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Feature Article

Tied Up and Isolated in the Schoolhouse

Wanda K. Mohr, PhD, APRN, FAAN, Janice LeBel, EdD, Ronald O'Halloran, MD, and Christa Preustch, MSN

In 1999, the United States General Accountability Office (USGAO) investigated restraints and seclusion use in mental health settings and found patterns of misuse and abuse. A decade later, it found the same misuse and abuse in schools. Restraints and seclusion are traumatizing and dangerous procedures that have caused injury and death. In the past decade, restraints and seclusion have gone from being considered an essential part of the psychiatric mental health toolkit to being viewed as a symptom of treatment failure. In most mental health settings, the use of restraints and seclusion has plummeted due to federal regulations, staff education, and concerted effort of psychiatric national and local leadership. The purpose of this article is to provide a background to and an overview of the present imbroglio over restraints and seclusion in public and private schools, articulate their dangers, dispel myths and misinformation about them, and suggest a leadership role for school nurses in reducing the use of these procedures.

Keywords: safety/injury prevention; violence; legal/ethical issues; school nurse education; school nurse knowledge/perceptions/self-efficacy

In the past decade or so, a remarkable confluence of events and efforts came together to produce a revolution and sustained impact on the care of patients with psychiatric illnesses. Psychiatric professionals, patients, journalists, and advocacy groups joined forces to redefine tying patients down from therapeutic intervention to treatment failure. The dangers of restraints have been widely publicized in the popular press and in the professional literature for many years, and federal regulations, as well as practice parameters, are explicit that they are to be used only in extraordinary circumstances in which an individual is an imminent danger to himself or herself or others. Professional organizations issued practice parameters (American Academy of Child and Adolescent Psychiatry, 2000; American Psychiatric Nurses Association, 2007), developed creative alternatives (e.g., Greene, Ablon, & Martin, 2006; LeBel et al., 2004), and with strong rules governing their use, restraint use plummeted in psychiatric settings

across the United States. Yet, despite such regulations and the efforts and publicity described above, the restraint and seclusion (R&S) issue has reared its head again. This time, the populations in question are children in school settings. At the insistence of parents and advocacy organizations, the United States General Accountability Office

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(USGAO) conducted an investigation of restraints and seclusion use in schools.

The 2009 USGAO report's findings echoed those of the original 1999 report on R&S in psychiatric settings. This is troubling, insofar as much good has been achieved in reducing the use, misuse, injury, and death in mental health settings. Perhaps, after issuing positions, parameters, and regulations, the mental health community did not consider that children live in ecologies beyond those limited to psychiatric settings. They develop and live within a myriad of different systems. While their family has the most proximal influences, the school setting is a very close second. Perhaps we, in the mental health arena, have paid insufficient attention to schools, assuming that schools could regulate and monitor their own. This has not been the case, and the education and school literature is notably quiet on the issue of restraint use in schools, save for a single article as of this writing (Ryan & Petersen, 2004).

The psychiatric community has over a decade of experience to share with the education and school health services community, and as colleagues and child advocates, we have a mandate to help them consider why R&S abuse is happening to school children, to help ameliorate conditions for children and their families, and to suggest actions and approaches to the issue that have been shown to be effective in reducing these coercive and dangerous measures.

The purpose of this article is to provide a background to and an overview of the present imbroglio over R&S, articulate the dangers of their use, dispel myths and misinformation about the use of restraints and seclusion, and suggest a leadership role for school nurses in reducing the use of these procedures. It does not provide a specific blueprint for intervention or action, insofar as school nurses should tailor their interventions to their individual workplace. It does, however, refer them to demonstrably successful programs that can serve as templates for action.

BACKGROUND

R&S are commonly used procedures that have been characterized as problem prone, high risk, dangerous, and lacking an evidence base for their use (Mohr, Petti, & Mohr, 2003). They are used

widely to control behavior deemed dangerous and are often used by staff in mental health settings and nursing homes who have little training or education (U.S. General Accounting Office [USGAO], 1999a, 1999b). The Harvard Center for Risk Analysis has estimated that 50–150 deaths occur annually as a result of R&S use and that this is probably a gross underestimation (USGAO, 1999a; Weiss, Altimari, Blint & Megan, 1998). As yet, there is no way to determine how many restraints are used across various settings, but in 2004, facilities receiving federal moneys were mandated to report deaths occurring within 24 hours of the use of a physical restraint. As significant of those who died are the uncounted numbers of people who have been psychologically and emotionally harmed and traumatized by the use of R&S, often resulting from the failure to follow instructions or a staff to client conflict over an institutional rule (Huckshorn, 2004). Seclusion and restraint are most often “ordered” by a staff nurse or other institutional staff, based on subjective decisions, although the order must technically be issued by a physician in all psychiatric settings. Often the order to seclude or restrain is decided on the basis of situations that do not often reach the threshold of imminent danger (Nunno, Holden, & Tollar, 2006).

