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CHILD PRONE RESTRAINT IN NEW HAMPSHIRE

PRESENTED TO THE NEW HAMPSHIRE HOUSE COMMITTEE ON CHILDREN AND FAMILY LAW

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EXECUTIVE SUMMARY

Prone restraint is a type of physical restraint in which an agitated individual is placed in a face-down position. It is used to control an individual who poses an imminent danger to themselves or others. The New Hampshire restraint law (RSA 126-U) is currently ambiguous. While some stakeholders believe it outlaws prone restraint, others argue to the contrary. In this report, we analyze pertinent sections of RSA 126-U. Additionally, we review the prone restraint statutes and reporting systems in eight other states. While we aimed to assess the incidence and safety of prone restraint in these eight states and New Hampshire, our assessment was limited by our inability to acquire comprehensive prone restraint data. Through interviews with medical experts, training program leaders, residential facility representatives, and a review of existing literature, we provide information about the relative value of prone restraint and the physiological, psychological, and economic consequences of prone restraint. Finally, the report presents the Office of the Child Advocate and the Committee on Children and Family Law with policy options concerning RSA 126-U.

1 INTRODUCTION

In this paper, prone restraint is defined as a restraint in which a child is placed in a face-down position and pressure is administered to their body. Prone restraints are used to subdue an individual who is actively posing a risk to themselves or those around them. The safest way to administer a prone restraint is to lay the child on a soft surface and apply pressure to the arms and legs (PCMA).[1] Additional maneuvers, such as applying pressure to the neck or chest area (as seen in the chokehold and prone basket–hold, respectively) increase the risks associated with prone restraint (PCMA).[2] An issue of utmost concern to the Office of the Child Advocate (OCA) and the Committee on Children and Family Law is ensuring that restraints used on children do not negatively impact their physical health and psychological development.

In New Hampshire, prone restraint is used by the Sununu Youth Services Center, as well as several private residential facilities that are certified by the Division for Children, Youth, and Families (DCYF).[3] These facilities typically keep their staff to patient ratios from 1:4 to 1:1 depending on child needs.[4] The frequency of restraint incidents also varies across treatment facilities; from 2014 to 2018, the Spaulding Youth Center, Crotched Mountain School, and Easterseals Zachary Road facility had 2,168, 3,880, and 5,205 incidents of restraint, respectively.[5]

RSA 126-U:4 states that "No school or facility shall use or threaten to use any of the following restraint and behavior control techniques [that] obstruct a child's respiratory airway or impair the child's breathing or respiratory capacity or restricts the movement required for normal breathing."[6] This statutory language is ambiguous; it leaves the legality of prone restraint open to interpretation. Although certain types of restraints, such as prone restraint, may "impair the child's breathing," these types of restraints are not explicitly mentioned in RSA 126-U.[7]

Although prone restraint may have harmful physiological and psychological effects, it can allow staff to de-escalate dangerous situations. Hence, this report assumes a balanced approach, thoroughly examining the potential harms and utility of prone restraint.

2 PURPOSE STATEMENT

Child safety, health, and well-being are essential for the proper growth and development of children into young adults. Therefore, child safety, health, and well-being must be preserved in familial, academic, and medical institutions. The use of prone restraint in New Hampshire residential treatment facilities and schools may be compromising these developmental goals. This report aims to investigate the risks, benefits, and incidents of prone restraint in New Hampshire. Furthermore, by examining the use of prone restraint in other states, this report aims to identify alternative prone restraint policies and effective prone restraint reporting systems.

3 PRONE RESTRAINT LEGISLATION

Restraint legislation has been advanced at a state and national level. At the state level, we provide information on the passage of RSA 126-U, recent revisions to RSA 126-U, and restraint incidence in New Hampshire. At the national level, we discuss legislation advanced by the 116th Congress in 2020. Although this legislation was ultimately unsuccessful, it would have created a federal statute that would have guided the use of restraint and seclusion in schools and eliminated discrepancies among state policies.

3.1 RSA 126-U: THE RESTRAINT LAW OF NEW HAMPSHIRE

The child restraint law in New Hampshire was originally introduced as SB 396 and was codified into law in 2010 as RSA: 126–U. In 2010, the bill was moderately partisan with five Democratic sponsors and one Republican sponsor.[8] Section 126-U:4 laid out certain restraint procedures that were prohibited in New Hampshire child residential facilities and schools:

"No school or facility shall use or threaten to use any of the following restraint and behavior control techniques:

1. *Any physical restraint or containment technique that:*
    1. *Obstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing;*
    2. *Places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child;*
    3. *Obstructs the circulation of blood;*
    4. *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*
    5. *Endangers a child's life or significantly exacerbates a child's medical condition"*[9]

To note, the word "prone" is not explicitly mentioned in the statutory language. As a result, it is unclear whether prone restraint is prohibited by RSA 126-U. Mike Skibbie, policy advocate and contributor to RSA 126-U, believes that prone restraint is prohibited by RSA 126-U. According to Mr. Skibbie, "you can't place anyone on their chest without impairing the movement necessary for normal breathing."[10] Other stakeholders, however, believe that prone restraint can be administered without impairing breathing or circulation.

During the drafting of RSA 126-U, some stakeholders, namely residential treatment facility staff, resisted an explicit ban on prone restraint. Some residential treatment facility staff stated that if prone

restraint were banned, their facilities would be unable to admit children with more aggressive tendencies. Please note, however, that Spaulding Academy banned prone restraint in their facility in April 2019, but continues to accept children with more aggressive tendencies, as reflected in our conversation with the Assistant Director of Residential Services, Walter Hall.[11]

3.1.1 PRONE RESTRAINT INCIDENTS IN NEW HAMPSHIRE

From 2014 to 2018, there were 15, 544 incidents of restraint in New Hampshire residential facilities.[12] In schools, there were 5,245 restraint incidents from 2015 to 2018.[13] The frequency of incidents does not provide an accurate description of the events at hand. Due to inconsistencies in documentation, incident reports often fail to mention the type of restraint, what happened, who was involved, who administered the restraint, why the restraint was administered, and what followed the use of the restraint. For example, it is unclear whether the 15,544 incidents represent the number of physical restraints administered or the number of distinct clients physically restrained. Hence, it is difficult to evaluate the incidence and safety of prone restraint in New Hampshire.

In 2014, RSA 126-U was revised to further standardize the restraint reporting system in residential treatment facilities and New Hampshire schools. It was a partisan driven revision with three Republican sponsors and zero Democratic sponsors.[14] The Department of Education and the Department of Health and Human Services were instructed to periodically go to schools and residential treatment facilities to ensure they were in compliance with the statute and to give feedback on their restraint use. Following the introduction of these requirements in October 2014, there were 5,123 incidents reported within a single year, a 30-fold increase from the previous five years. Subsequent to the increase in reporting, from 2015 to 2018, the State of New Hampshire saw an overall 37 percent decrease in the use of child restraint.[15]

