67] Minn. Stat. § 125A.0942, Subd. 3(4) (2011).

[68] Minn. Stat. § 125A.0942, Subd. 2(b) (2011).

[69] Minn. Stat. § 125A.0942, Subd. 3(7)(iv) (2011).

[70] Minn. Stat. § 125A.0942, Subd. 2(c) (2011).

[71] Minn. Stat. § 125A.0942, Subd. 1 (2011).

seclusion, and inconsistency in reporting forms, with recommendations for improvements both in data reporting and clarification on the use restrictive procedures.

During the 2012 legislative session, the restrictive procedures statute was amended to include a definition of prone restraint[72] and a revised definition of physical holding,[73] to limit use of prone restraint to "children age five or older," but allowed its use to continue until August 1, 2013,[74] and to require districts to report the use of prone restraint on a form provided by MDE.[75] Additionally, the Minnesota Legislature tasked MDE with developing a statewide plan "to reduce districts' use of restrictive procedures."[76] As noted above, MDE continued to collect data on prone restraint, gathered restrictive procedure summary data from the districts for the 2011-2012 school year, and assembled a group of stakeholders to assist MDE with developing a plan.[77]

MINNESOTA'S PRONE RESTRAINT DATA

Important Disclaimers Regarding the Data

Reporting Window. School districts have been statutorily required to report to MDE regarding their use of prone restraint since August 1, 2011. For the purpose of preparing MDE's 2012 legislative report, MDE included data from all prone restraint reports received August 1, 2011, through January 13, 2012. The current report includes data from prone restraint reports received since January 13, 2012, though December 31, 2012, with relevant comparisons to the previous data.

Not the Whole Picture. MDE acknowledged in its 2012 report that the use of prone restraint is best evaluated within the context of the statewide use of all other types of restrictive procedures by Minnesota school districts. Districts are required to maintain data on their use of restrictive procedures, including physical holding or seclusion[78] and were required to report a summary of this data to MDE by July 1, 2012.[79] As summary data, the restrictive procedures data has some limitations not present with the prone restraint data. The summary data necessarily lacks information about the range of numbers of physical holds and uses of seclusion per individual student. The data also lacks information about the length of time students were physically held and secluded and the types of restraints being used. In addition, even after multiple requests, not all districts submitted reports as required. It is important to note that the number of restrictive procedures, as self-reported summaries by districts, may not be aligned with MDE's definition of

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[72] Session Laws 2012, Ch. 146, Sec. 1(e).

[73] Session Laws 2012, Ch. 146, Sec. 1(c).

[74] Session Laws 2012, Ch. 146, Sec. 3(a)(7).

[75] Session Laws 2012, Ch. 146, Sec. 3(a)(7)(iv).

[76] Session Laws 2012, Ch. 146, Sec. 3(b).

[77] Session Laws 2012, Ch. 146, Sec. 3(b)

[78] Minn. Stat. § 125A.0942, Subd. 3 (2011).

[79] Session Laws 2012, Ch. 146, Sec. 3(b).

an “incident” of restrictive procedure, as discussed below. Therefore, incident-level comparisons between the two datasets would not likely be valid. However, as a result of the summary data, MDE is able to provide policy-makers with data to substantiate what percentage of students in the state have been reported as restricted in comparison to the data specific to prone restraint.

Inconsistent Forms. While the statute was specifically amended to require districts to report use of prone restraint on a form provided by MDE, the prone restraint dataset used to inform this document includes reports received prior to the amendment; consequently, the results include some disparity in consistency of reporting as previously noted.

Outliers. In the current dataset, 1 student accounted for 6%, or 58 of the 942 reports; 6 students accounted for 24%, or 230 of the 942 reports; and 10 students accounted for 35%, or 325 of the 942 reports of prone restraint. These figures are similar to the data reported in the 2012 report to the legislature, where 1 student accounted for 8%, or 23 of the 286 reports; 4 students accounted for 21%, or 61 of the 286 reports; and 10 students accounted for 36%, or 104 of the 286 reports of prone restraint. Of the top 10 students in the current data set, 4 students are found eligible through meeting criteria for Autism Spectrum Disorder (3% of all students restrained through the use of prone); 3 students are found eligible through meeting criteria for Emotional or Behavioral Disorders (2.5%); with the other 3 students each meeting different areas of eligibility criteria (2.5%).

Including these unique situations in the overall data counts does skew the appearance of the demographic data by incidents. However, this data is important for understanding the issues and potential solutions. The data illustrates that a relatively small number of students underlie the total number of reports and incidents. Though the specific students who make up this group change over time, services targeted to these students are likely to have the greatest impact on diminishing the use of restrictive procedures.

Prone Restraint Data

Districts submitted written reports to MDE through a secure website. Individual reports necessarily and appropriately included personally identifying information related to specific students, and as such constitute non-releasable data under the Minnesota Government Data Practices Act.[80] MDE prepared and posted a summary of reported data by quarter, which is posted at http://education.state.mn.us/MDE/SchSup/ComplAssist/RestProc/index.html.

[80] Minn. Stat. § 13.02, Subds. 5, 8a (2011).

Districts that Reported Use of Prone Restraint

District	Reports
Austin (492)	3
Bagley (162)	5
Brainerd (181)	2
Crosby-Ironton (182)	1
Elk River (728)	1
Goodhue County Ed Dist (6051)	3
Intermediate District 287	216
Intermediate District 917	207
Lake Park Audubon (2889)	1
Mankato (77)	22
Marshall (413)	59
Minneapolis (1)	1
Monticello (882)	1
Moorhead (152)	16
New London Spicer (345)	5
Northeast Metro 916	267
Pine City (578)	1
Pipestone Area (2689)	1
Rochester (535)	1
Southwest West Central (991)	77
West Central Area (2342)	4
Willmar (347)	48

Incidence of Prone Restraint, by District

Prone restraint is a type of "physical holding"[81] where a student is placed "in a face down position."[82] It begins when "body contact" or "physical contact" is initiated for the purpose of "limiting a child's movement" and ends when "body contact" or "physical contact" ends.[83] In common terms, prone restraint begins when the child is placed in a prone position by one or more trained staff persons holding onto the child; it ends when the child is no longer being held. That cycle – a hold followed by the release of the hold – constitutes one incident of prone restraint**.**

In some more complex situations related to the same precipitating incident, this hold/release pattern was repeated a number of times before the child is returned to the classroom or other activity. Given that the statutory definition of a "physical hold" is based on the presence or absence of "body contact" or "physical contact," MDE determined that this type of situation involved several incidents of prone restraint – all of which were included on one written report filed with MDE. This determination explains the difference between the number of "incidents" that occurred and the number of "reports" MDE received.

MDE received reports of 1756 incidents over the 2012 data collection period, an increase from 595 for the 2012 report to the legislature, but also covering an additional six months of data collection and reporting. Twenty-two districts reported the use of prone restraint, an increase from 21; and 256 children were involved, an increase from the data reported in the 2012 report to the legislature.

The majority of both incidents and reports involved students at one of Minnesota's three intermediate school districts. This is not surprising given that the intermediate districts provide, among other important services, a program of integrated services for special education students.[84] As a general rule, the intermediate districts provide services to special education students who have not experienced success at their original district, and a significant percentage of these students exhibit atypical behavioral challenges in a school setting.

The following two charts represent the distribution of both incidents and reports for the two full reporting periods. Again, for data collection purposes, MDE considers a report as a written form detailing the situation involving one child placed in one or more incidents of prone restraint and an "incident" as physically holding a child to limit movement, then releasing the hold or changing from one hold to another hold. A report may detail more than one incident of prone restraint.

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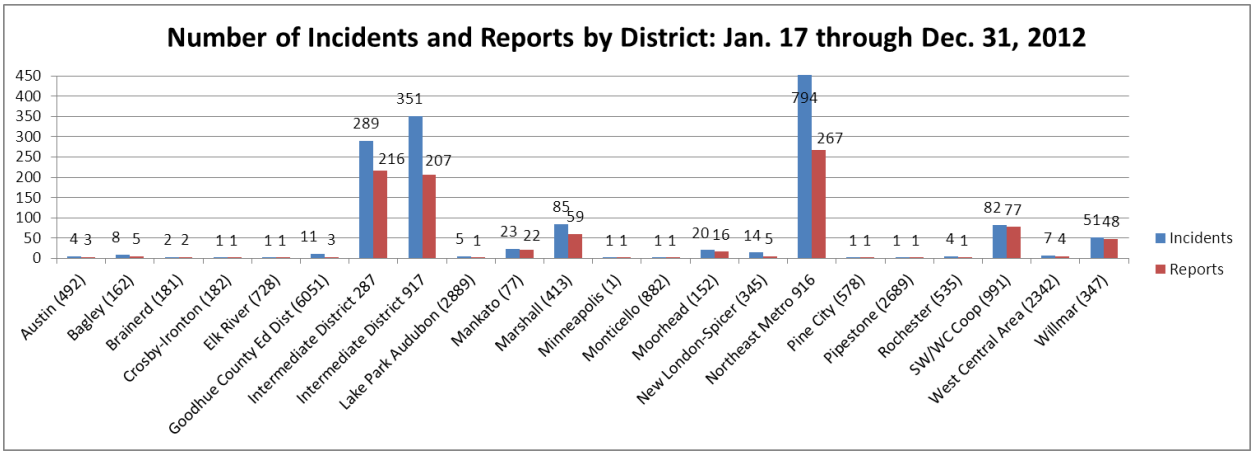
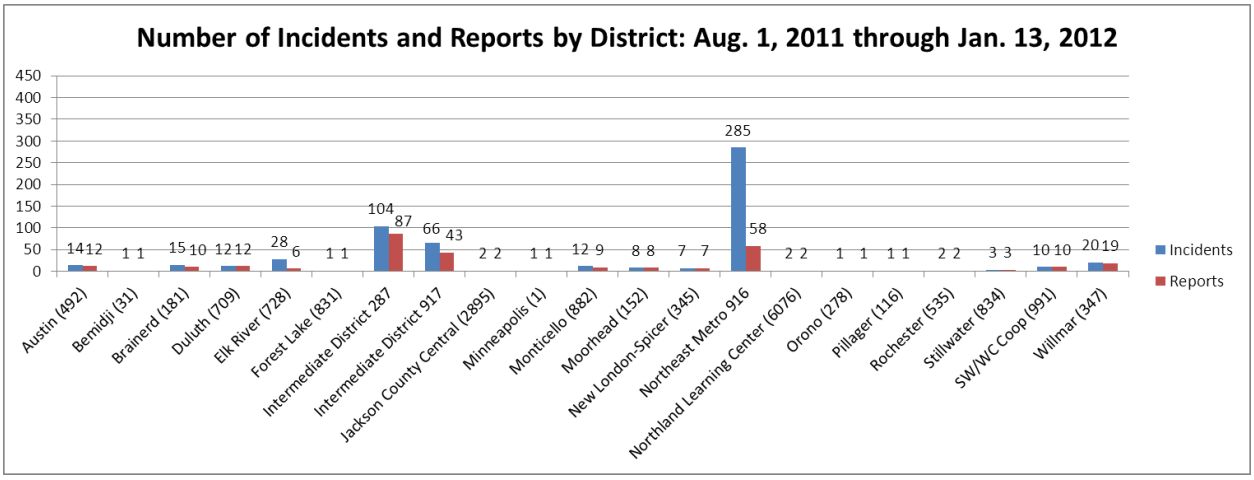
[81] *See* Minn. Stat. § 125A.0941, Subd. (c) (2011).

[82] Session Laws 2012, Ch. 146, Sec. 1(e).

[83] See Minn. Stat. § 125A.0941, Subd. (c) (2011); Minn. Stat. 125A.0942, Subd. 3(4) (2011).