“R&S are commonly used procedures that have been characterized as problem prone, high risk, dangerous, and lacking an evidence base for their use.”

For many years, physical restraints have been an assumed part of the *toolkit* available to mental health staff for the “control” of patients and their milieu. They are security measures designed to protect both patients and staff. Labeled as interventions in the past by the psychiatric community, they have not been demonstrated to be therapeutic nor safe especially when used with children. Moreover, they are based on a number of refutable and often unexamined assumptions (Mohr & Anderson, 2001). The misuse and dangers of R&S have been well known, with discussion appearing throughout the medical and mental health literature over many years (Singh, Singh, Davis, Latham,

& Ayers, 1999). In 1998, a Connecticut newspaper documented the deaths of 37 children during a 10-year period, attributable to the use of physical restraints in psychiatric facilities (Weiss et al., 1998). The story reported deaths in all 50 states. This number included only those deaths reported and documented. How many actual deaths occurred is not known as such data were not collected until recently.

In 1999, at the request of two U.S. senators, the USGAO, a nonpartisan investigation agency working for Congress, studied R&S use and issued a report detailing misuse, overuse, injury, and deaths (USGAO, 1999a, 1999b). It confirmed that there was no adequate system of R&S reporting at the state level, making it impossible to determine the true level of deaths and injuries that result from R&S abuses and preventing independent investigation. The USGAO called on U.S. Health Care Financing Agency (USHCFA) to issue regulations that (a) establish strict standards on the use of R&S in all facilities and (b) require reporting any patient death to the Center for Medicare and Medicaid Services (CMS) occurring while the patient is restrained or in seclusion. It also mandated that the state Protection and Advocacy (P&A) agencies investigate all deaths and serious injuries among those with mental illness or mental retardation proximal to R&S use.

Hence, regulations state that R&S may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. They also specify that the type or techniques used should be the least restrictive intervention that will be effective. The full interim law is summarized in the Federal Register, CMS 42 CFR Part 482, December 2006.

Other interim rules were enacted and the final rule defining and regulating R&S became effective on January 8, 2006, after 6 years of revision. It applies to *all* hospitals participating in Medicare and Medicaid (including both general hospitals and freestanding psychiatric hospitals) and sets minimum standards for patient care (Center for Medicare and Medicaid Services [CMS], 2006).

The final rule defines a restraint as "any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's

behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition." Retrieved November 16, 2009, from http://www.thenationalcouncil.org/cs/public_policy/restraints_seclusion_rules_chart

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. The revised standards clarify that seclusion *may only be used* for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

The use of R&S is not confined to psychiatric settings. They are used in schools, juvenile justice settings, and settings that serve persons who have developmental challenges. Since the Hartford Courant investigation, there has been an explosion of scholarly articles and research in the area of restraints and seclusion (over 1,200 scholarly articles on Medline).

Notwithstanding over a decade of national (and international) attention, the issue of R&S is not well discussed in nursing textbooks, with narrative concerning their dangers being ignored by most of them and with misinformation contained in some (Mohr, 2008). The situation in psychiatric medicine is somewhat better informed, with major textbooks starting to give the issues surrounding R&S more attention (e.g., Tasman, Kay, Lieberman, First, & Maj, 2008).

MISUNDERSTANDINGS REGARDING R&S

Over the years, there has been a range of practice myths and assumptions underlying the use of R&S (Evans & Strumpf, 1990; Mohr & Anderson, 2001). The most pervasive is that they protect patients from harm or injury. Others are listed in Table 1 and they are beyond the scope of this article to discuss in-depth. Readers are referred to the original sources for in-depth analysis. Suffice to say that these myths and assumptions have not held up to empirical scrutiny. While restraint in an emergency situation may be an unavoidable action on the part of staff members, they do not necessarily keep their charges safe insofar as they are dangerous procedures. Restraints have been associated with a wide range of serious and adverse consequences (Mohr et al., 2003).