The OCA "Restraining and Secluding Children" report noted that three providers reported over 2,000 restraints from 2014 to 2018: the Spaulding Youth Center, now known as the Spaulding Academy and Family Services, with 2,169 incidents, the Crotched Mountain School with 3,880 incidents, and the Easterseals Zachary Road facility with 5,205 incidents.[16] Each of these facilities acknowledged that their population of children are severely disabled. As mentioned earlier, Spaulding Academy as well as Easterseals Zachary Road no longer use prone restraint. It is unclear whether Crotched Mountain still uses prone restraint as the facility came under new management in June 2020. From the facility leaders that we interviewed, representatives from Sununu Youth Services Center (SYSC) and Nashua's Children's Home mentioned that they continue to use prone restraint. Since August of 2018, the staff at the SYSC placed children in prone restraints at least 20 times and in ten of these instances, the prone restraints were supplemented with the use of handcuffs.[17] Dave Villiotti, Executive Director of Nashua Children's Home, estimates that around 30-35 percent of physical interventions at the Nashua Children's Home are in the prone position.[18]

The changes in the use of prone restraint among facilities reflect a shift to alternative methods of defusing hostile situations with children that do not depend on the explicit use of restraint. The downward trend in prone restraint on children is also in line with changing attitudes among New Hampshire Police. John Scippa, director of the New Hampshire Police Standards and Training Academy, and Col. Nate Noyes of the New Hampshire State Police both support the ban of chokeholds and prone restraints among police.[19] Other forms of violent restraints that have the

potential to restrict one's airways, such as chokeholds and neck restraints, are not a part of the academy's use of force or de–escalation curriculum any longer.[20]

3.2 NATIONAL RESTRAINT LEGISLATION

In the 116th Congress of the United States, legislation was introduced in November 2020 that sought to limit the use of physical interventions in federally funded schools. This legislation failed to advance to the Senate. The bill was entitled the "Keeping All Students Safe Act" and would have placed a national ban on all types of restraints that can restrict breathing, including prone and supine restraints. Restraints in the standing or seated position would have been allowed in emergency situations. Furthermore, under the bill, physical restraint would not have been allowed in written behavior and education plans for disabled students. Finally, the bill would have required that schools have an appropriate number of school workers trained in de-escalation techniques, and that parents be notified of a restraint incident within 24-hours.[21]

This legislation was driven by two observations. First, legislators noted major differences among restraint and reporting rules at state levels and that many states did not require restraint oversight. Second, federal data revealed discrimination in restraint practices. The majority of those restrained had disabilities; those who were black and male were also disproportionately restrained.[22]

4 LITERATURE REVIEW

Existing literature provides key information about the risks and benefits of prone restraint. This information will be used to contextualize the use of prone restraint in New Hampshire and aid in our assessment of the legality and lethality of prone restraint as a practice. It is important to note that the risks of prone restraint are not fully understood. As a result, experts often disagree on the extent to which prone restraint may cause harm.

In this section, we first examine the adverse effects of using prone restraint on an individual. We then discuss the utility of prone restraint use.

4.1 THE ADVERSE EFFECTS OF PRONE RESTRAINT

Prone restraint has physical, social, and psychological consequences for both the children and staff involved. The following sections will break down each of these consequences.

4.1.1 THE PHYSIOLOGICAL CONSEQUENCES

Prone restraint may cause physical injury and sudden death. Sudden death results from positional asphyxia or cardiac arrhythmias. Positional asphyxia occurs when an individual is restrained in a position that impairs normal breathing. Normal breathing requires an open airway, the lungs, and movement of the chest wall, rib cage, diaphragm, and abdominal wall. (see Figure 4.1.1).[23]

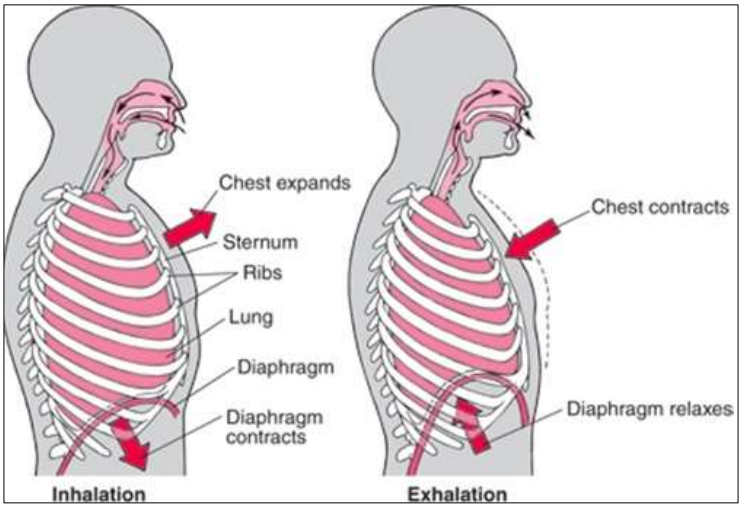

Figure 4.1.1: The Anatomy and Physiology of Breathing [24]

When an individual is restrained face-down, their mouth and nose can be obstructed. Additionally, their chest and diaphragmatic movement can be restricted. If the individual is restless, agitated, or uncooperative, a staff member may place a knee or hand on their back, further compressing their chest. Because of these particular positions, prone restraint can reduce oxygen intake and cause respiratory failure. Reduced oxygen intake can lead to lethal cardiac arrhythmias.[25] The heart needs oxygen to function properly. When the heart receives an insufficient supply of oxygen, it can produce dangerous, uncoordinated rhythms. These uncoordinated rhythms can then result in sudden cardiac death.

The process of restraint can also cause injury to staff members. These injuries may include fractures, abrasions, bruises, and facial trauma. Studies show that staff injury rates are higher in mental health settings where restraint is used than in high-risk industries, such as lumber, construction, and mining.[26]

4.1.2 THE PYSCHOLOGICAL CONSEQUENCES

Many of the children at residential treatment centers have experienced adverse childhood experiences (ACEs), including poverty, substance abuse, parental mental illness, violence, physical abuse, or sexual abuse. According to the Centers for Disease Control, ACEs "can have lasting, negative effects on health, well-being, and opportunity."[27] Numerous studies have shown that prone restraint can re-traumatize children to adverse childhood experiences. A 2004 study by Rolf Wynn, a health psychology specialist, found that physical restraint reignited memories of previous trauma. A female participant stated that physical restraint reminded her of "awful things that happened to [her] as a child."[28] By retraumatizing children to adverse childhood experiences, prone restraint can have detrimental effects on health and well-being.[29] These findings are supported by our conversations with Dr. Kay Jankowski, Director of the Dartmouth Trauma Interventions Research Center, and Dr. Nina Sand-Loud, a Developmental Pediatrician at Dartmouth-Hitchcock Medical Center. According to our conversation with Dr. Kay Jankowski, if a child is being restrained and believes their life is being threatened, the restraint experience may compound on previous trauma, and this is especially true if someone is hurt whilst in a restraint.[30] Dr. Nina Sand-Loud further argues that this retraumatization can manifest in physical responses such as a racing heartbeat, shortness of breath, and anxiety.[31] She

maintains that if physical management is necessary, there should be an emphasis on using more comforting restraints such as a vertical basket hold.[32] The vertical basket hold simulates the feeling of a hug and may reduce the physical or psychological risks that are associated with prone restraint.[33]

Moreover, prone restraint can impair mental health recovery. According to American psychologist Abraham Maslow, all individuals have physiological, safety, love and belonging, and esteem needs.[34] If these needs are not met, individuals cannot reach their fullest potential as human beings. In the context of mental health, having these needs met promotes recovery, whereas neglecting or obstructing these needs prevents recovery. When an individual is restrained in a prone position, their safety, belonging, and esteem needs are compromised.[35] A 2011 study by Haw et al. examined 252 patients' experiences and preferences for coercive treatment. The study found that "humiliation and loss of dignity were the commonest unpleasant thoughts and emotions evoked by restraint," directly undermining safety, love and belonging, and esteem needs.[36] One patient stated that "I feel guilty and shameful about being restrained and people seeing me being restrained."[37] A 2002 study by Sequiera and Halstead found that restraint left participants feeling degraded and out of control.[38] Wynn's 2004 study found that restraint made participants feel anxious, angry, fearful, and distrustful of staff.[39] By evoking fear, distrust, and shame, prone restraint may threaten all facets of an individual's basic needs. As a result, prone restraint may interfere with mental health recovery.[40]