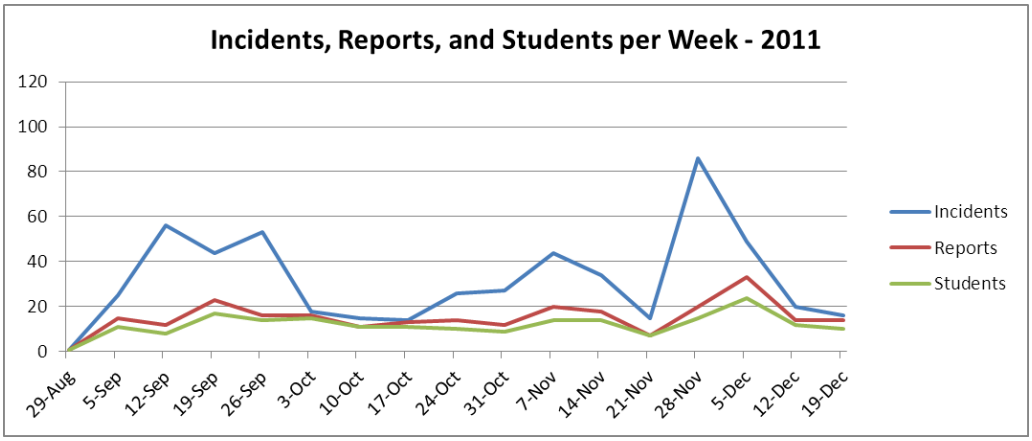
[84] Minn. Stat. § 136D.01 (2011).

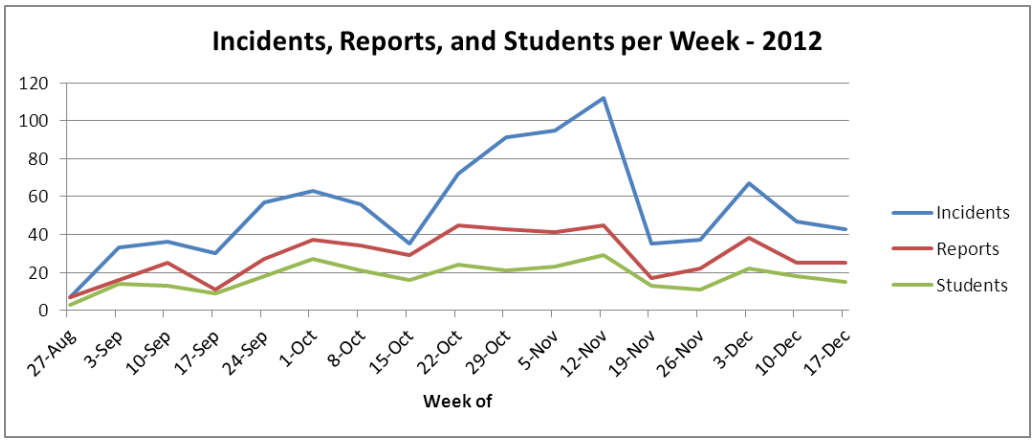




Number of Students in Prone Restraint

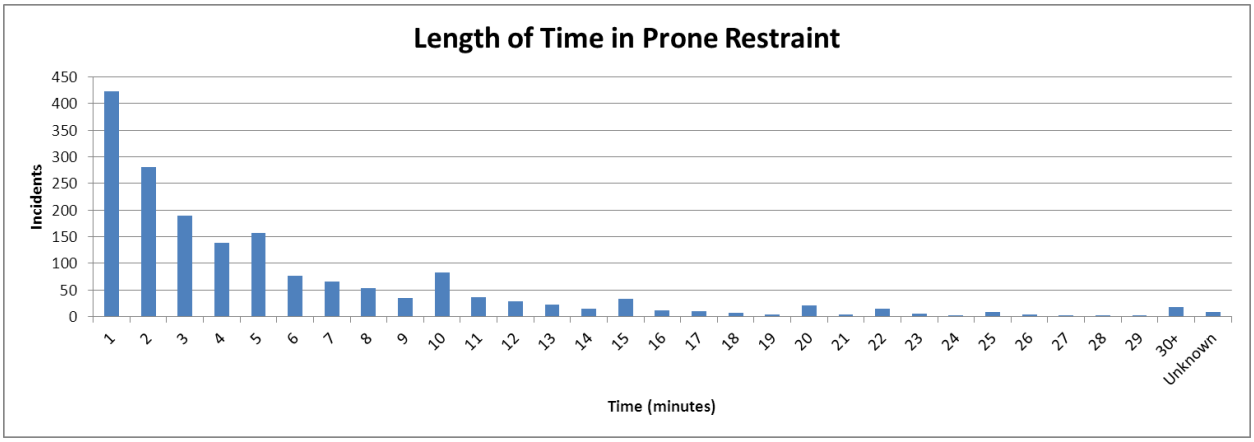
Data collection for this report reveals that 256 students were restrained through the use of prone restraint at some point during the reporting period. When considering the data in a week-by-week comparison for a parallel period in time, an increase is noted between fall 2011 and fall 2012. In fall 2011 the average number of students per week was approximately 12 students; in fall 2012 the average was approximately 17 students. In fall 2011, 99 students were reported as prone restrained; in fall 2012, 119 students were reported. Of these 119 students, 61 had also been reported as prone restrained during the 2011-2012 school year, with 29 first reported as prone restrained in fall 2011. The following graphs show the number of incidents, reports, and students per week for fall 2011 and fall 2012.





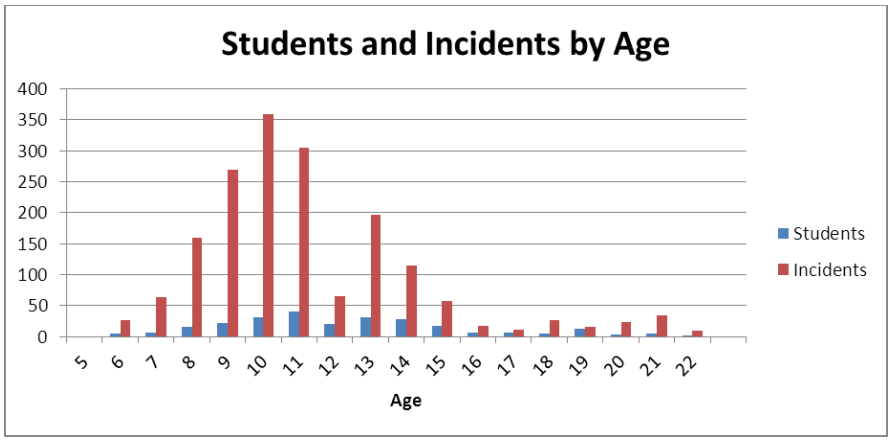
Length of Incident of Prone Restraint

The data indicates that approximately one-quarter of the 1756 incidents of prone restraint lasted for one minute or less; 68% of the incidents lasted 5 minutes or less; and 90% of the incidents lasted 13 minutes or less. While the length of time a student is in prone restraint appears to have increased when comparing 2013 data to the data from the 2012 report to the legislature, much of the difference may be attributable to the standardization of reporting.



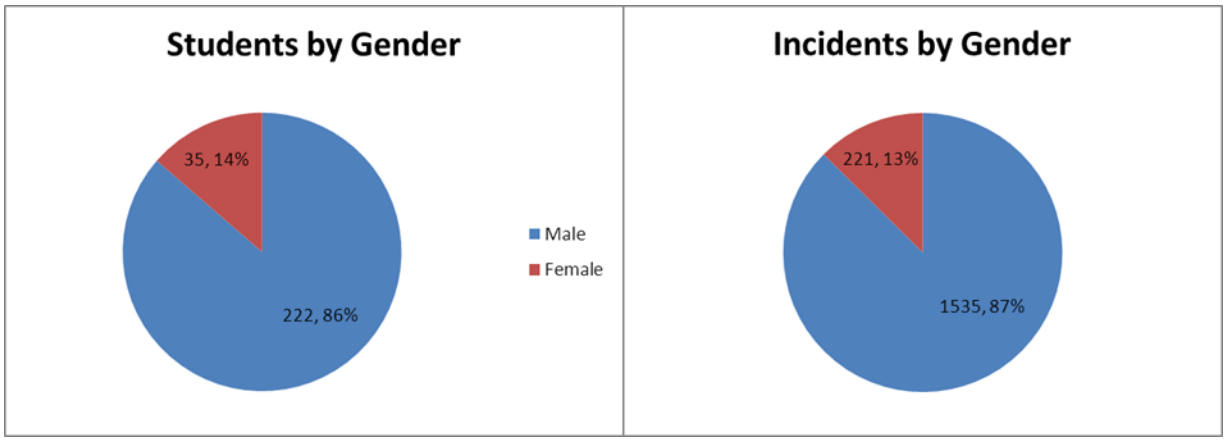
Age of Students Placed in Prone Restraint

As indicated in the following table, prone restraint was used on children as young as 6 years old and as old as 21. Consistent with the data from the 2012 report to the legislature, the relative peak usage of prone restraint by age, both by number of incidents and number of students, continues to be with 9 through 11 year old students.



Gender of Students Placed in Prone Restraint

The data shows that boys are more than 7 times more likely than are girls to be restrained in a prone position.

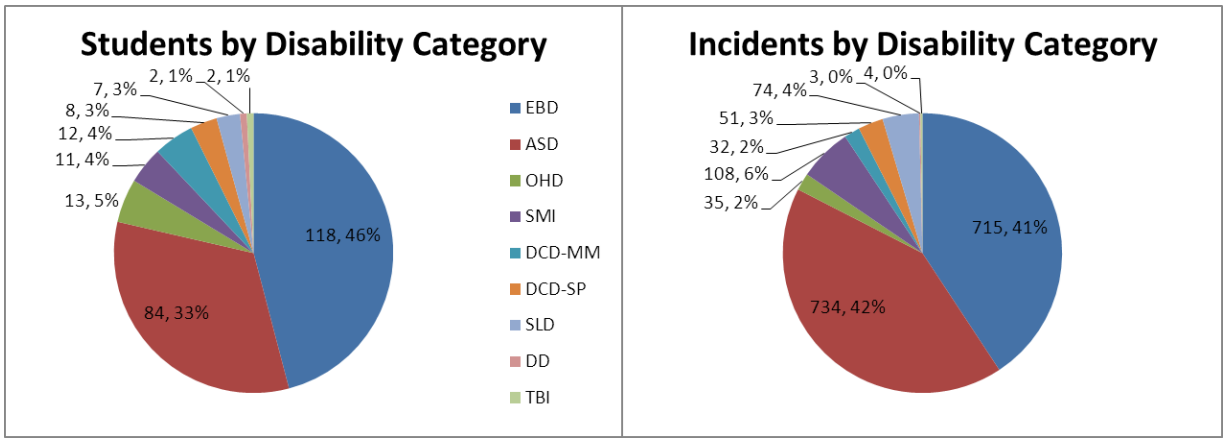


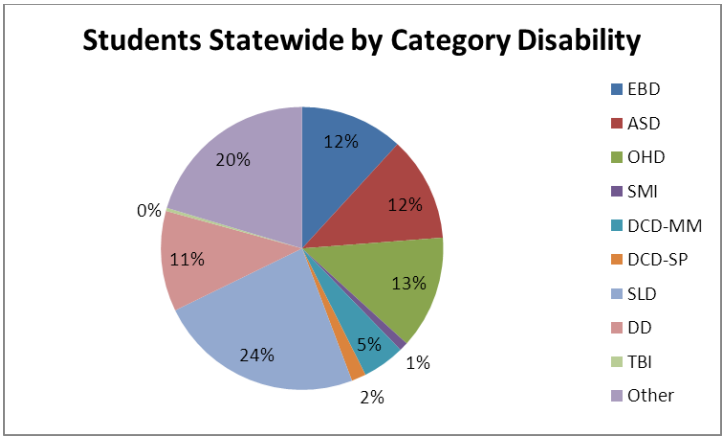
Students and Incidents by Disability Category

Overall, 83% of all incidents of prone restraint reported for the 2013 report involved students who were eligible for special education under the following eligibility criteria: Autism Spectrum Disorders (ASD) or Emotional or Behavioral Disorders (EBD). Compared to the data from the 2012 report to the legislature, this is an increase from 78% of the incidents, though the standardization of reporting may be a factor in this change.