TABLE 1. Assumptions and Myths Underlying the Use of Restraints

- There is an adequate body of empirical evidence supporting the use of restraint and seclusion.
- Staff members know how to recognize potentially violent situations.
- Staff members *know* how to de-escalate potentially violent situations and use least restrictive measures prior to resorting to restraints.
- Staff members are adequately trained in the use of restraints.
- Restraints do not constitute punishment.
- Restraint is an effective intervention as part of a unit management.
- Patients should be restrained because they may fall and seriously injure themselves.
- It is a moral duty to protect patients from harm.
- Failure to restrain puts individuals and facilities at risk for legal liability.
- It does not really bother (patients) to be restrained.
- We have to restrain because of inadequate staffing.
- Restraints calm people.

SOURCE: Adapted from Evans and Strumpf (1990) and Mohr and Anderson (2001).

Nursing organizations have published misleading information about restraint use. For example, a mainstay of nursing practice, the Nursing Intervention Classification (NIC) proposes that physical, manual restraints, or seclusion are appropriate interventions for control as needed to *calm a patient* who is expressing anger in a maladaptive manner (Dochterman & Bulechek, 2004). Not only is this an empirically unsupported assertion, but restraints can escalate patients in many instances, and they are no longer considered therapeutic interventions, rather are thought to be treatment failures (O'Brien & Cole, 2004).

“Nursing organizations have published misleading information about restraint use.”

Furthermore, nursing texts have omitted crucial information about the use and dangers of R&S or have suggested interventions for de-escalating patients that are counterproductive (Mohr, 2008, 2009). For example, psychologists have questioned catharsis theory and concluded that venting anger actually makes people more aggressive, over three decades ago (Bushman,

2002). Yet, nurses are still being taught to instruct patients to punch a pillow or punching bag if their charges are feeling angry and aggressive (Townsend, 2009). Such unsafe advice is also offered by mass marketing media (Sonna, 2003) and posted by pop psychologists on the Internet (see <http://www.sidran.org/sub.cfm?contentID=65§ionid=4>).

The emergency room literature is equally flawed with regard to management of restraint-related incidents. Another dangerous misconception is found in the emergency medicine literature in which Rund, Ewing, Mitzel, and Votalato (2006) provide an algorithm that includes a “show of force” as a strategy recommended for psychiatric patients who are acting aggressively. In fact, research documents that coercion actually begets more aggression (Goren, Singh, & Best, 1993). In the law enforcement, police have recognized that when they respond to an incident involving an individual with mental illness, the aggressiveness and assertiveness which usually helps them gain control of a situation with criminals will often cause an individual with mental illness to escalate further (see www.consensusproject.org).

SECLUSION AND RESTRAINT USE IS AN ADVERSE OUTCOME

Despite increasing professional and federal attention, many working in the field of mental health services remain unaware of the dangers of physical restraints and, as mentioned, nursing textbooks do not elaborate upon these. Some textbooks and facilities still use the euphemism “therapeutic hold” when they mean restraint, despite the fact that regulations clearly define holding a patient to manage aggressive or harmful behavior as a form of restraint (CMS, 2006).

In addition to reported morbidity and mortality, there is little empirical evidence to support the therapeutic efficacy of these practices (Day, 2002), and at best, they provide only short-term protection from harm (Singh et al., 1999).

The use of R&S has been justified as necessary to reduce the risk of harm that a person with psychiatric or developmental challenges might cause to himself or others. However, the use of these measures has been shown to have adverse outcomes that include physical injury, psychological

trauma, and in some instances death (Mohr et al., 2003; USGAO, 1999a, 1999b).

Some “aggression management” vendors may say that their restraint techniques are safe, but companies that base their programs on theory and research stress that there is no safe restraint and that skillful de-escalation (and prevention of a restraint) are the safest alternatives available to staff members. Descriptions of some of these programs, albeit only a select few, have been published by Ryan and Peterson (2004) and Morrison and Carney-Love (2003).