4.1.3 THE ECONOMIC CONSEQUENCES

The federal government and health insurers are not forgiving of restraint-related injuries. In 2008, the Center for Medicare and Medicaid Services (CMS) stopped reimbursing hospitals for "never events" which are preventable adverse events with serious consequences for the patient that should never happen in healthcare.[41] The list of never events has been adopted by many states and private insurers and includes the following two events related to prone restraint: "1) death or serious disability associated with restraints [and] 2) death or significant injury resulting from a physical assault."[42] Since government funding represents "roughly 40 percent of the revenue for mental health treatment facilities," this policy may dissuade facilities from reporting injuries caused by and related to prone restraint.[43] Without government funds, many residential treatment facilities would be unable to operate. Thus, the economic ramifications of reporting may contribute to the lack of data surrounding the use of prone restraint in the United States.

One of the most significant costs of using restraint is the amount of time staff members spend on restraining the child and reporting the restraint events: "a time/motion/task analysis of restraint estimated the cost of one episode from $302 to $354, depending on the number of containing methods used."[44] When accumulated over time, restraint use has a poignant financial impact. Across the United States, "restraint use claimed more than twenty-three percent of staff time and $1.4 million in staff-related costs."[45] While this study illustrates the financial cost of using restraint, it did not examine the financial cost of using restraint alternatives.

Treatment facilities may face additional medical expenses resulting from injuries to staff who administer prone restraint. These injuries lead to higher turnover, industrial accidents, absenteeism/sick time, replacement costs, hiring costs, and training/retraining time.[46] Higher turnover is associated with treatment facilities that practice restraint and seclusion techniques. The Village Network, a youth behavioral facility in Ohio, discovered that the use of restraint correlates with an increase in staff turnover rates. They reported that "the year of their highest restraint use was also the

year of their highest percentage of staff turnover (62 percent)."[47] In contrast, reductions in restraint incidents lead to entirely different outcomes. For example, Grafton School, Incorporated, a nonprofit organization in Virginia that serves children and adults with autism and other mental disorders, positively benefited from restraint reduction strategies (i.e., leadership oversight, client crisis–support, and staff training). Since the implementation of these strategies in 2004, restraint use by Grafton staff has been reduced by 99.8 percent.[48] The reduction in restraint use corresponded to "(1) reduced client related staff injuries by 41.2 percent; (2) reduced staff turnover (10 percent); (3) reduced employee lost time and lost time expenses (94 percent); (4) reduced number of worker's compensation claims (50 percent); (5) reduced total cost of worker's compensation claims; (6) reduced liability premiums (21 percent)."[49] This data suggests that there is a direct relationship between prone restraint and the economic costs shouldered by treatment facilities.

4.2 THE UTILITY OF PRONE RESTRAINT

Although many studies conclude that prone restraint has physical, social, and psychological consequences for children involved, these consequences may be the outcome of additional maneuvers used in tandem with prone restraint. When performed safely and efficiently, prone restraint may allow staff to diffuse dangerous situations.

4.2.1 THE VALUE OF PRONE RESTRAINT

Prone restraint allows staff members to control an emotionally and physically agitated child quickly and effectively. If the child is not controlled immediately, they may cause harm to themselves or others. Restraining the child in the prone position may allow the child to regain control of their behavior. As discovered by Wynn in his 2004 study, prone restraint may not only prevent a child from injuring themselves or others but may also have a calming or soothing effect on the child being restrained.[50] Expanding on Wynn's findings, Sequiera and Halstead reported that "female participants were found to instigate restraint to release feelings of agitation, but only when being restrained by female members of staff."[51] Hence, restraint can be used to quell a child's agitation, as long as both the child and the faculty member are comfortable and familiar with one another. Soothing effects aside, prone restraint can decrease the involvement of law–enforcement who may be ill–equipped to deal with those suffering from mental illness, decrease the use of psychotropic medication, and prevent disruption to teaching environments.[52]

4.2.2 THE RELATIVE SAFETY OF DIFFERENT TYPES OF PRONE HOLDS

Although the studies discussed in Section 4.1 suggest that all prone restraints may cause physical and psychological harm, other studies suggest that the basic prone restraint are not inherently dangerous. In the data collected by the Professional Crisis Management Association (PCMA), 62 percent of the holds considered dangerous went beyond the prone position, and in 74 percent of cases, staff ignored signs of distress from the individual held in the restraint.[53]

There are multiple ways to hold a person in a prone position that "involve different body mechanics, different numbers of staff, and different positions of the staff involved."[54] A basic prone restraint involves "being immobilized in a prone position, held only by the peripheral limbs, on a soft foam mat, with no pressure on the torso, with the arms out the sides" (Figure 4.2.1). It is the additional maneuvers, such as the prone "basket hold", that often cause significant harm (Figure 4.2.2). These

additional maneuvers are typically not condoned by training programs, including the Management of Aggressive Behavior, Handle with Care, and Therapeutic Crisis Intervention programs.

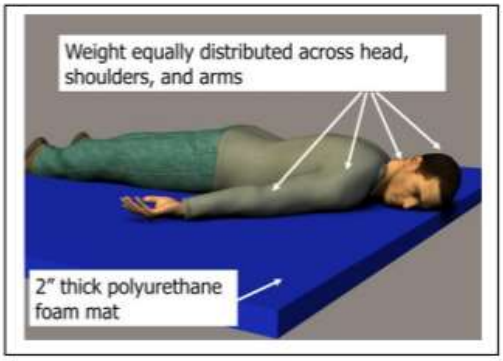

Figure 4.2.1: An Image of a Basic Prone Restraint[55]

Figure 4.2.2: An Image of a Dangerous Practice of Prone Restraint, the "basket hold"[56]

A study carried out in the *Child Abuse and Neglect: An International Journal* by Nunno, Holden and Tollar in 2006 documented forty-five child and adolescent fatalities over ten years.[57] Twenty-seven of these fatalities occurred in a prone position. It is important to note, however, that 70 percent of the prone restraint fatalities involved additional holds or maneuvers that made them more dangerous. These additional holds and maneuvers are featured in Table 4.2.