The first chart below illustrates the number and percentage of students upon whom prone restraint was used. The second chart illustrates the percentage of incidence represented by each specific category. For example, while ASD students represent 33% of all students restrained through the use of prone restraint, that same population represents 42% of all

incidents reported for the same time period. For further comparison, the percentages of these students within the state's total special education population are illustrated in the third chart. Specifically, the same ASD students who represent 33% of all students restrained through the use of prone restraint and represent 42% of all incidents reported, are represented in 12% of the state's total special education population.





Key

EBD = Emotional or Behavioral Disorders

ASD = Autism Spectrum Disorders

OHD = Other Health Disabilities

SMI = Severely Multiply Impaired

DCD-MM = Developmental Cognitive Disability-Mild to Moderate

DCD-SP = Developmental Cognitive Disability-Severe to Profound

SLD = Specific Learning Disability

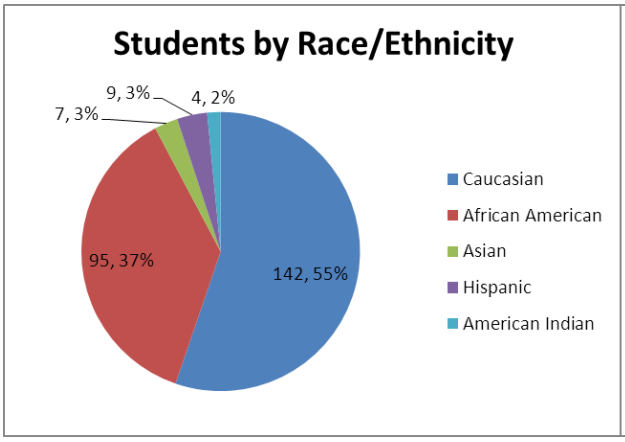
DD = Developmental Delay

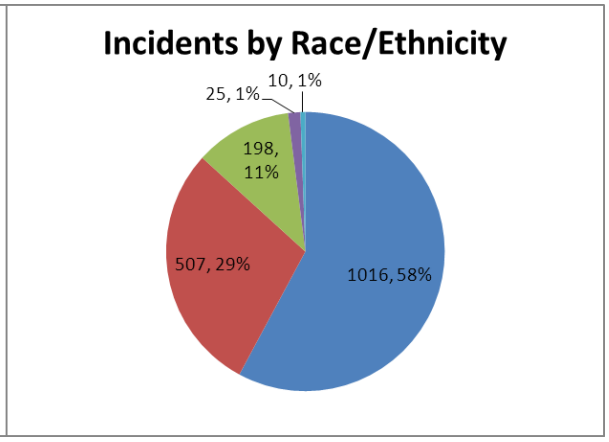
TBI = Traumatic Brain Injury

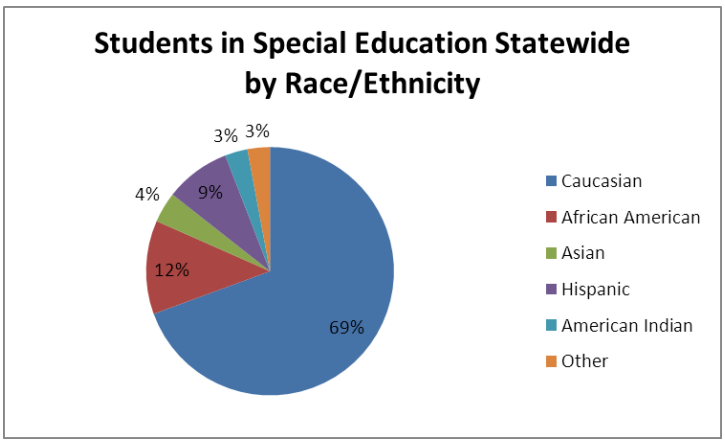
Students Involved In Prone Restraint by Race/Ethnicity

Compared to data from the 2012 report to the legislature, the proportion of African-American students in prone restraint increased from 29% to 36%. In contrast, the proportion of incidents for African-American students decreased from 41% in the 2012 report to the legislature, covering 5.5 months of data, to 29% for the 11.5 month time period represented in this report. At the same time the proportion of incidents for Caucasian students increased from 41% to 58% and for Asian students increased from 1% to 11%.

Much of the change in incidents by race/ethnicity can be attributed to the change in students who fall into the group of outliers described on page 15 under "Important Disclaimers Regarding the Data." In comparison to the statewide population of special education students, African-American students continue to be overrepresented in prone restraint by number of students. While more African-American students were placed in prone restraint, the numerical overrepresentation itself does not mean that the use of restraint was improper under the circumstance.







Restrictive Procedures Summary Data

Following the 2011-2012 school year, districts reported summary data to MDE on the use of restrictive procedures, which was due by July 1, 2012. On a form provided by MDE, districts reported:

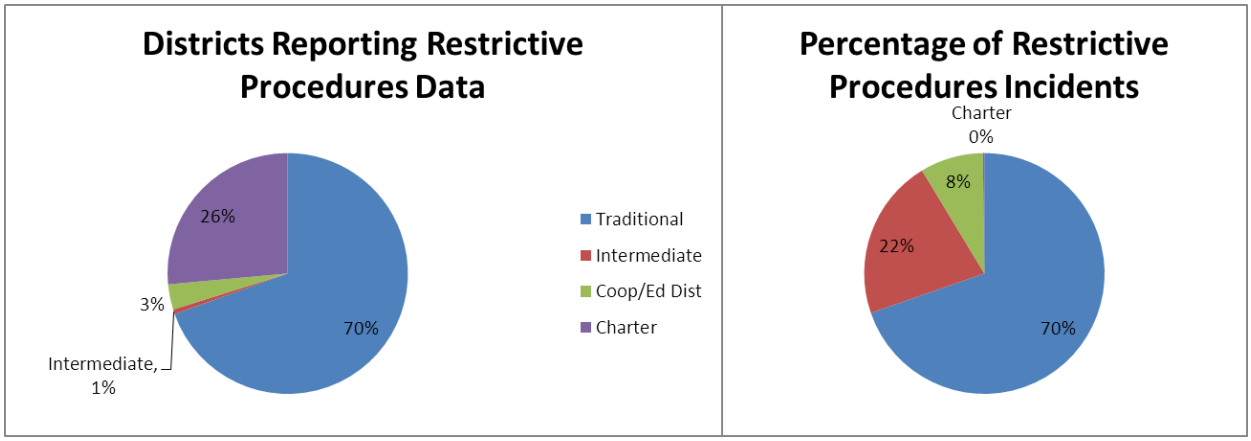
- the total number of special education students in the district;
- the total number of incident of restrictive procedures (including physical holds, prone restraint and seclusion);
- the total number of students with whom a restrictive procedure was used;
- the total incidents of physical holding (including prone restraint);
- the total number of uses of seclusion; and
- demographic information for the students (disability, age, race, and gender).

MDE received summary data from 474 districts (which includes traditional districts, charter schools, cooperatives, education districts, and intermediates). Approximately 53 districts have not responded to repeated requests for the legislatively required data reporting.

Districts that Reported Usage of Restrictive Procedures

Of the 474 districts that reported summary data to MDE as required, 216 of those districts reported use of restrictive procedures, whether solely physical holding, solely seclusion, or a combination of both.

- 186 of 329 traditional districts
- 3 of 3 intermediate districts
- 14 of 18 cooperatives and education districts
- 13 of 124 charter schools



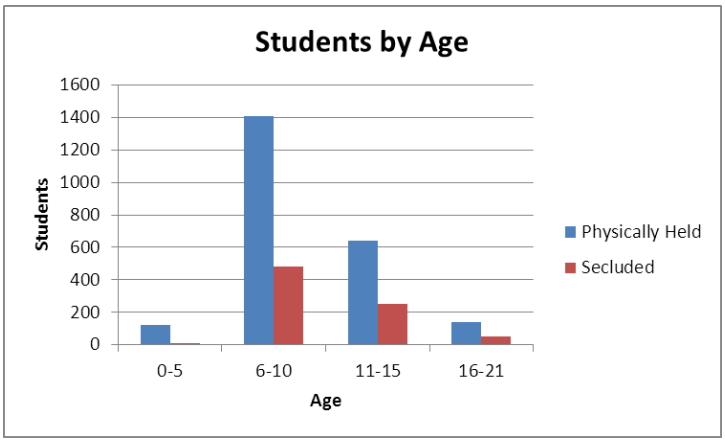
While intermediate districts, cooperatives, and education districts were approximately 4% of the reporting districts, combined they reported 30% of the restrictive procedure use in the state. By contrast, charter schools represent approximately 26% of the reporting districts, but reported nearly no use of restrictive procedures. Traditional districts represent approximately 70% of the reporting districts and reported 70% of restrictive procedure use. Of the 216 districts that reported use of restrictive procedures, 142 (66%) reported use of only physical holding, 5 (2%) reported use of only seclusion, and 69 (32%) reported use of both physical holding and seclusion.

Statewide Data on the Use of All Restrictive Procedures

Across the state, districts reported 16,604 physical holds and 5236 uses of seclusion for a total of 21,840 restrictive procedures during the 2011-2012 school year. Of 127,561 special education students,[85] restrictive procedures were used with 2592 students,[86] which is approximately 2% of the special education population. Physical holding was used with 2318 students, and seclusion was used with 790 students.[87] The average number of physical holds per physically held student was 7.2; the average number of uses of seclusion per secluded student was 6.6; and the average number of restrictive procedures per restricted student was 8.4.[88]

Age of Students in Restrictive Procedures

The majority of restrictive procedures were reported as used with elementary through middle school-aged students, with fewer uses with early childhood and high school students.



Gender of Students in Restrictive Procedures

The data shows that regarding use of restrictive procedures, boys are 5.2 times more likely to be physically held and 5.8 times more likely to be secluded than are girls.

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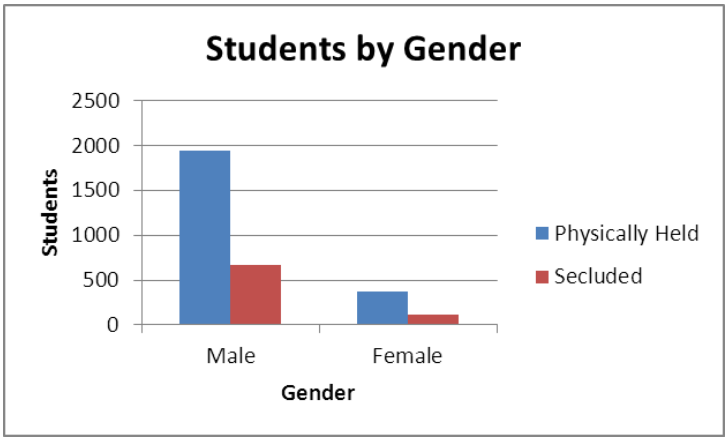
[85] The number of special education students is based on an aggregation of district self-report in conjunction with the restrictive procedures reporting and may not match exactly with other aggregations by MDE of the number of special education students in the state.

[86] Two districts included within their reports the use of restrictive procedures with 3 non-disabled students, though the restrictive procedures statute by its own terms applies only to students with disabilities. Minn. Stat. § 125A.094.