There are a number of ways in which people can die from a restraint. The most common cause of death from restraint is asphyxia due to impaired respiratory functioning. However, other causes may include aspiration, blunt trauma to the chest (commotion cordis), malignant catecholamine-induced cardiac dysrhythmias, thromboembolism, and overwhelming metabolic acidosis from intense struggle (Mohr et al., 2003).

Although any prone restraint has the potential to be deadly, children and adults receiving psychotropic medications are at great risk for asphyxiation in prone positions secondary to the abdominal adiposity resulting from second-generation antipsychotics. When a child who is forced into a prone position has a protuberant abdomen, he or she experiences significant reduction in the size of the respiratory cavity.

Detailed investigation of individual cases of deaths from asphyxia associated with restraints usually indicates that restrainers held the subject down in the prone position by putting pressure on the back for at least a few minutes, long enough to lose consciousness and die from asphyxiation. During restraint, the subjects could not use their arms or legs to relieve the compressive pressure because their arms were being forced behind their back and their legs were being held down or bent backward to prevent kicking. Frequently witnesses recalled hearing subjects say that they could not breathe. Restrainers often discounted expressions of breathing problems as being manipulative or simply impossible, because many believed that if one can talk then one can breathe. They did not realize the progressive nature of respiratory exhaustion from weight on the back. Restrainers often noted that the subjects quit struggling, gave up, or went limp shortly before the restraint ended. Rarely did restrainers or

witnesses recall distinct signs of consciousness, such as talking or purposeful movement, after the compressive force was removed. Unpublished cases, reviewed by one of the authors (R.L.O.) that happened to be videotaped, told the same story—people restrained prone with compressive force that died were already dead or unconscious before the compressive force was finally removed.

Chest compression appears to be the most common and controversial form of restraint asphyxia in prone situations. There are two physiologically sound mechanisms to explain compressional asphyxia deaths: restriction of breathing and restriction of blood flow. Restriction of breathing occurs when the weight on the chest is too great for the diaphragm and intercostal muscles to expand the chest to allow air into the lungs.

The other mechanism by which weight on a prone person's back can cause death is by compressing low pressure blood vessels such as the veins in the chest and abdomen over the vertebral column, the pulmonary artery, and the low pressure atria of the heart. Research indicates that rhythmic abdominal compression squeezes blood out of abdominal veins, increasing the effectiveness of chest compression during cardiopulmonary resuscitation (Geddes, Rundell, Lottes, Kemeny, & Otlewski, 2007). This suggests that 100 or more pounds of continuous weight on the back is enough pressure to impair or completely prevent blood flow to and through the heart by compressing it and the low-pressure blood vessels in the mediastinum that are sandwiched between the spine and sternum. This may decrease or eliminate the delivery of oxygenated blood to the brain and heart. Thus, whether weight applied continuously to the back causes impaired breathing, impaired blood flow through the heart, or both in concert, the result can be asphyxia. If the asphyxia lasts for a couple of minutes or more, the result can be anoxic brain damage and death.

R&S AS A RECENT HIGH-PROFILE ISSUE IN SCHOOL SETTINGS

In some respects, it is no surprise that R&S are used in schools. Corporal punishment has been used in the classroom for centuries (Butchart, 1998). One expert identifies it as part of pedagogy's “history of warfare with the child” (Raichle,

1978) used not only to punish but to underscore the authority of the "schoolmaster." Historically, obedience in school could be derived through physical means (i.e., whispering-sticks, yokes, unipods, whips, paddles) and psychological measures (name-calling, dunce cap, other shaming methods; Raichle, 1977). Surprisingly, corporal punishment is still permitted in 20 states, despite being prohibited under international law and in many other U.S. settings, including most juvenile correctional facilities (Human Rights Watch/American Civil Liberties Union, 2009).

In a scenario reminiscent of concerns raised about restraint use in psychiatric settings, reports of misuse of coercive containment measures in schools have been surfacing sporadically in the media over the past several years. Restraints in school settings were even mentioned in the 1998 Hartford Courant series. A Lexis-Nexis search readily yields the details of numerous cases in which criminal and civil suits were filed against school districts for the R&S misuse. These cases involved children with disabilities who were restrained and secluded, often in cases where they were not physically aggressive and in the absence of parental consent. They also involved teachers and staff who were often not trained on the use of R&S and improper techniques using prone restraint positioning that obstructed children's airways.