TABLE 4.2

Death Involving Prone Restraint and Additional Maneuvers (70.4%)

Deaths Involving Prone Restraint and No Additional Maneuvers	Deaths Involving Prone Restraint and a Staff Lying on the Child	Deaths Involving Prone Restraint and a Basket Hold	Deaths Involving Prone Restraint and Staff Sitting on the Child	Deaths Involving Prone Restraint and a Choke Hold
8/27 29.6%	7/27 25.6%	6/27 22.2%	4/27 14.8%	2/27 7.4%

Additionally, the PCMA argues that the risks of positional asphyxia and lethal cardiac arrhythmias are minimal when staff use the basic prone hold illustrated in Figure 4.2.1. Since there is no contact with the chest area, the risk of chest compression and breathing impairment diminishes. Additionally, the PCMA contends that prone holds are not wholly responsible for fatal cardiac arrhythmias. According to the PCMA, there is no causal relationship between prone restraint and sudden fatal cardiac arrhythmias. Rather, "sudden cardiac arrest can be the result of a complex chain of events and/or genetic predispositions" working in tandem with prone restraint.[58]

Finally, the PCMA notes that prone restraints may not necessarily inflict psychological trauma on the child being restrained. While children may show fear, cry, and scream when held in the prone position, these symptoms, according to the PCMA, may be indicative of fright, rather than psychological trauma. Nevertheless, steps can be taken to reduce the risk of trauma or re-traumatization.[59] Specifically, staff can show a child a video of the prone restraint procedure "and discuss with him or her what is happening" and "why the procedure is done."[60] Staff can "even review with the [child] how they would be lying on the mat for the procedure."[61] These steps help to familiarize the child with the practice of prone restraint, minimizing the risks of trauma or re-traumatization.

5 METHODOLOGIES

Our research has two parts: state case studies and semi-structured interviews. The results of the case studies can be found in Section 6; whereas key information from our semi-structured interviews has been integrated into the appropriate places throughout the report.

5.1 STATE CASE STUDIES

We have conducted a comprehensive review of prone restraint policy, incidence, and reporting methods in eight selected states. They are Alabama, Connecticut, Georgia, Maine, Massachusetts, New York, Rhode Island, and Vermont. These states were selected based on geographic, demographic, and political similarities and differences. For each state, we examined six categories: the definition of prone restraint in the selected state, the legality of prone restraint, safety requirements, follow-up procedures, reporting systems, and staff training.

These case studies aim to understand the use of prone restraint in other states:

1. What are the statutes, regulations, and policies addressing prone restraint?
2. What is the incidence of prone restraint?
3. Is prone restraint resulting in bodily injury to students or staff?
4. How is prone restraint reported?
5. What alternatives are being used to prone restraint?

These case studies are structured around a comprehensive analysis of state laws that address the use of restraint, and when possible, the use of prone restraint on children. These laws have been identified through the Office of the Child Advocate 2020 report, "Restraining and Secluding Children" and the United States Department of Education "Summary of Seclusion and Restraint Statutes, Regulations, Policies and Guidance, by State and Territory."

5.2 INTERVIEWS

We conducted several semi-structured interviews with policy experts, residential treatment staff, and medical experts. We first interviewed Mike Skibbie, Policy Director at the Disability Rights Center and contributing author of RSA: 126-U, to understand the political history of RSA 126-U. To gain insight into restraint practices in residential treatment settings, we interviewed the directors of several New Hampshire residential treatment facilities. These include: Dave Villiotti (Director of Nashua Children's Home); Rhonda Chasse (Director of Sununu Youth Services Center); Walter Hall (Assistant Director of Residential Operations at Spaulding Academy and Family Services); John Soucy (Senior Vice President of Children's Services at Easterseals Zachary Road Intensive Residential Treatment Facility). Additionally, we interviewed several medical experts, including Dr. Kay Jankowski (Dartmouth Trauma Interventions Research Center) and Dr. Nina Sand-Loud (Developmental Pediatrician at Dartmouth-Hitchcock Medical Center), to understand the psychological and physiological effects of prone restraint. Finally, to understand the technical aspects of physical holds, we identified and interviewed several training programs utilized by schools and residential treatment facilities in New Hampshire. We interviewed Andrea Turnbull (TCI Program Manager) and Mike O'Malley (President of MOAB Training).

6 CASE STUDY RESULTS

The results of our case studies take two forms. Foremost, we have determined whether or not relevant policies are in place to guide the use of prone restraint in public schools and residential treatment facilities. The results can be found below and have been simplified for clarity. For specific differences in statutes between the various states, please see the appendices.

For public schools, we found that prone restraint is only expressly prohibited in Georgia and Rhode Island and is prohibited, but with some exceptions in Massachusetts. In fact, for four of the states that provide a specific definition of prone restraint, three of these same states prohibit prone restraint to some degree. All states require monitoring during the administration of the restraint, and all states require follow up procedures, except for Alabama and Georgia where it is only recommended. Finally, all states have specific requirements for reporting systems following the use of restraint (prone or otherwise), while Connecticut, Georgia, Maine, Massachusetts, New York, Rhode Island, and Vermont require staff to participat4e in restraint training programs.

TABLE 6.1

Public Schools

State	Prone Restraint Definition	Legality of Prone Restraint: Laws, Policies, Statutes, and Regulations	Safety Requirements (Student Monitoring during Physical Restraint, Duration of Restraint)	Follow-up Procedures	Reporting System	Staff Training
NH	Not Available	Not clearly prohibited	Monitoring required. Maximum restraint duration of 15 minutes	Yes	Yes	Not Available
AL	Not Available	Not clearly prohibited	Monitoring recommended. No clear time constraint	Recommend ations only	Yes	Periodic Review but not training
CT	Not Available	Not clearly prohibited	Monitoring required. Maximum restraint duration of 15 minutes	Yes	Yes	Yes
GA	"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"[62]	Prohibited	Monitoring required but details depend on the school	Recommend ations only	Yes	Yes
ME	Not Available	Not clearly prohibited	Monitoring required	Yes	Yes	Yes
MA	"A physical restraint in which a student is 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 face-down position"[63]	Prohibited except on individual student basis	Monitoring required. Maximum restraint duration of 20 minutes	Yes	Yes	Yes

NY	Not Available	Not clearly prohibited	Monitoring recommended. No clear time constraint	Yes	Yes	Yes
RI	"Prone restraint is a type of manual restraint or hold that limits or controls the movement or normal functioning of any portion, or all, of a person's body while the person is in a face-down position"[64]	Prohibited	Monitoring recommended. No clear time constraint	Yes	Yes	Yes
VT	"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"[65]	Not prohibited	Monitoring recommended. No clear time constraint	Yes	Yes	Yes

Similar to public schools, states that provided a clear definition of prone restraint were more likely to clearly prohibit prone restraint. For example, prone restraint is prohibited in Maine and Rhode Island, and is severely restricted in Vermont. Both Rhode Island and Vermont are the only states to offer a working definition of prone restraint as it pertains to child residential treatment facilities. Additionally, in all states except for New York (where it depends on the facility in question), monitoring is required during the administration of any restraint. Moreover, almost all states require follow-up procedures; Connecticut and Rhode Island did not provide specific requirements and Vermont leaves the follow-up procedures to the facility's discretion. Finally, all states have implemented unique reporting systems and all states require staff training for those who administer restraints, with the exception of New Hampshire which did not offer specific training details. Again, to see the specific differences between the states in each of these categories, please see the appendices.