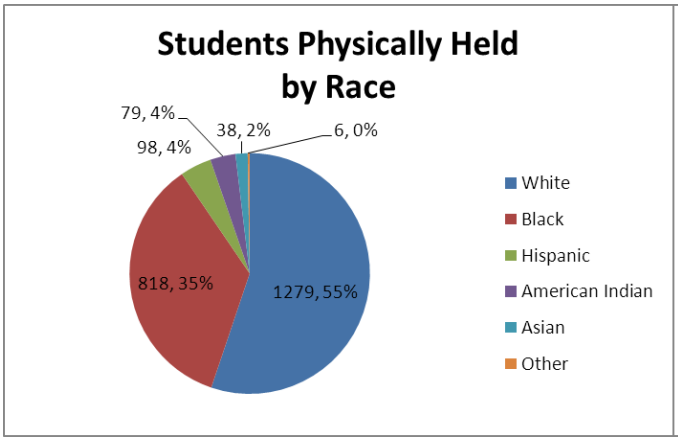
[87] The number of physically held students plus the number of secluded students is greater than the total number of students with whom restrictive procedures were used because a number of students where reported as both physically held and secluded.

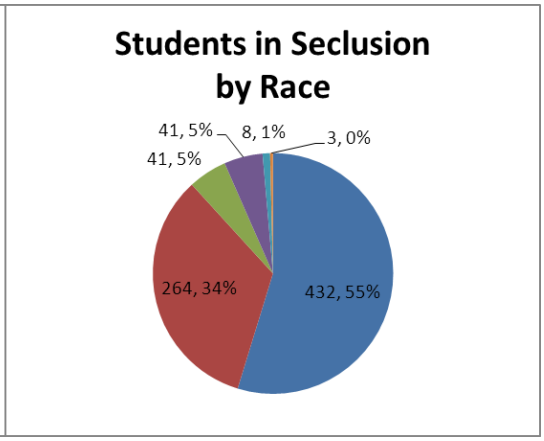
[88] As with the previous footnote, the average number of restrictive procedures per restricted student is higher than the averages for both physical holding and seclusion because a number of students were both physically held and secluded.

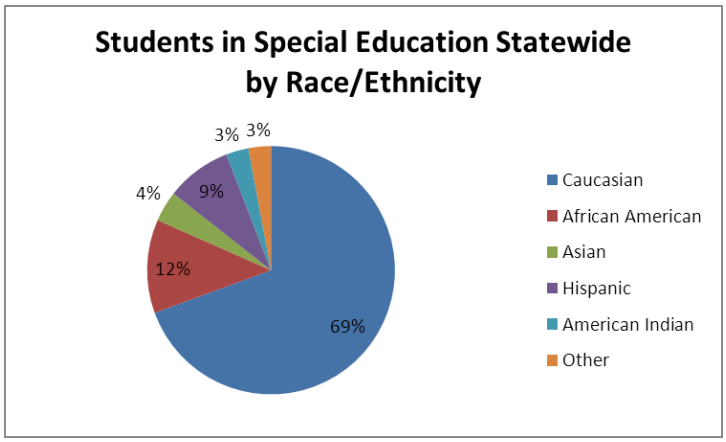


Race/Ethnicity of Students in Restrictive Procedures

African American students, who account for approximately 12% of the special education student population, are overrepresented in both the physical holding and seclusion data. Asian students, who account for approximately 4% of the special education student population, are also overrepresented in the seclusion data, though not to as great a degree.

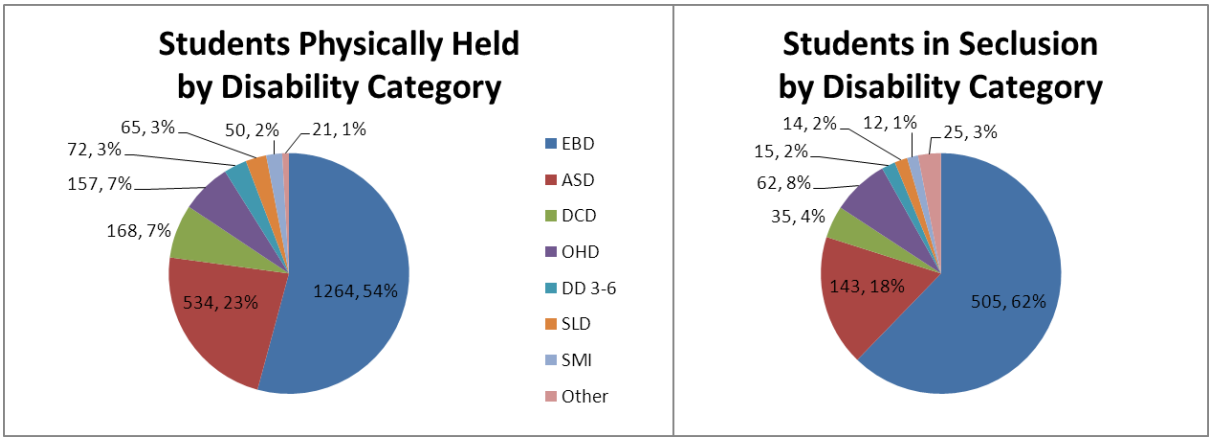


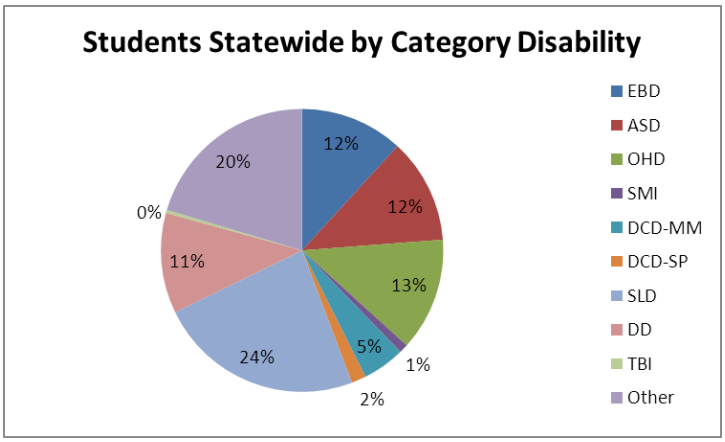




Disability Categories for Students in Restrictive Procedures

Students who are eligible with a primary disability category of Emotional or Behavioral Disorder (EBD) or Autism Spectrum Disorder (ASD) account for more than three-fourths of the students with whom restrictive procedures have been used. ASD students make up approximately 12% of the special education student population and EBD students make up approximately 12%. The remaining one-fourth of restrictive procedures were used with students with Developmental Cognitive Disability (DCD), Other Health Disabilities (OHD), Developmental Delay, ages three through six (DD 3-6), Specific Learning Disability (SLD), and Severely Multiply Impaired (SMI). The categories of disabilities included in the 1% of the "other" category are Deaf and Hard of Hearing (DHH), Speech or Language Impairment (SLI), Traumatic Brain Injury (TBI), Physical Impairment (PI), and Deaf-Blind (BD). No restrictive procedures were reported for students eligible under Developmental Delay for children ages birth through two.





RECOMMENDATIONS FOR IMPROVEMENT

MDE, under the leadership of Commissioner Brenda Cassellius, is committed to ensuring that all students and all staff are safe in the environments in which they learn and work. MDE is also committed to working with the Minnesota Legislature and all interested stakeholders, including parents, educators, school administrators and community leaders, to make sure that schools have necessary and effective tools to support safety while we work together to eliminate the use of prone restraint and minimize the use of other restrictive procedures in Minnesota. MDE looks

forward to assisting the legislature in this important work in a manner that best serves the needs of both students and the public school districts that serve them. In this regard, MDE respectfully offers the following recommendations for improvement.

1. Support Stakeholder-Driven Changes to Statute

   MDE supports the consensus-based recommendations reached by the stakeholder group regarding changes to the statute as attached to this document in Appendix A1. MDE finds particularly critical those portions of the recommendations that emphasize that restrictive procedures are to be used only in an emergency and not as punishment or discipline and the clarification of the meaning of seclusion.

2. Support Stakeholder Planned Action Items

   MDE supports the consensus-based recommendations reached by the stakeholder group regarding actions that various stakeholders, agencies and the legislature can take to best ensure a reduction in the use of restrictive procedures in the Minnesota education system.

3. Require Advance Medical Certification

   As is recommended in its February 2012 report, MDE continues to recommend that, upon amendment, the statute allow the use of prone restraint only if a district or charter school has obtained medical certification of no contraindication prior to its use. The prone restraint statute then would more closely mirror the Rule 40 limitations that apply in DHS-licensed facilities, which require prior consultation with an individual's treating physician "to determine whether the procedure is medically contraindicated."[89] This would especially help assure that medical conditions that are not necessarily obvious are considered. The following language would accomplish this amendment:

   > (v) a district, prior to using prone restraints <u>or by the first IEP meeting held in response to the use of restrictive procedures</u>, must, <u>with the consent of the parent</u>, <u>obtain from the child's medical provider a certification that the child has no</u> ~~review any~~ known medical or psychological limitations that contraindicate the use of prone restraints.[90]

   Pursuant to standard practice in Minnesota's public schools, neither general education nor special education students are allowed to participate in school-sponsored athletics without first providing the school with medical certification that they have no medical or other conditions that should prevent physical activity.[91] Every hockey player, wrestler, dancer, and gymnast is required to undergo a physical every three years and to submit their doctor's approval annually before they are allowed to participate in school sports.

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[89] Minn. R. 9525.2750, Subp. 1, H.

[90] Minn. Stat. § 125A.0942, Subd. 3(7)(v) (2011).

[91] MSHSL Bylaw 305.00 1B, retrieved at http://mshsl.org/mshsl/Publications/code/handbook/HandbookTOC.htm?ne=8.

Although undergoing prone restraint is not similarly a voluntary activity, it is a very physical activity that most often involves significant physical resistance and avoidance activities. Currently, the statute does not require advance medical certification but instead requires only that, prior to using prone restraint, a district "review any known medical or psychological limitations that contraindicate the use of prone restraints."[92] MDE believes that this proposed language, though more prescriptive than the language recommended by the stakeholder group, is consistent with its intent to insure that medically contraindicated restrictive procedures not be used.

4. Change Training Review Requirements

As required by the current statute, MDE maintains a list of training programs that meet the requirements of 125A.0942, Subd. 5. This review addresses the 12 items set forth in that subdivision. The stakeholder group has recommended that item 6, "standards for using restrictive procedures" be amended to read "standards for using restrictive procedures <u>only in an emergency</u>." MDE strongly supports this proposed amendment and will review training programs in conformity with the proposed change such that no training on the use of restrictive procedures would be approved unless it clearly informs participants that restrictive procedures can solely be used in an emergency situation. That is, MDE would assure that no training was provided that did not conform to that fundamental legal standard of the statute.

5. Strengthen Pre-Enrollment Screening

For students facing a change of educational placement as a result of significantly challenging behavior, existing behavior-related data exists in the sending district to inform the discussion of appropriate placement options. Best practice would require supplementation and use of the sending district's data – prior to change of placement – to inform the receiving districts' plan for modifying the behavior(s) and ensuring safety in the event of an emergency. Pre-enrollment screening for change of placement should be conducted for students exhibiting challenging behaviors in order to pair consequences (both in emergency and in modification) with individual needs. This screening data should include a current (within the past 30 days) functional behavior assessment to ensure that receiving districts are able to design behavior response plans that are specific to the needs of the individual.

Very often, intermediate school districts are the receiving districts in these situations. By relying on thorough pre-enrollment screening based on a detailed report of what interventions were used in prior placements and to what effect, intermediates and other receiving districts will be better equipped to address the needs of each of their students. With this data, intermediate districts will have more effective tools for designing individualized and instructional behavior improvement plans that reflect which interventions are considered the least restrictive, most effective and least potentially traumatizing for the particular child at issue.

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[92] Minn. Stat. § 125A.0942, Subd. 3(7)(v) (2011).

CONCLUSION

The Minnesota Department of Education respectfully submits this report in an effort to provide the legislature with objective data to inform its continuing policy discussions regarding the difficult topic of prone restraint. While the number of students affected by this discussion is small, about 0.2% of the special education student population in the case of prone restraint and about 2% for restrictive procedures in general, it is clear that the needs for these students are significant and complex.