In 2007, the California P&A Investigative Unit gave their state "A Failing Grade" with respect to their use of restraints and seclusion in schools (available at <http://www.disabilityrightsca.org/pubs/702301.pdf>). The P&A subsequently drafted legislation to eliminate seclusion and restrict restraint use in California schools but was vigorously opposed by the education sector (Senate Bill 1515, 2008; L. Morrison, personal communication, August 21, 2009).

The abusive use of R&S in public and private schools causing serious injury trauma and "death to children with disabilities" came to national attention as a result of an investigative report issued by the National Disability Rights Network (NDRN, 2009), a membership organization of the P&A system, which has the authority to investigate reports of abuse and neglect in facilities.

Legal advocates maintained that disabled student's rights to a free, appropriate public education and full and safe inclusion assured through

the Education for the Handicapped Act (1978) and the Individuals with Disabilities Education Act (2004) were denied because of these abusive practices (NDRN, 2009). Their report, "School is not Supposed to Hurt" (2009), highlighted many examples from 38 states of abuse inflicted on disabled children in public schools including but not limited to denying children food, forcing them to sit in their urine, locking them in closets, breaking arms, and physically restraining children, which resulted in several deaths. The report stressed these incidents were "the tip of the iceberg," because of the lack of a local and national system of reporting school abuse. Citing a "patchwork of inadequate state laws," NDRN identified that 41% of states have no laws, policies, or guidelines governing R&S use in school. In addition, they reported nearly 90% of states permit prone restraint use in schools and only 45% of states require/recommend that schools notify parents/guardians if restraint or seclusion is used (NDRN, 2009).

In response to constituents and advocacy groups' concerns and armed with previous USGAO investigations of R&S abuse in mental health settings (1999a, 1999b) and residential schools/boarding schools/wilderness camps (2008), legislators directed the USGAO to investigate abusive practices in *public and private* schools. The subsequent investigation found "hundreds of cases of alleged abuse and death related to the use of these methods on school children during the past two decades" and affirmed advocates' findings (USGAO, 2009). Once again, investigators of the forensic unit of the USGAO was testifying before the U.S. Congress House recounting cases of students being held on the floor for hours at a time, handcuffed, locked in closets, and otherwise maltreated by school personnel during the past two decades. The report cites instances in which this treatment resulted in death and injury and related at least one suicide of a child who hung himself in a seclusion room after a prolonged confinement (USGAO, 2009).

The White House convened a meeting of experts shortly thereafter and the Departments of Health and Human Services and Education are working together to develop informational materials (L. Morrison, personal communication, August 21, 2009). In addition, the Department of Education recently directed each state "to review its current policies and guidelines

regarding the use of restraints and seclusion in schools to ensure every student is safe and protected, and if appropriate, develop or revise its policies and guidelines” before the start of the 2009–2010 school year (Duncan, 2009).

ALTERNATIVES TO R&S

The well-documented morbidity and mortality associated with R&S, and the absence of an empirical base supporting their use, exist alongside a growing body of evidence describing effective alternatives to these practices (Johnson & Hauser, 2001). In the nursing literature, successful use of alternatives involves functions and activities typically performed by nursing staff, beginning with timely observations that inform effective nursing interventions.

Evidence in the psychiatric literature has emerged affirming that setting characteristics, rather than patient characteristics, distinguish those settings that use alternatives to R&S from those that do not (Duxbury, 2002). However, those setting characteristics have only been described generally and have not been well delineated. Because contemporary standards require minimal R&S use, these characteristics must be understood for all settings to make the changes necessary to implement alternatives to seclusion and restraint. Some of the answers that are emerging have to do with the strength of cultures; others are rooted in stigma, the power of labels, and mindsets so firmly established that they create powerful incentives within people or groups to act in certain ways and to explain things (or make attributions). It is beyond the scope of this article to discuss all of these; hence, we will present only that relevant to culture.