TABLE 6.2

Residential Treatment Facilities

State	Prone Restraint Definition	Legality of Prone Restraint: Laws, Policies, Statutes, and Regulations	Safety Requirements (Student Monitoring during Physical Restraint, Duration of Restraint)	Follow-up Procedures	Reporting System	Staff Training
NH	Not Available	Not clearly prohibited	Monitoring required. Maximum restraint duration of 15 minutes	Yes	Yes	Not Available
AL	Not Available	Allowed in Emergency Situations	Monitoring in 15-minute intervals	Yes	Yes	Yes
CT	Not Available	Not clearly prohibited	Monitoring required. No time constraint	Not Available	Yes	Yes
GA	Not Available	Not prohibited but two trained staff members required	Monitoring in 15-minute intervals	Yes	Yes	Yes
ME	Not Available	Prohibited	Monitoring required. No time constraint	Yes	Yes	Yes
MA	Not Available	Not clearly prohibited	Monitoring in 15-minute intervals	Yes	Yes	Yes
NY	Not Available	Not clearly prohibited	Dependent on the facility	Yes	Yes	Yes
RI	"Prone restraint means a restraint or hold that limits or controls the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a face down position. Prone restraint does not include the temporary controlling of an	Prohibited	Monitoring required. No clear time constraint	Not Available	Yes	Yes

	individual in a prone position while transitioning to an alternative, safer form of restraint"[66]					
VT	"Restraints that impede a child/youth's ability to breathe or communicate are prohibited"[67]	Must be approved by the licensing authority	Monitoring required. No time constraint	Depends on the facility in question	Yes	Yes

In the second part of our case studies, we attempted to retrieve data pertaining to the incidence of prone restraint in the selected states' public schools and child residential treatment facilities. For each state, we contacted the relevant stakeholders who might have access to this information, including but not limited to the Office of the Child Advocate, the Department of Health and Human Services, the Department of Mental Health, the Department of Children, Youth, and Their Families, and the Department of Education. Despite the reporting requirements that each state has, one of our findings was that states lack a central place in which data on restraint use in child residential treatment facilities and schools is compiled. Accordingly, most states were not able to provide the data that we requested– the incidence of prone restraint for the years 2010 – 2020. The limited amount of data that we received therefore prevented a comprehensive analysis of the effect of restraint statutes on the incidence of prone restraint.

Despite the limitations of this study, we were able to secure comprehensive data on prone restraint for some states. For example, Connecticut provided us with the most comprehensive data for child residential treatment facilities. In the period between 2011 and 2020, 3,089 instances of prone restraint occurred.[68] [69] However, in this same time period, the percentage of holds that were prone restraints decreased dramatically–in 2011, prone restraints accounted for 26.6 percent of physical restraints (1,219) but by 2020, prone restraints only accounted for 1.2 percent of physical restraints (8).[70] Between 2011 and 2020, injuries resulting to both clients and staff from prone restraint also decreased. For example, in 2011, 170 and 137 clients and staff respectively were injured during the administration of prone restraint.[71] By 2020, this number had decreased to four clients and three staff members.[72] Please see Appendix C for the aggregate Connecticut data. As mentioned, prone restraint is not explicitly prohibited in Connecticut; rather, life threatening physical restraints are prohibited. This marked decrease in the incidence of prone restraint then cannot be attributed to changes in Connecticut statutes guiding prone restraint. In fact, it is unclear whether there is a correlation between more stringent prone restraint laws and a decrease in the incidence of prone restraint. For example, Georgia, which was also able to provide some data on prone restraint in child residential treatment facilities, reported ten episodes of manual holds between 2019 and 2021 and zero prone restraints.[73] Please note, this data may be influenced by a lack of reporting among residential treatment facilities in Georgia. Similar to Connecticut, Georgia does not prohibit prone restraints; differently, however, it requires two individuals for a prone restraint to be administered. Nonetheless, the incidence of prone restraint in both of these states either demonstrates a downward trend in the use of prone restraints or is already low, even in states where prone restraint is not prohibited.

The only state that could provide information on the incidence of prone restraint in public schools was Massachusetts. In 2016, 2017, 2018, and 2019, 32, 25, 14, and 12 instances of prone restraint occurred, respectively (this includes counting restrained students multiple times if a child was restrained more than once).[74] To recount, Massachusetts prohibits the use of prone restraint in public schools except on an individual student basis. Even though the incidence of prone restraint use was low, prone restraint continued to occur even in a state that banned the use of prone restraint in almost all situations. Rather than a condition of the law, Connecticut, Georgia, and Massachusetts demonstrate that the incidence of prone restraint is more reflective of the state's culture towards restraint use which is often revealed in the state's definition of prone restraint and statute concerning the administration of prone restraint. Again, Georgia is unique in that two faculty members are required to administer a prone restraint in child residential treatment facilities. Connecticut is unique in its use of the terms "life-threatening" when describing restraints that are prohibited and Massachusetts is unique in its partial ban on prone restraint.[75]

7 PRONE RESTRAINT REPORTING

Our inability to acquire comprehensive data on the incidence of prone restraint in New Hampshire child residential treatment facilities and schools suggests that there are issues with the prone restraint reporting process. These issues likely include:

1. Insufficient detail and underreporting by schools and residential treatment facilities.
2. Inconsistencies in prone restraint reporting terminology. For example, in New Hampshire, prone restraint is also referred to as "MACH 2," "PRT Neutral Position," and "Tripod Stand." These inconsistencies make it difficult to accurately quantify the incidents of prone restraint in New Hampshire.[76]
3. Broad caveats for reportable events. RSA 126-U:1 defines "physical restraint" as occurring "when a manual method is used to restrict a child's freedom of movement or normal access to his or her body."[77] RSA 126-U:7(VI) specifies situations where restraints do not have to be reported, effectively limiting the power of this definition:
    1. "When a child is escorted from an area by way of holding of the hand, wrist, arm, shoulder, or back"[78]
    2. "When actions are taken such as separating children from each other, inducing a child to stand, or otherwise physically preparing a child to be escorted"[79]
    3. "When the contact with the child is incidental or minor, such as for the purpose of gaining a misbehaving child's attention"[80]
4. Insufficient review of restraint records by the Department of Education and the Department of Health and Human Services as specified by RSA 126-U:8 and RSA 126-U:9. According to the *New Hampshire Union Leader* reporter, Josie Grove, schools are creating detailed restraint-of-student reports, but they are not being read. She reports: "[The department of education] is not regularly reviewing the detailed reports schools create after each incident, several school district officials said. All the department does is count the number of incidents."[81] This assertion was corroborated by special education officers in Nashua, Manchester, and Hudson, who revealed that the state department of education does not look at their incident reports and only requests the annual count. Unfortunately, due to the COVID-19 pandemic and the subsequent demands placed on schools, we were unable to interview representatives from New Hampshire public schools about the reporting process.

5. A lack of publicly available restraint data. Prone restraint data is not available on the New Hampshire Department of Education or the New Hampshire Department of Health and Human Services website.

It is outside the scope of this report to fully investigate the aforementioned issues.

8 POLICY OPTIONS

Before turning to the policy options, it is worth noting again that the broader issue affecting the incidence of prone restraint in New Hampshire is reporting. Although we do not have a specific policy recommendation that may improve reporting, it is still an issue that the Office of the Child Advocate and the Committee on Children and Family Law may want to investigate further.

After reviewing the prone restraint statutes of other states, evaluating the incidence of prone restraint in New Hampshire, and interviewing several restraint specialists, we have devised the following policy options for the New Hampshire House Committee on Children and Family Law.