This topic is not unique to Minnesota or to educational institutions. Currently, at least 30 states have legislation and/or education agency regulations or policies that prohibit the use of prone restraints or restraints that impede a child's ability to breathe within the school setting. Appendix B contains a citation to and description of the provisions in place for each of these 30 states that have addressed prone restraint or restraints that impede a child's ability to breathe. Thirteen states specifically prohibit the use of prone restraint in educational settings by statue statute, rule, or policy,[93] which is defined as any restraint in which a child is held "face down" and/or in which physical pressure is exerted on the child's torso, head, or neck to keep the student in a prone position. Only two states (Vermont and Minnesota) prohibit the use of restraints that impede a child's ability to breathe and specifically allow the use of prone restraint in limited circumstances.

As they have historically, states and governmental agencies will continue to balance evidence-based data with anecdotal reports of challenging student behaviors as they seek to ensure the safety of a vulnerable student population and the adult staff who serve them.

MDE anticipates the data provided, with its acknowledged limitations, will result in informed decision-making promoting healthy student development within safe educational environments in Minnesota. MDE appreciates the opportunity to inform a task of this magnitude and commends the legislature for its continued commitment to this important work.

[93] District of Columbia; Georgia; Iowa; Maryland; Michigan; Nebraska; Ohio; Oklahoma; Oregon; Pennsylvania; South Carolina; Wisconsin; Wyoming

Appendix A

Plan to Reduce the Use of Restrictive Procedures in Minnesota

I. Purpose

During the 2012 legislative session, the Minnesota Legislature tasked the Minnesota Department of Education (MDE) with developing a statewide plan "to reduce districts' use of restrictive procedures."[1] To assist with developing a plan,[2] MDE assembled a group of stakeholders consistent with the directive of the statute. The stakeholder group included representation from advocacy organizations, special education directors, intermediate school districts, school boards, day treatment providers, state human services department staff, mental health professionals, and autism experts.[3]

MN Statute § 125A. 0942 Subd. 3.(b)

The department must develop a statewide plan by February 1, 2013, to reduce districts' use of restrictive procedures that includes: measurable goals; the resources, training, technical assistance, mental health services, and collaborative efforts needed to significantly reduce districts' use of prone restraints; and recommendations to clarify and improve the law governing districts' use of restrictive procedures. The department must convene interested stakeholders to develop the statewide plan and identify the need for technical assistance, including representatives of advocacy organizations, special education directors, intermediate school districts, school boards, day treatment providers, state human services department staff, mental health professionals, and autism experts. To assist the department and stakeholders under this paragraph, school districts must report summary data to the department by July 1, 2012, on districts' use of restrictive procedures during the 2011-2012 school year, including data on the number of incidents involving restrictive procedures, the total number of students on which restrictive procedures were used, the number of resulting injuries, relevant demographic data on the students and school, and other relevant data collected by the district.

Minnesota Department of Education

[1] Session Laws 2012, Ch. 146, Sec. 3(b).

[2] Session Laws 2012, Ch. 146, Sec. 3(b).

[3] Session Laws 2012, Ch. 146, Sec. 3(b)

II. Stakeholder Group Members

ARC Minnesota ..... Jacki McCormack
Autism Society of Minnesota ..... Jean Bender
..... Michele Kopesky
Institute on Community Integration ..... Tim Moore
Intermediate District 287 ..... Dolly Lastine
Intermediate District 917 ..... Melissa Schaller
Minnesota Administrators for Special Education ..... Jill Skarvold
Minnesota Association for Children Mental Health ..... Deborah Saxhaug
Minnesota Council of Child Caring Agencies ..... Mary Regan
Minnesota Department of Human Services ..... Gary Cox
Minnesota Disability Law Center ..... Dan Stewart
Minnesota School Board Association ..... Dan Cater
National Alliance on Mental Illness ..... Sue Abderholden
..... Matt Burdick
Northeast Metro 916 ..... Connie Hayes
..... Dan Naidicz
Pacer Center ..... Jody Manning
..... Virginia Richardson

III. Minnesota Department of Education Participants

Director, Compliance and Assistance ..... Barbara Case
Meeting Facilitator ..... Adele Ciriacy
Office of Government Relations ..... Daron Korte
Supervisor, Due Process ..... Marikay Litzau
Director, Office of Government Relations ..... Kevin McHenry
Supervisor, Program Monitoring ..... Donna Nelson
Compliance Monitoring ..... Ross Oden
Autism Spectrum Disorders ..... Phil Sievers
Supervisor, Interagency Partnerships ..... Robin Widley

IV. Process

Between September 2012 and January 2013, MDE convened stakeholder group members to review the restrictive procedures data and identify possible components of a plan to result in the desired outcome of the reduction in district staff's use of all restrictive procedures for students with disabilities. The stakeholder group's contributions were accumulated and refined from meeting to meeting and resulted in this current statewide plan. Prior to the initial meeting, MDE conducted a survey of each member of the stakeholder group in order to garner input on the topic. The initial questions posed in the survey are included below; the results were shared with the stakeholder group members at the initial meeting and ultimately contributed to the drafting of the plan.

A. Survey Questions

1. The plan must include measurable goals. The goal of "reducing districts' use of restrictive procedures" has been set forth by the legislature. In addition to this goal, are there other goals that you think the plan can and should address? If so please list below and provide support for your position.
2. The plan is to address "the resources needed to significantly reduce districts' use of prone restraints." What resources do you view as necessary to reduce districts' use of prone restraints?
3. The plan is to address "the technical assistance needed to significantly reduce districts' use of prone restraints." What technical assistance do you view as necessary to reduce districts' use of prone restraints? What technical assistance should be available from MDE? What other entities should provide technical assistance that you think is necessary? If you have suggested multiple types of technical assistance, please pair the need with the recommended technical assistance provider.
4. The plan is to address "the mental health services that are needed to significantly reduce districts' use of prone restraints." What mental health services do you view as necessary to reduce districts use of prone restraints? Who do you believe should receive the services? If you feel districts should receive the services, how should they be obtained? If you feel it should be the student or family in receipt, how should the student or family obtain these services? What barriers are there to students receiving these services? In each case, where might the services be provided and by whom?
5. The plan is to address "the collaborative efforts that are needed to significantly reduce districts' use of prone restraints. Please identify any current collaborative efforts that the department is undertaking that are targeted at the reduction of the use of prone restraint. Please identify any current collaborative efforts that the department is undertaking that are targeted at the reduction of the use of restrictive procedures. Please provide any additional suggestions for collaborative efforts to reduce the use of prone restraint or other restrictive procedures.
6. The plan is to address and make recommendations to "clarify and improve the law governing districts' use of restrictive procedures." What changes would you recommend to the state statute to clarify the law regarding the use of restrictive procedures?

B. Stakeholder Group Meetings

MDE staff convened members of the stakeholder group five times between September 27, 2012, and January 14, 2013. MDE staff facilitated an exchange of information and stakeholder input through:

- Reviewing aggregate data from districts' self-reported use
- Review of summary survey responses
- Review of existing statutory language

Through the use of large and small group discussion, the stakeholder group identified areas of mutual agreement, including a shared desire to develop a plan to reduce restrictive procedures including prone restraint. The topic of some prone restraint was identified by some stakeholders as a topic on which they could not compromise. Certain representatives of education agencies feel it is a necessary procedure, and certain advocates believe that it is never safe and should be banned. The process of exchanging ideas in both the small and large group format resulted in participants gaining a better understanding of their different points of view on a variety of topics and realizing their level of shared agreement. Upon establishing areas of agreement, the stakeholder group identified action strategies that should be implemented by one or more state agencies, school districts, or community level entities. In response to draft versions of the proposed plan, stakeholder group members subsequently identified action strategies for which their respective organizations could provide support.

The stakeholder group also spent time discussing what types of incidents would be considered an emergency situation as defined by the restrictive procedures statute. This resulted in much discussion over situations in which restrictive procedures are currently being used and whether these met the group's understanding of an emergency situation. There was also a discussion related to the application of the reasonable force statute (121A.582) to emergency situations. The discussion indicated that there was some misunderstanding among stakeholders related to when restrictive procedures are allowed under current state law.

In general, the process underscored the stakeholders' desire to reduce or eliminate restrictive procedures, with a shared belief that emergency situations in educational settings could be greatly reduced or eliminated with additional resources; especially mental health services and additional training on positive behavior intervention. The stakeholder group generated a range of ideas about how to reduce the need for the use of restrictive procedures. For purposes of this report, these ideas were synthesized and ranked by the group into the top ten most potentially impactful areas. The various components that resulted from the work of the stakeholder group are presented in this document

Finally, the stakeholder group discussed proposed statutory revisions needed to provide clarification or to support the implementation of some pieces of the proposed plan. The group agreed that it desired to present a unified voice to the legislature on the proposed changes. While it was ultimately able to agree on almost all of the proposed changes, the disagreement on the use of the prone restraint that existed at the beginning of the process continues to exist.

As indicated by the recommendations of the group, the work on a plan to greatly reduce or eliminate the use of restrictive procedures needs further discussion and study in order to create a more specific plan, including committed resources and timelines. To that end, the group

proposes to continue to meet, perhaps with a broader membership, while MDE continues to collect and report the restrictive procedures data and convene the stakeholder meetings.

V. Action Items Recommended by Stakeholder Group

The following action items are recommended by the stakeholder group, and are reflected in a format that includes corresponding stakeholder support and commitment to action. All recommendations by the stakeholder group are intended to reduce school district's use of restrictive procedures.

A. Use of Positive Behavior Interventions and Supports (PBIS)

Encourage the use of positive behavior interventions and supports (PBIS) by more districts across the state of Minnesota to establish school-wide cultures where positive behavior of students is more systematically recognized and reinforced. Increase number of districts statewide that are implementing school-wide PBIS.

- Increase capacity to systematically recognize and reinforce school-wide cultures of positive behavior
- Provide incentives to districts to participate in PBIS initiatives
- Provide ongoing regional support beyond the initial two-year initiative

Commitment to supporting the PBIS initiative can be recognized through the following methods of demonstration of support:

- **MDE:** provide ongoing technical assistance support, and strive to adjust the fiscal burden partially away from special education.
- **School Districts:** strive to create staff investment in the PBIS culture
- **University of Minnesota**: provide training and technical assistance for "Tier 3" level of PBIS
- **Legislature:** legislative action consistent with the recommendations in the State Advisory

Council on Mental Health's 2012 Report to the Governor and Legislature as regards PBIS. View the 2012 Report to the Governor and Legislature on the Minnesota Department of Health website (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4278-ENG).

- **Legislature:** legislative action consistent with prioritizing Safe School Levy funds for school-linked mental health services

B. Increasing Access to School-Linked Mental Health Services

Assess which models of school-linked mental health services are most effective and promote effective models.

- Deliver necessary, earlier, and targeted mental health services to students
- Deliver targeted mental health services in school settings without disruption in service
- Deliver targeted mental health services that are tailored to student need.

Commitment to supporting school-linked mental health services can be recognized through the following methods of demonstration of support:

- **Minnesota Department of Human Services (DHS):** provide assessment of effectiveness of mental health service models
- **School Districts and Private Providers:** ensure availability of and access to services
- **Legislature:** legislative action consistent with the State Advisory Council on Mental Health's 2012 Report to the Governor and Legislature as regards School-Linked Mental health. View the 2012 Report to the Governor and Legislature on the Minnesota Department of Health website (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4278-ENG).
- **Legislature:** support prioritizing Safe School Levy funds for school-linked mental health services

C. Reduce Barriers to Accessing Day and Residential Treatment

Fiscal and legal barriers to accessing day treatment and residential treatment for students in need of such services should be reduced.

- Fiscal barriers should be identified and reduced, across agencies
- Legal barriers should be identified and reduced, across agencies

Commitment to supporting reducing barriers to access to day treatment and residential treatment services can be recognized through the following methods of demonstration of support:

- No specific areas of support noted.

D. Increase and Dedicate Safe School Levy Funds

Increase the Safe School Levy to provide funding for training staff to reduce the use of restrictive procedures and for supporting PBIS.