UNDERSTANDING SITUATIONAL AND DISPOSITIONAL FACTORS

Social psychologist, Philip Zimbardo (2007), has studied what he calls situational and dispositional phenomena over many years and his work has significant implications for psychiatric nurses. Dispositional factors are those that people attribute as inherent personal qualities that lead to an action: character, free will, genetic makeup. It is a traditional explanation, especially in

individualistic societies such as the United States, because in individualistic societies, both blame and fame are attributed to characteristics of the person rather than to the forces outside of that individual (i.e., environment). Situational factors are those thought to be the vectors or the transmitters of certain actions. An easy way to think about the difference between the two factors are that dispositional factors and explanations are along the lines that a person is evil, talented, successful, and so forth because of something inherent within that person. Situational factors, however, tend to look at the influence of social phenomena (e.g., peer pressure) on a person's or a group's behavior. Zimbardo (2007) asserts that organizational cultures' strong social forces are in operation and that people fall into their respective roles very quickly. Conformity and obedience are exceedingly strong urges in human beings and in social situations; human beings will default both because the situational factors are far stronger than the dispositional ones.

In fact, human beings have a tendency to overestimate the importance of dispositional factors or qualities and to underestimate the importance of situational qualities when trying to understand behaviors. As seen in Zimbardo's famous prison experiment (available at <http://www.prisonexp.org/>) and in other examples (e.g., Abu Ghraib in Iraq), otherwise good people are capable of cruelty toward their fellow human beings. Moreover, such actions tend to be tolerated and even reinforced by the hierarchy and by peers.

How do Zimbardo's findings apply to school settings? In such settings, children with mental illnesses, developmental delay, or other challenges are vulnerable. Teachers, administrators, and staff, for all the rhetoric of positive behavior supports and equality of educational access, are in a position of power. This power comes from not only their position but also their status as members of a profession with specialized knowledge that children and their families may not have. The power differential is even greater in schools that are closed to the public. Power differentials have a potential to result in coercion.

The history of the care of emotionally challenged and developmentally delayed children has not always been pretty. In psychiatric arenas, children have been unnecessarily incarcerated simply because they have lucrative insurance policies,

they have been subjected to capricious punishment by staff members (Mohr, 1997), they have been treated shabbily, they have been secluded for hours, and they have been killed proximal to restraint use that may or may not have been a necessary intervention (Nunno et al., 2006). Those working in institutions in which atrocities against clients were committed were not evil people. Rather, being immersed in situations that unleashed powerful situational forces transformed normal behavior. The importance of Zimbardo's research to nurses is that, although we may think of ourselves as having a consistent and stable personality across time and space, we are not always the same people working alone as we are working in a group (Zimbardo, 2007). The American Nurses' Association *Code of Ethics* is quite specific about the principles of beneficence, nonmaleficence, and justice. Nurses must be aware of the cultures in which they find themselves and be prepared to deal with these powerful forces (Mohr, in press).

IMPLICATIONS FOR SCHOOL NURSES AND RECOMMENDATIONS

The fact that vulnerable children continue to be abused by those who are charged with their care and education is troubling. It is troubling not only because it happens but more so because it has happened despite the best efforts of the psychiatric and advocacy communities to publicize the dangers and misuse of R&S use and to stop their use. The same children who the USGAO found were being forcibly restrained and secluded in 2009 are similar to the children who had previously suffered such treatment in psychiatric facilities. Nurses have been an integral part of exposing this issue in the past, in advocating for patients, issuing position papers, and in being part of significant reduction efforts and milieu redesign.

What is disturbing is the absence of school nurses in the hearings and on the advocacy position papers and in efforts that have recently been promulgated to address R&S in schools. Despite drafting issue briefs and position papers on tangentially related topics, that is, corporal punishment, child abuse and neglect, the school nursing trade groups have been silent on the practice of R&S in schools.

The issue of abusive R&S is of coercion and is not devoid of a larger context. It is part of a cultural norm that does not value its most vulnerable citizens, and when those citizens are children with few rights and choices, and little voice, the stage is set for the kinds of conditions on which the USGAO reported. Such systemic and cultural norms are formidable and they require, not a single leader, but *many* leaders to overcome. This means bringing together many voices from disciplines that do not always talk with or engage each other. School nurses, who are in very short supply and already work under a tremendous burden, need not take this issue on by themselves. Colleagues who can be of help to them include attorneys who are child advocates, psychologists, and child psychiatrists, and their own colleagues in psychiatric nursing can provide numbers as well as the synergy that is part of cross-pollination of knowledge when different disciplines come together.