1. The first approach is to accept RSA: 126-U as it currently stands and to pursue no further changes. Current data suggests that prone restraint accounts for less than ten percent of restraint use in New Hampshire residential treatment facilities.[82] In other words, prone restraint may be less prevalent than previously thought. It is important to note, however, that the exact incidence of prone restraint is currently unknown due to inconsistencies in restraint reporting and terminology. Additionally, we were unable to obtain data on the incidence of injury and death due to prone restraint as such incidents are not reported in New Hampshire. Moreover, if prone restraint is not inherently dangerous, as suggested by our conversations with staff from licensed training programs, there may be no reason to outlaw the practice. Furthermore, according to our conversations with New Hampshire residential treatment facility leadership, prone restraint use in such facilities is naturally trending downward.[83] [84]Many of the facility leaders we interviewed, including John Soucy of Easterseals and Walter Hall of Spaulding, have already decided to cease the use of prone restraints.[85] [86] Therefore, legislative interventions may not be necessary to reduce the use of prone restraint. As long as facilities are receiving proper training and understand the danger of certain techniques, there should be a natural reduction in injuries and deaths related to prone restraint. As it stands, prone restraint incidence may not be rampant enough to merit legislative action.

2. The second approach involves a revision of RSA 126-U. At present, RSA 126-U is being interpreted differently by different stakeholders. While some stakeholders believe that RSA 126-U explicitly outlaws prone restraint, others do not. These different interpretations are a result of ambiguity in the statutory language. To address such ambiguity, the legislature could clarify the statutory language. If the original intent of the law was to outlaw prone restraint, RSA 126-U should be amended to explicitly prohibit prone restraint. The phrase "prone restraint" should be included in the statutory language. If the original intent of the law was to not outlaw prone restraint, RSA 126-U should specify that prone restraint is permitted.

Regardless of the chosen policy option, it may be prudent to create a committee to independently study and assess the physical and psychological risks of prone restraint as well as the restraint reporting process in New Hampshire. In addition to establishing a committee, the statute could include language

to specify that all staff that will be restraining children in facilities have proper training in physical management and de-escalation techniques. As per our conversations with training program leadership, the majority of fatal and injurious incidents of prone restraint result from improper techniques.[87] [88]

In addition to clarifying the legality of prone restraint, RSA 126-U could also be revised to improve compliance. As the statute is currently written, there are no explicit consequences for performing a restraint that is not permitted by the statute. Should the legislature wish for the statute to be adhered to by facilities and schools, it would be beneficial to outline consequences that could occur if an institution were to violate the statute. Additionally, the legislature could establish a committee to visit schools or facilities with an unusually high incidence of restraints to ensure that said facility or school is meeting the regulations outlined in the statute.

9 FUTURE DEVELOPMENTS

In addition to the information that this report provides on prone restraint, it is in the interest of the Office of the Child Advocate and New Hampshire House Committee on Children and Family Law to know about future developments concerning New Hampshire residential treatment facilities. At present, the majority of children in youth residential treatment are poor, white, male and over the age of eight. As of January 2020: 180 children (14 percent) were aged five to seven, 237 children (19 percent) were aged eight to eleven, and 471 children (37 percent) were aged 12+. These children were referred to residential treatment services in two ways: 710 children (80 percent) were referred from child welfare and 179 children (20 percent) were referred from juvenile justice (See Figure 9.1).

Table 1 – Data on population currently served in residential programs (as of January 2020)

Ages	- 180 (14%) aged 5-7 - 237 (19%) aged 8-11 - 471 (37%) aged 12+		
Gender	- 43% Female - 57% Male		
Race / ethnicity	**Race/Ethnicity of Children 5 and older in out of home care**	**Jan-20**	**Share (%)**
	White	649	73%
	Hispanic	74	8%
	Multi race	34	4%
	Black/African American	37	4%
	Asian	< 5	<1%
	American Indian/Alaskan Native	< 5	<1%
	Native Hawaiian/Pacific Islander	< 5	<1%
	Not Documented	87	10%
	Grand Total	888	-
Referral pathway	- 710 (80%) referred from child welfare - 179 (20%) referred from juvenile justice		

Figure 9.1: Demographic Breakdown of Treatment Facility Population in New Hampshire[89]

On December 11th of 2020, New Hampshire's Department of Health and Human Services published "Request For Proposals RFP-2021-BH-RESID For: Residential Services for Children's Behavioral Health."[90] This proposal outlines a new method of contracting vendors and partners to provide youth residential services through a statewide referral system. As stated: "The New Hampshire Department of Health and Human Services seeks proposals to establish a Residential Treatment Services system of vendors that will provide high-quality behavioral health treatments services in Residential Treatment settings. The Residential Treatment settings will accommodate referrals from all over the State with the goal of quickly stabilizing behaviors and treating symptoms of children and youth with behavioral health needs to enable them to return to a lower level of treatment or family-based settings.

The Department of Health and Human Services is interested in building in state capacity for residential treatment services and thus is seeking proposals for beds in state and along New Hampshire's bordering states."[91] The referral system will be overseen by the Bureau of Children's Behavioral Health, so that families will be able to access residential services as clinically indicated based on medical necessity without the need for DCYF or in-court involvement.

To be under consideration for referral, the vendors would have to demonstrate high-quality health treatments and services in residential treatment settings. This approach is in line with DHHS' renewed focus on providing more "intensive, focused, high–quality residential treatment for children with the most significant, acute behavioral health needs."[92] As always, the key goal is to provide services that are trauma–informed and that use evidence–based practices to ensure the highest quality of care and best possible outcome for youth.

Regarding restraint, DHHS has indicated that it is committed to further reducing restraint and seclusion for youth in residential treatment facilities with the overall goal of eliminating these practices entirely. In fact, a facilities' use of restraint will be a specific metric under consideration when DHHS decides whether or not to recommend clients to partnered treatment providers. To achieve this, the document provides a model performance metric to be used when scoring different treatment facilities' attempts at reducing restraint in general. Those with the best performance metrics will rise in the referral system. The performance metrics can be found below. As part of the effort to reduce restraint in its entirety, DHHS will work to ensure that children are kept within the State, and therefore within the jurisdiction of statues guiding restraint in New Hampshire, and close to their families and friends (See Figure 9.2).

Category	Key performance metrics:
Referral	• % of referrals that receive a response to the referral source within 24 hours [e.g., email or phone call on availability and next steps] • Median time from referral to acceptance • Median time from referral to admission
Family & youth engagement	• % of treatment meetings where youth participates • % of treatment meetings where caregiver participates • Median # of contacts with family/caregivers per month per child
Quality of treatment	• % of children with improved CANS scores after 3 and 6 months (*based on CANS system report which DHHS will access*) • Median # of restraint/seclusion incidents per child and % of children with any restraint/seclusion during treatment stay
Transition & discharge	• Median length of stay: days from admission to discharge to less restrictive setting • % children discharged to home-based setting – overall and within 30, 60, 90, 180, and 365 days • % of children who remain in either a lower-treatment setting OR home-based setting after 6 and 12 months (*based on internal data which DHHS will access through CME and DCYF system*) • % of children receiving referral to after-care services (e.g., Residential treatment oversight, Fast Forward) before discharge • % of DCYF-involved children who have achieved their permanency goal at 12 months after discharge (*based on internal DCYF data which DHHS will access*)

Figure 9.2: Performance Metrics for Scoring Facilities[93]

10 CONCLUSION

In order to provide a greater picture of the use of prone restraint in New Hampshire, this report looks at the following: 1) the legislative history of RSA 126-U, 2) existing literature on the physiological, psychological, and economic consequences of prone restraint, 3) the incidence of prone restraint and prone restraint laws in selected states, 4) potential issues affecting incident reports on prone restraint, and 5) future developments in the management of child residential treatment facilities. The literature review reveals that although prone restraint is not inherently dangerous, it can cause physical harm if performed incorrectly. Moreover, it may cause psychological harm to the individual being restrained, especially if they have a history of trauma. Additionally, there may be economic consequences, as Medicaid has explicitly stated that it will not reimburse accidents that could have been preventable– for example, those resulting from restraint. Specifically, the case studies reveal that New Hampshire is similar to other states in taking an ambiguous stance on the legality of prone restraint in residential treatment facilities and schools. However, it is the only state that does not require that all staff receive training on the administration of restraints. Additionally, we have discovered that certain New Hampshire facilities have already chosen to stop using prone restraints because they believe that the restraint is dangerous if performed incorrectly. Considering these findings, we then identify a set of policy options that have varying degrees of action, ranging from a revision of the current statute to the implementation of training for staff and faculty that perform restraints. We hope this research will inform the Office of the Child Advocate and the House Committee of Children and Family Law on addressing concerns related to prone restraint in New Hampshire, as well as RSA 126-U.

