

# A Review of Crisis Intervention Training Programs for Schools

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*Recent advocacy organization reports, Congressional hearings, and proposed federal legislation have called attention to the abusive use of physical restraint procedures in school settings. As a result, administrators and school officials wonder whether they should purchase "crisis intervention" training for staff and faculty members from outside vendors. Unfortunately, there is limited information available regarding the content of these training programs, and the vendors who provide this training view the subject matter as proprietary and confidential. As a result, it can be difficult for schools to obtain information that might help them make choices about the training they are purchasing. Comparing different programs' emphasis on certain topics, course content, duration, and type of instruction can assist administrators and educators in selecting a crisis intervention training program that is most appropriate for their school.*

Educators, policy makers, and communities recently have become focused on the use of physical restraint procedures in school settings. *Physical restraint*—sometimes referred to as *ambulatory restraint*—is "any physical method of restricting [an individual's] freedom of

movement, physical activity, or normal access to his/her body" (International Society of Psychiatric and Mental Health Nurses, 1999, ¶3). Although several commercial vendors offer training programs intended to provide information and skills to deescalate crisis situations and employ in a safe and effective manner, most educators know little about their content or training procedures. In this article, we examine the content emphases of these programs and the differences in training delivery methods. Issues relating to seclusion of students are beyond the scope of this study. In light of current controversy and policy changes related to the implementation of restraint procedures in schools, this information should be helpful to schools and programs intending to purchase or renew contracts for this kind of training.

## Background

Over the last several years newspaper and television media have brought to the attention of the community numerous instances of children being killed or injured as a result of being physically restrained in schools. Among the risks associated with restraint include physical injuries resulting from falls, punches, kicks, bites, or falling into furniture. Students may also experience psychological trauma from being



restrained, although the impact may not be initially evident. Mohr, Petti, & Mohr (2003) cautioned that the use of restraint has resulted in fatalities for numerous reasons, including asphyxia (e.g., suffocation), aspiration (e.g., choking), and blunt trauma to the chest.

During this same timeframe national protection and advocacy agencies strived to promote public awareness of this issue by releasing reports documenting abusive situations in which restraints were improperly used with children (Council of Parent Attorneys and Advocates, 2009; National Disability Rights Network, 2009), as well as supporting parent complaints and encouraging legal action on such cases. In spring 2009, a U.S. House of Representatives Congressional Committee on

Education and Labor held a hearing on this topic, and the Government Accountability Office (GAO) issued a report documenting many of these abuses (2009). This was followed quickly by a White House briefing on this topic and a letter from U.S. Secretary of Education Arne Duncan (2009) calling for all states and school districts to examine their policies on the use of restraint and to ensure that appropriate policies and safeguards were in place to protect children. In December 2009, federal legislation was introduced to regulate the use of these procedures in schools in order to prevent abusive situations (H.R. 4247 and S. 2860, 2009), thereby emphasizing the need for professional training of staff members in crisis intervention.

#### **Standards and Policies**

Most medical, psychiatric, and law enforcement agencies have licensing standards that govern their use of physical restraint. The Children's Health Act of 2000 regulates the use of restraint in hospitals and treatment centers that receive federal funds. These requirements have resulted in widespread training and certification of staff in medical and psychiatric programs that employ physical restraints. Over the last 2 decades, many of these types of programs have attempted to drastically reduce their use of restraint

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procedures because of the number of deaths and injuries related to their use (Carter, Jones, & Stevens, 2008; Colton, 2008).

Schools, however, are largely governed by state education agencies. Unfortunately, there has been little guidance on these topics from state departments of education; where policies do exist, they vary greatly in content and are often advisory in nature (GAO, 2009; Ryan, Robbins, Peterson, & Rozalski, 2009; U.S. Department of Education, 2010). The lack of commonly accepted written standards for the

use of physical restraint in school settings increases the potential for inappropriate use of restraint due, in part, to inadequate training in the use of these procedures.

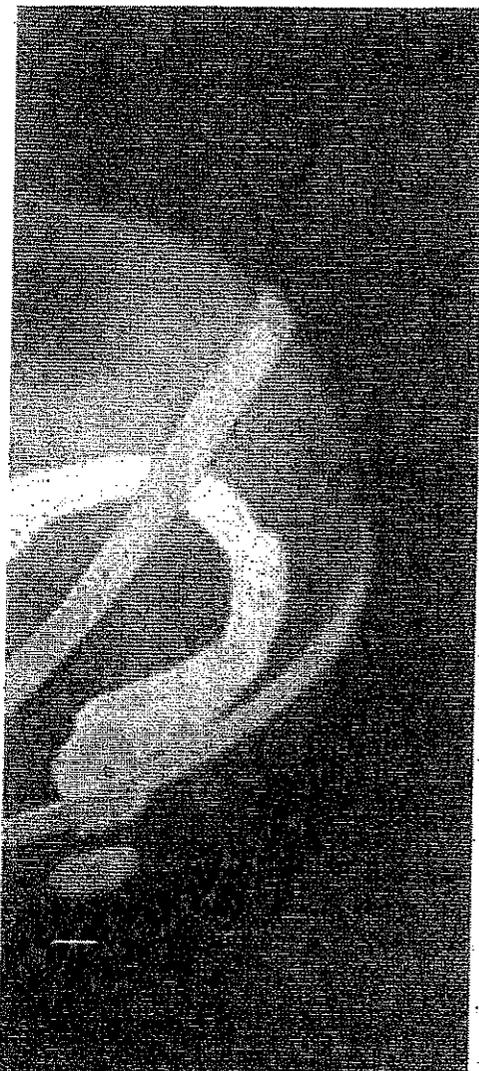
#### **The Need for Behavior Crisis Training in Schools**