School nurses are well positioned as on-site, medically trained staff to assume a leadership role in preventing R&S in the classroom. Consistent with practice and ethical standards, the National Association of School Nurses (NASN) has articulated several position statements including corporal punishment, child abuse and neglect, mental health, and violence prevention (National Association of School Nurses [NASN], 2002, 2005, 2006, 2008). Within these documents and particularly relevant to the issue of R&S, school nurses are charged with

1. Recognizing that corporal punishment is the intentional infliction of physical pain used to change behavior that historically was used in school settings (NASN, 2002) but is still allowed, occurring in many states, and associated with abusive R&S episodes (NDRN, 2009). The NASN does not support the use of corporal punishment and believes it should be abolished in schools. Furthermore, NASN states "School nurses must advocate for the rights of children by informing educators of the potential risk of harm in the use of corporal punishment. Administrative assistance must be sought to protect the student, preventing the use of corporal punishment" (NASN, 2002).

"School nurses are well positioned as on-site, medically trained staff to assume a leadership role in preventing R&S in the classroom."

2. Recognizing that abuse and neglect results in significant harm to a child's well-being or inactions that result in a child being deprived of the basic need for nurturance, support, and safety (NASN, 2006). In addition, "... school nurses must be familiar with and comply with applicable laws that identify them as mandated reporters of child abuse and neglect and be actively involved in establishing safe environments for all children, provide personal body safety education to students, educating and supporting staff regarding the signs and symptoms of child abuse and/or neglect, and support victims of child abuse and/or neglect" (NASN, 2006).

R&S abuses have occurred in schools and have been acknowledged as abusive and neglectful (NDRN, 2009)—school nurses must be attuned to this reality and intervene within the scope of their practice accordingly.

3. Enhancing "a positive school climate by becoming part of their school district's interdisciplinary team whose responsibility it is to create safe school environments" (NASN, 2008). Just as a treatment team works in tandem in hospital settings, so too should school nurses work with faculty, school psychologists, and administrators, to promote a safe and supportive learning environment for all students.

A unique challenge for school nurses is the odd silence if not tacit permission under The Individuals with Disabilities Education Act (IDEA), which permits R&S to be included in a student's Individualized Educational Program (IEP; Jones & Feder, 2009). This is strictly forbidden in psychiatric settings, and school nurses, consistent with their discipline, should vigorously work to instruct colleagues on the medical and psychological risks associated with these procedures and necessity of preventing R&S, much less sanction their practice in an IEP.

4. Using their skills "to assist students to develop problem solving and conflict resolution techniques, coping and anger management skills, and a positive self-image ..." (NASN, 2005).

Seclusion and restraint stands in stark contrast to this charge to school nurses and these specific tasks. Seclusion and restraint thwarts the development and mastery of these essential social skills, impedes trust and learning, models violent behavior by adult, and essentially teaches youth to manage problems with physical aggression (National Association of State Mental Health Program Directors [NASMHPD], 2009).

The NASN further states that "school nurses should be active members of crisis intervention teams and curriculum committees, and be involved in the development and planning of prevention and intervention programs within the school and community" (NASN, 2005). Within this purview, school nurses could lead their school community in an effort to prevent educational violence through a Positive Behavioral Interventions and Supports (PBIS) initiative. This framework is consistent with IDEA, focuses on building positive behavior in students across the entire school, and uses a tripartite model to prevent problematic behavior and a range of interventions if problems occur.

Similar to PBIS, but explicitly focused on preventing the use of R&S, is NASMHPD's public-domain curriculum based on Six Core Strategies© to change organizational culture and practice and eliminate violence in care settings (NASMHPD, 2009). This comprehensive teaching tool, available to all professionals at no cost, teaches leaders committed to reducing and preventing violence how to effectively change practice through key strategies: (a) including leadership to create organization change; (b) using prevention tools to assess medical risks and risks of violence, use sensory interventions, and create individual crisis prevention plans; (c) using data to inform practice; (d) developing and supporting the workforce; (e) including consumers (i.e., youth and families) in the process; and (f) debriefing methods to prevent reoccurrence if R&S occurs (NASMHPD, 2009).

Finally, if school nurses are conflicted about R&S use and which standards should guide their clinical work, consider adopting the "platinum rule" and treat others, specifically the students in their care, the way their parents want them to be treated. Given the outpouring of parental outrage on advocacy blogs and by way of legal action against school districts, it is clear that they do not want their children tied up or isolated in the schoolhouse.

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