11 APPENDICES

Appendix A: Statutes Guiding Restraint Policies in Schools

State	Prone Restraint Definition	Legality of Prone Restraint (Laws, Policies, Statutes Regulations)	Safety Requirements (Student Monitoring during Physical Restraint, Duration of Restraint)	Follow-up Procedures	Reporting System	Staff Training
NH[94]	Not Available	Prohibition of restraint that "obstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing; Places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child"	"Continuous direct observation by personnel trained in the safe use of restraint," cannot exceed 15 min without approval from director, cannot exceed 30 min unless there is a face-to-face assessment of the child's well-being by director	The school shall review the individual education program and/or Section 504 plan and make adjustments as are indicated	Within five business days, the employee is supposed to submit a written notification to the director with requested information, and a report should be sent to the parents/guardians within two days	Not Available
AL[95]	Not Available	"Regulations governing public schools. 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"	The Alabama State Board of Education Guidance states that "appropriate staff must be trained in the use of the adopted restraint techniques but only recommends that all instances of restraint should be monitored"	"As soon as appropriate after the restraint is removed, the staff should discuss the incident leading up to the restraint with the student and discuss alternative behaviors that could have been utilized." Note this is only a guideline provided to ensure that Alabama schools comply with rule 290-3-2-.02	Parental notification; documentation and debriefing session. Reports are given to the Alabama Department of Education	Each school must have procedures for the periodic review of the use of restraint
CT[96]	Not Available	"No school employee shall use a life-threatening physical restraint on a student." "Life-threatening physical	Continual monitoring of student; approval for restraint exceeding 15 minutes; Team	Not Available	Parental notification; documentation of the restraint in the student's medical record;	Training to members of the crisis intervention team. Training includes: Restraint

		restraint" means any physical restraint or hold of a person that… immobilizes or reduces the free movement of a person's arms, legs or head while the person is in the prone position"	meeting if a student is restrained more than four times in twenty days		report physical injuries to the State Board of Education; submit annual compilation of use of restraint to State Board of Education; Local/regional boards of education establish procedures for internal reporting	prevention; types of physical restraint and seclusion; the differences between life-threatening physical restraint and other levels of physical restraint; the differences between permissible physical restraint and pain compliance techniques; and monitoring methods
GA[97]	"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"[1]	Prone physical restraints are expressly prohibited in public Georgia schools and educational programs	A school's written policies must include: procedures for observing and monitoring the use of physical restraint	No specific requirements, but there are recommendations	Parental notification; the restraint should be documented in an incident report that is turned in to the school or program administrator	Training shall be provided as a part of a program which addresses a full continuum of positive behavioral intervention strategies, crisis intervention, and de-escalation techniques
ME[98]	Not Available	"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"	At least two adults must be present at all times when physical restraint is used except when, for safety reasons, waiting for a second adult is precluded. A student in physical restraint must be continuously monitored until the student no longer presents a risk of injury or harm to self or others	Within two days, an administrator will discuss the following with the student: What triggered the student's escalation; and what the student and staff can do to reduce the future need for restraint or seclusion	Parental notification; incident report; cumulative report by building must be made to the superintendent or chief administrator on a quarterly and annual basis	Staff training is in place

MA[99]	"A physical restraint in which a student is 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 face-down position"[1]	"Prone restraint shall be prohibited in public education programs except on an individual student basis...Physical restraint, including prone restraint where permitted, shall be considered an emergency procedure of last resort"	"During the administration of a restraint, a staff member shall continuously monitor the physical status of the student, including skin temperature and color, and respiration." Students are to be released from restraint immediately if they demonstrate signs of physical distress. Restraints longer than 20 mins require approval of principal	Include "reviewing the incident with the student to address the behavior that precipitated the restraint, reviewing the incident with the staff person(s) who administered the restraint to discuss whether proper restraint procedures were followed, and consideration of whether any follow-up is appropriate for students who witnessed the incident"	Staff member who administered restraint must inform the administration (via written report) by next working school day. Parental notification (via written report) within two school working days. Report all physical restraints to the RI Department of Education	Required training for all staff at the beginning of each academic year. Training includes prevention strategies, alternatives, safety considerations. Selected staff participate in in-depth training (16 hours) and serve as a school-wide resource
NY[100]	Not Available	"Restraint or seclusion should never be used in a manner that restricts a child's breathing or harms the child"	"Every instance in which restraint or seclusion is used should be carefully and continuously and visually monitored to ensure the appropriateness of its use and safety of the child, other children, teachers, and other personnel"	"The use of restraint or seclusion, particularly when there is repeated use for an individual child, multiple uses within the same classroom, or multiple uses by the same individual, should trigger a review and, if appropriate, revision of strategies currently in place to address dangerous behavior; if positive behavioral strategies are not in place, staff should consider developing them"	"Policies regarding the use of restraint and seclusion should provide that each incident involving the use of restraint or seclusion should be documented in writing and provide for the collection of specific data that would enable teachers, staff, and other personnel to understand and implement the preceding principles"	"Teachers and other personnel should be trained regularly on the appropriate use of effective alternatives to physical restraint and seclusion, such as positive behavioral interventions and supports and, only for cases involving imminent danger of serious physical harm, on the safe use of physical restraint and seclusion"
RI[101]	"Prone restraint is a type of manual restraint or	"Restraint shall be administered in such a way so as to prevent or minimize physical	"During the administration of a restraint, a staff member shall continuously	Include "reviewing the incident with the student, as appropriate, to	Staff member who administered restraint must inform	Required training for all staff at the beginning of each academic year. Training includes

	hold that limits or controls the movement or normal functioning of any portion, or all, of a person's body while the person is in a face-down position…"[1]	harm. Prone restraint shall not be used"	monitor the physical status of the student, including skin color and respiration." Students are to be released from restraint immediately if they demonstrate signs of physical distress	address the behavior that precipitated the restraint, reviewing the incident with the staff person(s) who administered the restraint to discuss whether proper restraint procedures were followed, and consideration of whether any follow-up is appropriate for students who witnessed the incident"	principal (via written report) by next working school day. Parental notification (via written report) within three school working days. Individual student review (identification and assessment of students who have been restrained multiple times in a week). Administrative review (monthly review of school-wide restraint data). Report all restraint-related injuries to DESE within three school working days. Report all physical restraints to DESE	prevention strategies, alternatives, safety considerations. Selected staff participate in advanced training and serve as a school-wide resource
VT[102]	"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"[1]	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	If "the student demonstrates that he/she is in unnecessary pain or significant physical distress indicating a possible need for emergency medical assistance or that his/her breathing or communication is compromised," physical restraint is terminated	"Following termination of any physical restraint or seclusion, the student shall be evaluated and monitored for the remainder of the school day on which physical restraint or seclusion is imposed. The evaluation shall include a routine physical/medical assessment conducted by someone not involved in the restraint or seclusion, and	Reported to School Administrator (no later than end of school day of use), Parents (no later than end of school day of use, Superintendent (within three school days), and the Commissioner of the Department of Education (within three school days of receipt of report)	Training includes: alternatives, preventative measures, simulation which allows for recognition of dangerous behaviors, and effects of restraint on student after the fact

				documentation of any injury received by the student as a result of the restraint or seclusion" Within two days, there are multiple follow-up procedures working on reviewing the incident and working towards preventing a future incident		