- Safe School Levy funds are dedicated to training staff
- Training is provided consistent with other action items

Commitment to supporting dedicated Safe School Levy Funds for the purpose of increased training to staff to reduce the use of restrictive procedures and for supporting PBIS can be recognized through the following methods of demonstration of support:

- **Legislature:** support increasing Safe School Levy and prioritizing Safe School Levy funds for school-linked mental health services
- **School District:** dedicating Safe School Levy funds to activities that reduce the use of restrictive procedures, including training for staff

E. Provide Training on Statutory Requirements

Continue to provide, and expand, training on the statutory requirements for use of physical holding and seclusion, including the requirement of a statutory "emergency," to bridge the gaps between systems of crisis prevention and intervention and Minnesota law and identify or develop materials as technical assistance for the key statutory terms of "emergency" and "least intrusive intervention."

- Provide training that specifically addresses the requirement of a statutory "emergency"
- Provide training that specifically addresses the requirements for statutory "least intrusive intervention"
- Determine and bridge gaps between systems of crisis prevention and intervention and law
- Develop training materials to support direct service staff

Commitment to supporting increased training on statutory requirements for the use of restrictive procedures can be recognized through the following methods of demonstration of support:

- **MDE:** provide training on statutory requirements
- **MDE:** ensure development of training and technical assistance
- **School Districts:** ensure staff are properly trained
- **School Districts**: identify and bridge gaps between systems

F. Develop Models for Post-Use Debriefing and Oversight Committee

Identify or develop, in conjunction with school districts, models for post-use debriefing and oversight committee.

- Through review of existing models, establish models for review
- Identify necessary components
- Develop models that include necessary components
- Develop training materials to support implementation

Commitment to supporting the development of models for post-use debriefing and oversight committee responsibility can be recognized through the following methods of demonstration of support:

- **DHS:** Identify and develop models
- **MDE:** identify and develop models
- **School Districts**: identify, develop, and implement post-use debriefing and oversight

committee based on model examples

G. Ensure Adequate Provider Training

Develop greater competency through pre-service and in-service for assessment of the functions of a student's behaviors, designing positive behavior interventions, and using non-physical

interventions in crisis situations. This may include trauma training and other training to increase mental health awareness, as well as training opportunities for parents and families.

- In collaboration with representatives of Educator Licensing and representatives of Higher Education, determine specific competencies to address
- Develop associated training curriculum at respective levels
- Provide in-service training materials to districts for implementation

Commitment to supporting the development of greater levels of district staff competency can be recognized through the following methods of demonstration of support:

- **School Districts:** provide in-service training on functions of behavior
- **School Districts:** provide in-service training on non-physical interventions in crisis situations
- **Higher Education:** provide pre- and in-service training on function of behavior
- **Higher Education:** provide pre- and in-service training on non-physical intervention in crisis situations
- **Advocacy Organizations:** provide training opportunities for parents and families regarding function of behavior
- **Advocacy Organizations:** provide training opportunities for parents and families regarding the use of non-physical intervention in crisis situations
- **DHS and MDE:** provide access to trauma training
- **DHS and MDE:** provide training to increase mental health awareness

H. Develop and Publish Resources

Identify resources and experts external to districts, both at the state level and regionally, and develop referral lists to be made available on MDE's website. This would include culturally responsive resources and experts, which may include intermediate districts.

- Publish resources currently available to guiding direct service providers, administrators and parents
- Update resource lists ongoing
- Ensure cultural responsiveness, and develop resources to address as necessary

Commitment to providing a published list of experts and resources for referral can be recognized through the following methods of demonstration of support:

- **MDE, with Stakeholder Group:** identify resources and experts external to districts
- **MDE, with Stakeholder Group:** develop referral lists posted to MDE website
- **MDE, with Stakeholder Group:** ensure cultural responsiveness
- **MDE, with Stakeholder Group:** ensure resources are posted to district staff and to parents

- **Advocacy Organizations:** identify resources and experts external to districts
- **Advocacy Organizations:** ensure parents are informed of the resource directory

I. Define Data-Driven Process for State Agency Targeted Technical Assistance

Define a threshold and create a process for individual student situations, based on the number of days in which a restrictive procedure is used with a particular student, when MDE oversight would be required, and a DHS crisis intervention team would be dispatched to assist the school district with troubleshooting the behavior.

- Establish a process for determining when state-level support and technical assistance should be provided
- Establish a process for determining what the state-level support and technical assistance would include
- Establish a means for using data to determine effectiveness of implementation

Commitment to defining a data-drive process for activating state agency targeted technical assistance can be recognized through the following methods of demonstration of support:

- **MDE, with Stakeholder Group input:** define a threshold
- **MDE, with Stakeholder Group input:** create a process
- **MDE, with Stakeholder Group input:** analyze aggregate data to determine effectiveness of the plan
- **DHS:** provide crisis intervention teams
- **DHS:** analyze aggregate data to determine effectiveness of the plan as it relates to school-linked mental health
- **School Districts and MDE:** continue data collection of the use of restrictive procedures
- **School Districts and Crisis Intervention Teams:** analyze student specific data to determine effectiveness of the plan

J. Continue Current Stakeholder Group Efforts

Designate a point person from each relevant state agency and a continuation of the current restrictive procedures stakeholders group to ensure positive school success for students with mental health and behavior health needs.

Commitment to continuing the dedicated efforts of the current stakeholder group can be recognized through the following methods of demonstration of support:

- **Stakeholder Group:** designate point of contact from each agency
- **Stakeholder Group:** continue policy work to ensure positive school outcomes
- **Stakeholder Group:** continue policy work to ensure students with behavior and health needs are receiving necessary services

- **Stakeholder Group:** ensure resource delivery is reviewed and modified as necessary

VI. Recommendations to Clarify and Improve Statute

The stakeholder group devoted two meetings to a line-by-line discussion of the current restrictive procedures statute. The group generated many proposed changes that the members believe would make the statute easier to understand and to implement. The stakeholders believed that greater clarity and that potentially would lead to a reduction in the use of restrictive procedures.

Four organizations: PACER Center, Minnesota Disability Law Center, the ARC of Minnesota, and the Autism Society of Minnesota generated a written statement which read, in part, that they continued to oppose prone restraint as a behavioral intervention while they supported the stakeholder group's other proposed legislative changes. As indicated in the meetings and, in some cases, by written support provided to MDE, the majority of the stakeholders fully supported the changes that the group proposed to the existing statute. The proposed changes are set forth in their entirety as Appendix A1.

APPENDIX A1

A bill for an act relating to education; amending Minnesota Statutes 2012; sections 125A.0941 and 125A.0942.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1 Minnesota Statutes 2010, section 125A.0941 is amended to read:

DEFINITIONS.

(a) The following terms have the meanings given them.

(b) "Emergency" means a situation where immediate intervention is needed to protect a child or other individual from physical injury~~ or to prevent serious property damage~~. The term emergency does not mean situations that include but are not limited to:

(1) a child not responding to a task or request by, for example, placing his or her head on the desk or hiding under a desk or table;

(2) a child not complying with a staff member's request, unless the child's actions would result in physical injury to the child or other individual; or

(3) emergency incidents that have already occurred and there is no current threat of physical injury.

(c) "Physical holding" means physical intervention intended to hold a child immobile or limit a child's movement, where body contact is the only source of physical restraint, and where immobilization is used to effectively gain control of a child in order to protect ~~the~~ a child or other ~~person~~ individual from physical injury. The term physical holding does not mean physical contact that:

(1) helps a child respond or complete a task;

(2) assists a child without restricting the child's movement;

(3) is needed to administer an authorized health-related service or procedure; or

(4) is needed to physically escort a child when the child does not resist or the child's resistance is minimal.

(d) "Positive behavioral interventions and supports" means interventions and strategies to improve the school environment and teach children the skills to behave appropriately.

(e) "Prone restraint" means placing a child in a face down position.

(f) "Restrictive procedures" means the use of physical holding or seclusion in an emergency. Restrictive procedures must not be used as punishment or discipline.

(g) "Seclusion" means confining a child alone in a room from which egress is barred. Egress may be barred in the following manner:

(1) the door is locked;

(2) the door is closed and the child is not allowed to leave the room; or

(3) an adult is at or near the door and prevents the child from leaving the room.

Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion.

125A.0942 STANDARDS FOR RESTRICTIVE PROCEDURES.

Subdivision 1**. Restrictive procedures plan.**

Schools that intend to use restrictive procedures shall maintain and make publicly accessible a restrictive procedures plan for children with disabilities that includes at ~~least~~ a minimum, the following components:

(1) the list of restrictive procedures the school intends to use;

(2) a description of how the school implements a range of positive behavior strategies and linkages to mental health services;

(~~2~~3) a description of how the school will monitor and review the use of restrictive procedures, including

(i) conducting post-use debriefings consistent with Subd. 3(a)(5), and

(ii) convening an oversight committee~~; and~~ that is charged with reviewing the use of restrictive procedures on at least a quarterly basis to consider the following:

(a) any patterns or problems indicated by similarities in the time of day, day of week, duration of the use of a procedure, individuals involved, or other factors associated with the use of restrictive procedures;

(b) the number of times a restrictive procedure was used schoolwide and for individual children;

(c) the number and type of injuries, if any, resulting from the use of restrictive procedures;

(d) whether restrictive procedures were used in non-emergency situations; and

(e) the need for additional training of staff, and proposed actions to minimize the use of restrictive procedures.

(4) yearly identification of the oversight committee members who will include, at a minimum, a) a mental health professional, school psychologist, or school social worker, b) an expert in positive behavior strategies, c) a special education administrator, and d) a general education administrator; and

(~~3~~5) a written description and documentation of the training staff completed under subdivision 5.

Subd. 2. **Restrictive procedures.**

(a) Restrictive procedures may be used only by a licensed special education teacher, school social worker, school psychologist, behavior analyst certified by the National Behavior Analyst Certification Board, a person with a master's degree in behavior analysis, other licensed education professional, highly qualified paraprofessional as defined under section 120B.363, or mental health professional under section 245.4871, subdivision 27, who has completed the training program under subdivision 5.

(b) A school shall make reasonable efforts to notify the parent on the same day a restrictive procedure is used on the child, or if the school is unable to provide same-day notice, notice is sent within two days by written or electronic means or as otherwise indicated by the child's parent under paragraph (~~d~~f).

(c) ~~When restrictive procedures are used twice in 30 days or when a pattern emerges and restrictive procedures are not included in a child's individualized education program or behavior intervention plan, t~~The district must hold a meeting of the individualized education program team, conduct or review a functional behavioral analysis, review data, consider developing additional or revised positive behavioral interventions and supports, consider actions to reduce the use of restrictive procedures, and modify the individualized education program or behavior intervention plan as appropriate when one of the following occurs:~~.~~

(1) The first time in a school year that district staff have used a restrictive procedure on two separate school days within a thirty calendar day time period, or when a pattern emerges, and the child's individualized education program or behavior intervention plan does not address the use of a restrictive procedure in an emergency situation. Once this occurs, the meeting must take place as soon as possible, within ten calendar days;

(2) Each subsequent time a restrictive procedure is used on two separate school days within a thirty calendar day time period, or when a pattern emerges, when the child does not have a behavior intervention plan in place and the child's individualized education program does not address the use of a restrictive procedure in an emergency situation. Once this occurs, the meeting must take place as soon as possible, within ten calendar days;

(3) The first time in a school year that district staff have used a restrictive procedure on two separate school days within a thirty calendar day time period, or when a pattern emerges, and at the annual IEP meeting, when a child's individualized education program includes the use of a restrictive procedure in an emergency situation; or

(4) upon district or parental request after the use of a restrictive procedure.

(d) If the IEP team, in reviewing the data as described in (c) above, determines that the interventions and supports are not effective in reducing the use of restrictive procedures, or when a district uses a restrictive procedure on a child on ten or more school days during the same school year, the team shall : a) invite other professionals already working with the child; b) consult with experts in behavior analysis, mental health, communication, or autism; c) consult with culturally competent professionals; d) review existing evaluations, resources, and successful strategies; or e) consider whether a reevaluation is necessary.

(e) At the IEP meeting, held consistent with (c) above, the team must review any known medical or psychological limitations, including any medical information voluntarily provided by the parent, that contraindicate the use of a restrictive procedure, consider whether to prohibit that restrictive procedure, and document any prohibition in the individualized education program or behavior intervention plan.

(~~d~~f) An individualized education program team may plan for using restrictive procedures and may include these procedures in a child's individualized education program or behavior intervention plan; however, the restrictive procedures may be used only in response to behavior that constitutes an emergency, consistent with this section. The individualized education program or behavior intervention plan shall indicate how the parent wants to be notified when a restrictive procedure is used.

Subd. 3. **Physical holding or seclusion**.

(a) Physical holding or seclusion may be used only in an emergency. A school that uses physical holding or seclusion shall meet the following requirements:

(1) the physical holding or seclusion must be the least intrusive intervention that effectively responds to the emergency;

(2) the physical holding or seclusion must not be used as a form of discipline or punishment contingent upon a child's noncompliance;

(~~2~~3) physical holding or seclusion must end when the threat of harm ends and the staff determines that the child can safely return to the classroom or activity;

(~~3~~4) staff must directly observe the child while physical holding or seclusion is being used;

(~~4~~5) each time physical holding or seclusion is used, the staff person who implements or oversees the physical holding or seclusion shall document, as soon as possible after the incident concludes, the following information:

(i) a description of the incident that led to the physical holding or seclusion;

(ii) why a less restrictive measure failed or was determined by staff to be inappropriate or impractical;

(iii) the time the physical holding or seclusion began and the time the child was released; and

(iv) a brief record of the child's behavioral and physical status;

(~~5~~6) the room used for seclusion must:

(i) be at least six feet by five feet;

(ii) be well lit, well ventilated, adequately heated, and clean;

(iii) have a window that allows staff to directly observe a child in seclusion;

(iv) have tamperproof fixtures, electrical switches located immediately outside the door, and secure ceilings;

(v) have doors that open out and are unlocked, locked with keyless locks that have immediate release mechanisms, or locked with locks that have immediate release mechanisms connected with a fire and emergency system; and

(vi) not contain objects that a child may use to injure the child or others;

(~~6~~7) before using a room for seclusion, a school must:

(i) receive written notice from local authorities that the room and the locking mechanisms comply with applicable building, fire, and safety codes; and

(ii) register the room with the commissioner, who may view that room; and

(~~7~~8) until August 1, ~~2013~~2017, a school district may use prone restraints with children age five or older under the following conditions:

(i) a district has provided to the department a list of staff who have had specific training on the use of prone restraints;

(ii) a district provides information on the type of training that was provided and by whom;

(iii) prone restraints may only be used by staff who have received specific training;

(iv) each incident of the use of prone restraints is reported to the department within five working days on a form provided by the department; and

(v) a district, prior to using prone restraints, must review any known medical or psychological limitations that contraindicate the use of prone restraints.

~~The department will report back to the chairs and ranking minority members of the legislative committees with primary jurisdiction over education policy by February 1, 2013, on the use of prone restraints in the schools. Consistent with item (iv), t~~The department must collect data on districts' use of prone restraints and publish the data in a readily accessible format on the department's website on a quarterly basis.

(b) ~~The department must develop a statewide plan by February 1, 2013, to reduce districts' use of restrictive procedures that includes:~~ By March 1, 2014, the stakeholders shall recommend specific, measureable implementation goals for stakeholders and outcome goals for reducing the use of restrictive procedures. The department will submit to the legislature a report on the progress being made in reducing restrictive procedures, and recommendations for how to further reduce these procedures and eliminate the use of prone restraints. The state-wide plan includes the following components: measurable goals; the resources, training, technical assistance, mental health services, and collaborative efforts needed to significantly reduce districts' use of prone restraints; and recommendations to clarify and improve the law governing districts' use of restrictive procedures. The ~~department must convene~~ commissioner will consult with interested stakeholders ~~to develop on the statewide plan and identify the need for technical assistance,~~ on the development of the report, including representatives of advocacy organizations, special education directors, intermediate school districts, school boards, day treatment providers, county social services, state human services department staff, mental health professionals, and autism experts. School districts must report summary data to the department on an annual basis before July 1st of each year, on districts' use of restrictive procedures on a form created by MDE. ~~To assist the department and stakeholders under this paragraph, school districts must report summary data to the department by July 1, 2012, on districts' use of restrictive procedures during the 2011-2012 school year, including data on the number of incidents involving restrictive procedures, the total number of students on which restrictive procedures were used, the number of resulting injuries, relevant demographic data on the students and school, and other relevant data collected by the district.~~

Subd. 4. **Prohibitions**.

The following actions or procedures are prohibited:

(1) engaging in conduct prohibited under section 121A.58;

(2) requiring a child to assume and maintain a specified physical position, activity, or posture that induces physical pain;

(3) totally or partially restricting a child's senses as punishment;

(4) presenting an intense sound, light, or other sensory stimuli using smell, taste, substance, or spray as punishment;

(5) denying or restricting a child's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the child's functioning, except when temporarily removing the equipment or device is needed to prevent injury to the child or others or serious damage to the equipment or device, in which case the equipment or device shall be returned to the child as soon as possible;

(6) interacting with a child in a manner that constitutes sexual abuse, neglect, or physical abuse under section 626.556;

(7) withholding regularly scheduled meals or water;

(8) denying access to bathroom facilities; and

(9) physical holding that restricts or impairs a child's ability to breathe, restricts or impairs a child's ability to communicate distress, places pressure or weight on a child's head, throat, neck, chest, lungs, sternum, diaphragm, back, or abdomen, or results in straddling a child's torso.

Subd. 5. **Training for staff**.

(a) To meet the requirements of subdivision 1, staff who use restrictive procedures shall complete training in the following skills and knowledge areas:

(1) positive behavioral interventions;

(2) communicative intent of behaviors;

(3) relationship building;

(4) alternatives to restrictive procedures, including techniques to identify events and environmental factors that may escalate behavior;

(5) de-escalation methods;

(6) standards for using restrictive procedures only in an emergency;

(7) obtaining emergency medical assistance;

(8) the physiological and psychological impact of physical holding and seclusion;

(9) monitoring and responding to a child's physical signs of distress when physical holding is being used; ~~and~~

(10) recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding is used~~.~~;

(11) the districts' policies and procedures for the timely reporting and documentation of each incident in which a restrictive procedure is used; and

(12) school wide programs of positive behavior strategies.

(b) The commissioner, after consulting with the commissioner of human services, must develop and maintain a list of training programs that satisfy the requirements of paragraph (a). MDE shall also develop and maintain a list of experts who can assist an IEP team in developing a more effective plan for the reduction of restrictive procedures as a resource for districts. The district shall maintain records of staff who have been trained and the organization or

professional that conducted the training. The district may collaborate with children's community mental health providers to coordinate trainings.

Subd. 6. **Behavior supports**.

School districts are encouraged to establish effective schoolwide systems of positive behavior interventions and supports. Nothing in this section or section 125A.0941 precludes the use of reasonable force under sections 121A.582; 609.06, subdivision 1; and 609.379.

Subd. 7. **Funding.**

$200,000.00 is appropriated to assist districts in addressing the needs of children who have experienced a high use of prone restraints. In addition, the commissioner and the commissioner of human services will discuss how to coordinate use of the appropriated funds with existing resources and expertise available within the Department of Human Services.

APPENDIX B

Legislative Language or Policy Guidance Currently in Effect in All States Relating Specifically to Prone Restraint or Restraint that Restricts a Child's Ability to Breathe Within the School Setting

State	Citation	Language
Alabama	Ala. Admin. Code r. 290-3-1-.02(1)(f)(1)	Prohibits: "(iv) Physical Restraint that restricts the flow of air to the student's lungs—Any method (face-down, face-up, or on your side) of physical restraint in which physical pressure is applied to the student's body that restricts the flow of air into the student's lungs. Use of this type of restraint is prohibited in Alabama public schools and educational programs."
California	Cal. Code Regs. tit. 5, § 3052(i)(4)(B)-(C) and (l)(1) and (5)	(i)(4) Emergency interventions may not include:…(B) employment of a device or material or objects which simultaneously immobilize all four extremities except that techniques such as prone containment may be used as an emergency intervention by staff trained in such procedures; and (C) an amount of force that exceeds that which is reasonable and necessary under the circumstances. (l) Prohibitions. (1) Any intervention that is designed to, or likely to, cause physical pain; (5) "Restrictive interventions which employ a device or material or objects that simultaneously immobilize all four extremities, including the procedure known as prone containment, except that prone containment or similar techniques may be used by trained personnel as a limited emergency intervention pursuant to subdivision (i)."
Colorado	1 Colo. Code Reg. §§ 301-45, 2620-R-2.00 et seq.	2620-R-2.00(4) defines "positional asphyxia" to mean "an insufficient intake of oxygen as a result of body position that interferes with one's ability to breathe." 2620-R-2.02(1)(a) "the public education program shall ensure that: (i) no restraint is administered in such a way that the student is inhibited or impeded from breathing or communicating; (ii) no restraint is administered in such a way that places excess pressure on the student's chest, back, or causes positional asphyxia."
Connecticut	Conn. Gen. Stat. §§ 46a-150(4) and 46a-151	46a-150(4) defines "life-threatening physical restraint" to mean "any physical restraint or hold of a person that restricts the flow of air into a person's lungs, whether by chest compression or any other means." 46a-151 prohibits the use of a life-threatening physical restraint.

State	Citation	Language
District of Columbia	57 D. C. Reg. 9457	2818.1 “Nonpublic special education school or program shall not use any form of prone restraint on a District of Columbia student. Use of such restraints as a policy or practice shall be grounds for denying or revoking a certificate of approval.”
Florida	Fla. Stat. § 1003.573	(4) Prohibited restraint. “School personnel may not use a mechanical restraint or a manual or physical restraint that restricts a student’s breathing.”
Georgia	Ga. Comp. R. & r. 160-5-1-3.5	Defines “physical restraint” to mean, in part, “direct physical contact from an adult that prevents or significantly restricts a student’s movement. The term physical restraint does not include prone restraint, mechanical restraint, or chemical restraint.” “Prone restraint” is defined as “a specific type of restraint in which a student is intentionally placed face down on the floor or another surface, and physical pressure is applied to the student’s body to keep the student in the prone position. Use of prone restraint is prohibited in Georgia public schools and educational programs.” Prone physical restraints are expressly prohibited in Georgia schools and educational programs. Guidance from the Georgia DOE on the rule provides: “When a student is intentionally placed face down on the floor or another surface, and physical pressure is applied to the student’s body to keep the student in the prone position, there is an increased risk of injury to the student. Pressure applied on the back and chest areas can result in the student experiencing respiratory distress. When the staff member applying the restraint is substantially larger than the student, the student may also experience broken bones or other physical injuries. Another danger associated with the use of prone restraints is the limited ability of the staff to monitor the student’s physical status.”
Iowa	Iowa Admin. Code r. 281-103.8	“(1) No employee shall use any prone restraints. For the purposes of this rule, “prone restraints” means those in which an individual is held face down on the floor. Employees who find themselves involved in the use of a prone restraint as the result of responding to an emergency must take immediate steps to end the prone restraint.”