Appendix B: Statutes Guiding Restraint Policies in Residential Treatment Facilities

State	Prone Restraint Definition	Legality of Prone Restraint (Laws, Policies, Statutes Regulations)	Safety Requirements (Student Monitoring during Physical Restraint, Duration of Restraint)	Follow-up Procedures	Reporting System	Staff Training
NH[103]	See Appendix A	See Appendix A	See Appendix A	See Appendix A	See Appendix A	See Appendix A
AL[104]	Not Available	Prone restraint is allowed in emergency situations	Continuous monitoring to include 15-minute assessments of the consumer's status	"Within 24 hours after a restraint or seclusion has ended, the consumer and staff who were involved in the episode and who are available participate in a face-to-face debriefing about each episode of restraint or seclusion"	Comprehensive reporting system. See below for more details. Reports are given to the Alabama Department of Mental Health	Annual training to demonstrate an understanding of the following before one participates in any use of restraint/seclusion
CT[105]	Not Available	Life-threatening physical restraints are prohibited. ("Life-threatening physical restraint" means 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)	"Any person at risk who is physically restrained shall be continually monitored by a provider or assistant." (Monitored for signs of physical distress)	Not Available	Any use of physical restraint or seclusion on a person at risk shall be documented in the person's medical record. Each facility must record each instance of physical restraint and the nature of the emergency that necessitated its use, and include such information in an annual compilation on its use of such restraint and seclusion	"Each institution or facility that provides direct care or supervision of a person at risk shall develop policies and procedures that… require training of all providers and assistant providers of care or supervision of persons at risk in the use of physical restraint and seclusion"
GA[106]	Not Available	Behavior Management and Emergency Safety Interventions: emergency safety interventions utilizing prone restraints require at least two trained staff members to	"The patient's breathing, verbal responsiveness, and motor control shall be continuously monitored during any manual hold. Documentation	"Within one (1) hour of the initiation of an emergency safety intervention and immediately following the conclusion of the emergency safety intervention, a physician or other licensed independent	Comprehensive reporting system. Monthly review of restraint and seclusion log and patient's records. Reports are given to the Department of	Extensive emergency safety intervention program that takes into account the physiological impact of restraint on a

		carry out the hold. This is pertinent to an improved bill on prone restraint	of the monitoring by a trained staff member shall be recorded every fifteen (15) minutes during the duration of the restraint"	practitioner; or a registered nurse or physician assistant; trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well-being of patients must conduct a face-to-face assessment of the patient"	Community Health	patient, as well as recognizing signs and symptoms of positional and compression asphyxia and restraint associated cardiac arrest
ME[107]	Not Available	Children's Residential Care Facilities Licensing Rule 10-144 Code Of Maine Rules: Prone restraint is explicitly prohibited	"Facility staff trained in the use of restraints must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention"	Within 24 hours after the use of restraint, staff involved in an emergency safety intervention and the resident must have a face-to-face debriefing, when feasible	Reports are given to the Department of Health and Human Services, Office of Child and Family Services, and the Office of Aging and Disability Services	Training policy includes training in the following areas (obviously not limited to these): physical restraint techniques; effective crisis intervention techniques; rights of residents
MA[108]	Not Available	"A patient shall be placed in a position that allows airway access and does not compromise respiration. A face-down position shall not be used, unless: there is a specified patient preference and no psychological/medical contra-indication to its use; or there is an overriding psychological or medical justification for its use, which shall be documented"	Physical restraint order shall be made by an authorized physician or authorized staff person. Patients in restraints or seclusion shall be fully clothed. Staff person assigned to monitor patient one-on-one. Monitoring documented every 15 mins. No episode of physical restraint shall exceed two hours	Staff and patient debriefing. Senior administrative and clinical staff shall conduct a review of each episode of restraint or seclusion by the next business day	Completion of a restraint and seclusion form on each occasion when a patient is placed in restraint or seclusion. Form placed in patient's record. At the end of each month, copies of all restraint forms and attachments and aggregate reports must be sent to the Department of Mental Health	Initial training and annual retraining for all staff involved in restraint/seclusion. Additional training for staff directly involved in authorizing, ordering, or administering restraint/seclusion. Staff must demonstrate competencies in all areas of training

NY[109]	Not Available	EIPs are not allowed to use any type of physical restraint Section 441.4 of Title 18: Facilities are allowed to use restraint if they submit their restraint proposal to Office of Children and Family Services (and it is approved) [110]	Not Available- seems to vary depending on facility	Facility needs to conduct a post-restraint examination on the child within an hour of the incident	Daily reports of incidents are required, and parents of the child in addition to the appropriate department is supposed to be updated about details of incident	Each staff member must undergo a minimum of six hours of training
RI[111]	"Prone restraint means a restraint or hold that limits or controls the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a face down position. Prone restraint does not include the temporary controlling of an individual in a prone position while transitioning to an alternative, safer form of restraint"	"No service provider of any covered facility may use a prone restraint at any time"	Restraint administered by trained providers; continual monitoring of the child in a restraint; restraint must be ended at earliest possible time	Not Available	Documentation in each child's record; Each facility must maintain a weekly log of the use of physical and include this information in an annual compilation of its use of restraint; If the use of restraint results in serious physical injury or death to the child, the covered facility shall report the incident immediately to DCYF and to the director of the state agency that has supervisory control over the covered facility	"Require training of all service providers in the reduction/elimination of restraint and seclusion"
VT[112]	"Restraints that impede a child/youth's ability to breathe or communicate are prohibited"	Prone restraint may be used if approved by the licensing authority	Extended restraints need supervision	Depends on the facility	Comprehensive reporting system that goes to parents and facility supervisor data is reported annually to Vermont Children and Family Services	Staff undergoes annual training that focuses on de-escalation and appropriate uses of restraint

Appendix C: Policy Research Shop Analysis of Connecticut Restraint Data[113] [114]

Year	Sum of Physical Restraint, any	Sum of Physical Restraint, hold	Sum of Prone Restraint	Sum of Prone with Client Injury	Sum of Prone with Staff Injury	Percent of Physical Restraints that were Prone	Percent of Holds that were Prone
2011	4896	4584	1219	170	137	24.9	26.6
2012	5610	4905	1058	153	133	18.9	21.6
2013	5008	4496	505	51	70	10.1	11.2
2014	5660	4528	160	16	35	2.8	3.5
2015	5063	4061	91	10	18	1.8	2.2
2016	4795	3799	25	1	10	0.5	0.7
2017	4686	3264	8	1	1	0.2	0.2
2018	4278	3018	6	3	1	0.1	0.2
2019	1742	1553	9	1	1	0.5	0.6
2020	901	681	8	4	3	0.9	1.2
Grand Total	42639	34889	3089	410	409		

12 REFERENCES

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