State	Citation	Language
Louisiana	La. Rev. Stat. § 17:416.21(C)	(1)"Physical restraint shall be used only … (c) In a manner that causes no physical injury to the student, results in the least possible discomfort, and does not interfere in any way with a student's breathing or ability to communicate with others;" . . . (3) "No student shall be physically restrained in a manner that places excessive pressure on the student's chest or back or that causes asphyxia; (4) A student shall be physically restrained only in a manner that is directly proportionate to the circumstances and to the student's size, age, and severity of behavior."
Maine	05 071 Code Me. R. Chapter 33, § 6(2)	Prohibits "C) no physical restraint may be used that restricts the free movement of the diaphragm or chest or that restricts the airway so as to interrupt normal breathing or speech (restraint-related positional asphyxia) of a student; D) no physical restraint may be used that relies on pain for control, including but not limited to joint hypertension, excessive force, unsupported take-down (e.g. tackle), the use of any physical structure (e.g. wall, railing or post), punching and hitting."
Maryland	Md. Regs. Code tit. 13A. § 13A.08.04.05(A)(1)(e)	Provides: "In applying restraint, school personnel may not: (i) Place a student in a face down position; (ii) Place a student in any position that will obstruct a student's airway or otherwise impair a student' s ability to breathe, obstruct a staff member's view of a student's face, restrict a student's face, restrict a student's ability to communicate distress, or place pressure on a student's head, neck, or torso; or (iii) straddle a student's torso."
Massachusetts	Mass. Regs. Code, tit. 603, § 46.05(5)(a)	Safety requirements. Additional requirements for the use of physical restraint: "(a) No restraint shall be administered in such a way that the student is prevented from breathing or speaking. During the administration of a restraint, a staff member shall continuously monitor the physical status of the student, including skin color and respiration."

State	Citation	Language
Michigan	Michigan State Bd. of Educ.: Supporting Student Behavior: Standards for the Emergency Use of Seclusion and Restraint, December 2006, p. 18	VI. Restraint, E. Prohibited Practices. "The following procedures are prohibited under all circumstances, including emergency situations: …" and includes "any restraint that negatively impacts breathing; [and] prone restraint." Furthermore, "school personnel who find themselves involved in the use of a prone restraint as the result of responding to an emergency must take immediate steps to end the prone restraint." Prone restraint is defined as "the restraint of a person face down."
Minnesota	Minn. Stat. §§ 125A.094 - .0942	Minn. Stat. § 125A.0942, Subd. 4(9) prohibits "physical holding that restricts or impairs a child's ability to breathe." Minn. Stat. § 125A.0942, Subd. 3(7) provides "until August 1, 2012, a school district may use prone restraints under the following conditions: (i) a district has provided to the department a list of staff who have had specific training on the use of prone restraints; (ii) a district provides information on the type of training that was provided and by whom; (ii) prone restraints may only be used by staff who have received specific training; (iv) each incident of the use of prone restraints is reported to the department within five working days on a form provided by the department or on a district's restrictive procedure documentation form; and (v) a district, prior to using prone restraints, must review any known medical or psychological limitations that contraindicate the use of prone restraints."
Missouri	Missouri Rev. Stat. 160.263; Missouri Dep't of Educ. Elementary and Secondary Educ., Model Policy on Seclusion and Restraint, p. 2	State statute requires all school districts to adopt a written policy addressing the use of restrictive behavioral interventions, including but not limited to definitions of restraint, seclusion, and time-out and descriptions of circumstances under which a restrictive behavioral intervention is allowed and prohibited. It also required the state education agency to develop a model policy. The model policy states that "[t]his policy is not an endorsement of the use of seclusion and restraint. A school district may adopt a policy prohibiting the use of seclusion, isolation or restraint." It further provides that "[p]hysical restraint shall: not place pressure or weight on the chest, lungs sternum, diaphragm, back, neck or throat of the student which restricts breathing."

State	Citation	Language
Nebraska	Nebraska Educ. Dept., Developing School Policies & Procedures for Physical Restraint and Seclusion in Nebraska Schools, June, 2010, p. 12, 27, 29, and 34	At this time Nebraska does not have any statutes, regulations, or state policies regarding restraint or seclusion but schools are required to have school safety and security committees in charge of developing safety and security plans for each school in order to be accredited. Procedures related to these procedures "could be interpreted as coming under the scope of Nebraska's school safety policies," p. 12. Each school district may choose to format its policies according to its own practices, p. 27. Model policies include the following language: "The only physical restraints to be used are those taught by the approved Crisis Intervention Training Program," p. 29 and "Prone or supine forms of physical restraint are not authorized and should be avoided," p. 34.
New Hampshire	N.H. Rev. Stat. Ann. §§ 126-U:1 – 126-U:13	126-U: 4 "Prohibition of Dangerous Restraint Techniques. No school or facility shall use or threaten to use any of the following restraint and behavior control techniques: I) Any physical restraint or containment technique that: a) obstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing; b) places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child; c) obstructs the circulation of blood; d) involves pushing on or into the child's mouth, nose, eyes, or any part of the face or involves covering the face or body with anything, including soft objects such as pillows, blankets, or washcloths; or e) endangers a child's life or significantly exacerbates a child's medical condition."
New Mexico	State of New Mexico Public Educ. Dep't, Use of Physical Restraint as a Behavioral Intervention for Students with Disabilities, Memorandum, p. 4	The Public Education Department, "Offers the following guidance to IEP teams and building administrators: . . . No form of physical restraint may be used that restricts a student from speaking or breathing."

State	Citation	Language
Ohio	Ohio Exec. Order No. 2009-13S, signed August 3, 2009, p. 2	Ohio's Policy on the Use of Prone Restraint, Transitional Hold, and Other Types of Physical Restraint, in part, "Prone Restraint: The use of prone restraint is prohibited across all state systems. Prone restraint is defined as all items or measures used to limit or control the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a face-down position. Transitional Hold: Transitional hold is defined as a brief physical positioning of an individual face-down for the purpose of quickly and effectively gaining physical control of that individual in order to prevent harm to self and others, or prior to transport to enable the individual to be transported safely. Transitional hold may include the use of handcuffs and other restraints incident to arrest or temporary detention by law enforcement consistent with departmental policy. The use of transitional hold may be permitted only when all of the following conditions are met and as determined by departmental policy: 1) transitional hold may be applied only by staff with current training on the safe use of this procedure, including how to recognize and respond to signs of distress in the individual; 2) transitional hold may be applied only in a manner that does not compromise breathing, including the compromise that occurs with the use of (1) pressure or weight bearing on the back; (2) soft devices such as pillows under an individual's face or upper body; or (3) the placing of an individual's or staff's arms under the individual's head, face, or upper body; (3) Transitional hold may be applied only for the reasonable amount of time necessary to safely bring the person or situation under control and to ensure the safety of the individuals involved; and (4) Transitional hold may be applied only with consistent and frequent monitoring during and after the intervention with every intent to assure that the person Is safe and suffers no harm."

State	Citation	Language
Oklahoma	Policies and Procedures for Special Education in Oklahoma, 2007, Amended May 2010: Oklahoma State Dep't of Educ., Guidelines for Minimizing the Use of Physical Restraint for Students with Disabilities in Oklahoma. P. 174-5.	"Prone restraints (restraints that position a student face down on his or her stomach or face up on the back) or any maneuver that places pressure or weight on the chest, sternum, lungs, diaphragm, neck, throat, or back must not be used. No restraint that prevents a student from speaking or breathing is allowed."
Oregon	2011 Or. Laws Chapter 665, Section 2(1); Oregon Administrative Rules, OR Dept. of Education, Division 21, School Governance and Student Conduct, OR Administrative Rules, 581-021-0553: Use of Physical Restraint and Seclusion in Public Education Programs. See also 581-021-0550, 0556, 0559, 0563, and 0566.	"The use of mechanical restraint, chemical restraint or prone restraint on a student in a public education program in this state is prohibited." Oregon Laws, Chapter 665, Section 2(1); OAR 581-021-0533. "Prone restraint means a restraint in which a student is held face down on the floor." (Section 2(3)(b)(B)(ii)(c)). "'Physical restraint' does not include prone restraint."
Pennsylvania	22 Pa. Code § 14.133(c)(3)	Provides "The use of prone restraints is prohibited in educational programs. Prone restraints are those in which a student or eligible young child is held face down on the floor."

State	Citation	Language
Rhode Island	R.I. Bd. of Regents Physical Restraint Regulations, 6.2(e) and 7.3(a), Effective September 1, 2002.	Provides "6.2 Prohibitions: Physical restraint/crisis intervention are prohibited in the following circumstances:… "As in a restrictive intervention which employs a device or material or objects that simultaneously immobilize all four extremities, including the procedure known as prone containment, except that prone containment may be used by trained personnel as a limited emergency intervention when a documented part of a previously agreed upon written behavioral intervention plan." 7.3 Safety Requirements. Additional requirements for the use of physical restraint/crisis intervention are: (a) No restraint shall be administered in such a way that the student is prevented from breathing or speaking. During the administration of a restraint, a staff member shall continuously monitor the physical status of the student, including skin color and respiration. A restraint shall be released immediately upon a determination by the staff member administering the restraint that the student is no longer at risk of causing imminent physical harm to him or herself or others."
South Carolina	South Carolina Dep't of Educ., Guidelines on the Use of Seclusion and Restraint, p. 8	"Prone restraints (with the student face down on his or her stomach) or supine restraints (with the student face up on the back) or any maneuver that places pressure or weight on the chest, lungs, sternum, diaphragm, back, neck or throat are prohibited."
Tennessee	Tenn. Code Ann. § 49-10-1305(d)	"Any form of life threatening restraint, including restraint that restricts the flow of air into a person's lungs, whether by chest compression or any other means, to a student receiving special education services … is prohibited."
Vermont	Vt. Code R. 4500 et seq.	4500.3(9) defines prone physical restraint "means holding a student face down on his or her stomach using physical force for the purpose of controlling the student's movement." 4502.1.1 provides "prone and supine physical restraints are more restrictive than other forms of physical restraint and may be used only when the student's size and severity of behavior require such a restraint because a less restrictive restraint has failed or would be ineffective to prevent harm to the student or others." 4501.1(c) prohibits school personnel and contract service providers from imposing on a student "any physical restraint, escort, or seclusion that restricts or limits breathing or communication, causes pain or is imposed without maintaining direct visual contact."

State	Citation	Language
Washington	Wash. Admin. Code § 392-172A-03125(3)(a)	The following uses of force or restraint . . . are presumed to be unreasonable and therefore unlawful: (iv) interfering with a student's breathing."
West Virginia	W. Va. Code § 126.28-8.14	"Handling Behavior Problems. Staff members and other adults in a WV Pre-k classroom shall not handle behavior problems by: … 8.14.3. Restraining a child by any means other than a firm grasp around a child's arms or legs and then for only as long as is necessary for the child to regain control."
Wisconsin	Wisconsin Dep't of Public Instruction, WDPI Directives for the Appropriate Use of Seclusion and Physical Restraint in Special Education Programs, August 2009, p. 2; and Prohibited Practices in the Application of Emergency Safety Interventions with Children and Adolescents in Community Based Programs and Facilities, March 13, 2009, p. 2.	WDPI Directives provides "Prohibited practices include prone restraints as well as other techniques." WDPI also provides that it supports information contained in the memo by the Wisconsin Department of Children and Families and the Wisconsin Department of Health Services, which prohibits the following procedures "any maneuver that places pressure or weight on the chest, lungs, sternum, diaphragm, back or abdomen, causing chest compression [and] any maneuver that places pressure, weight, or leverage on the neck or throat, on any artery, or on the back of the child's head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway, for example straddling or sitting in the torso."
Wyoming	Wyoming Educ. R. Chapter 42: Seclusion and Restraint in Schools, p. 42-3 and 42-5.	Section 6(h)(iv) states that "prone restraints" include holding a student in a face down position or in any position that will: A) Obstruct a student's airway or otherwise impair the ability to breathe; B) Obstruct a staff member's view of a student's face; C) Restrict a student's ability to communicate distress; D) Place pressure on a student's head, neck, or torso; or E) Straddle a student's torso." Section 7(b) states "Procedures. School policies must, at a minimum, include the following procedural components: …(b)(i)(B) provides: "Schools shall not utilize aversive interventions, mechanical restraints, or prone restraints at any time."