##### **Challenging Student Behaviors**

The number of students with serious behavior issues who are served in general school settings has increased dramatically. This population includes students with emotional or behavior disorders, autism spectrum disorders, traumatic brain injury, and other health impairments (which may include attention deficit disorders and other mental health diagnoses). Problems may arise when students with behavioral disabilities are integrated into general education classroom settings in schools where staff lack the expertise needed to effectively prevent and manage student conflict and other behavior problems. Further, ineffective educational programming (e.g., failure to provide appropriate curricular, instructional, and/or behavioral interventions) may exacerbate the behavioral difficulties of some students, leading to a vicious cycle of antecedents that set the stage for problem behavior (Long, 1996). All this, combined with personnel who lack training in effective responses for

preventing or managing behavioral escalation, may lead to seriously disruptive or dangerous behavior that is managed by physically controlling the student through the use of restraint.

In addition, educators must cope with violent and disruptive behavior caused by other students, including student gang members, students with drug or alcohol problems, and students with undiagnosed or untreated mental illness. Although infrequent, there have also been widely publicized episodes of school violence and assault occurring in schools. Being able to manage



the aggressive behaviors commonly displayed by these students is no longer the sole concern of only special educators who have historically served students with the potential for behavioral crisis in segregated settings. Having the ability to safely manage a behavioral crisis has now become critically important for all staff members who work with these students, including general education teachers, paraprofessionals, counselors, and administrators.

### Prevention and Deescalation

Although physical restraint may be needed in emergency situations in schools where student behavior may threaten injury or death to that student or others, these procedures are sometimes being used in inappropriate circumstances and without awareness of the dangers that their use creates. Being able to determine the need for physical intervention and how to correctly and appropriately use these procedures in emergency situations requires staff training. Staff training strategies for preventing behavior problems and for conflict deescalation may also reduce the number of situations that might require using these procedures (Ryan, Peterson, Tetreault, & Van der Hagen, 2007).

There are several primary prevention strategies to prevent conflict and inappropriate behavior from initially developing. One widely used evidence-based preventive approach is positive behavior interventions and supports (PBIS), which focuses on (a) teaching students how to behave appropriately, (b) increasing reinforcement for appropriate student behavior, and (c) using data to design and monitor behavioral interventions and supports. PBIS-based interventions have demonstrated efficacy in increasing prosocial behavior and reducing challenging behavior when (a) applied universally throughout the school or agency; (b) applied to particular settings such as classrooms, playgrounds, or home settings; and (c) used with individual students (Sugai et al., 2005).

There is a variety of other preventive approaches, including curricula to

promote cooperation and reduce conflict (e.g., Peaceable School Program, Bodine, Crawford, & Schrupf, 1994; Creative Conflict Resolution, Kreidler, 1984; Peace Patrol, Steele, 1994); meditation programs (e.g., Community Board Program, 1990; Copeland, 1995; Kreidler, 1997); bullying preventing programs (e.g., Bonds & Stoker, 2000; Espelage & Swearer, 2004; Garrity, Jens, Porter, Sager, & Short-Camilli, 1994; Hoover & Oliver, 1996; Newman, Home, & Bartolomucci, 2000; Olweus, 2000); and schoolwide social skills or character education programs (e.g., Boyer, 1995; Likona, 1988; and organizations such as the Search Institute, Character Counts, and The Character Education Partnership).

Research indicates that preventive approaches can indeed reduce challenging behavior and thus reduce the need for physical restraint to control disruptive or dangerous behaviors (George, 2000; D. N. Miller, George, & Fogt, 2005; J. Miller, Hunt, & George, 2006). There are also techniques for deescalating individuals who are exhibiting out-of-control behavior, that are essential for any school personnel working with students who have the potential for such behavior. Unfortunately, when staff are not properly trained in effective crisis intervention techniques and don't know how to properly respond to students as they progress through the various stages of the cycle of aggression (i.e., agitation, acceleration, peak, deescalation; Colvin, 2004), their actions, both verbal and physical, may inadvertently exacerbate the behavior.

### Assessing Crisis Intervention Training Programs

Although school-based programs may offer the potential for preventing or reducing the likelihood of crisis situations occurring in school, specific training is also needed regarding how to manage crisis situations. Commercial crisis intervention training programs are geared toward staff in a variety of settings where clients have the potential for behavioral crises requiring intervention, such as psychiatric hospitals, correctional facilities, mental

health treatment programs, police forces, and even schools. Although many of these programs refer to "prevention" or "conflict deescalation" components, most people think of this type of training as "restraint training."

Selecting a program that provides sufficient evidence-based information about the broad range of variables that are important to prevention of behavioral crises (e.g., variables related to curriculum, instruction, behavior management, or verbal interactions) is an important task for school and agency administrators. Unfortunately, it can be hard to access the critical information administrators need to know prior to selecting an appropriate training program for their specific school, such as course content, emphases, length of training, and types of physical interventions taught. How do these programs differ regarding course content, duration, and training features?

### Commercial Training Programs

We used a common Internet search engine and nominations from professional educators based on their experience to identify 22 commercial programs (for-profit and not-for-profit) that currently offer training in crisis deescalation procedures for educators. We contacted either the company's owner or a lead trainer directly and asked that they respond via interview or in writing to a 38-item questionnaire (available from the first author upon request) addressing the following areas: (a) purpose of program, (b) terminology, (c) components of training program, (d) time allotted for each training component, (e) training and certification/recertification requirements, (f) types of programs offered, and (g) instructional strategies incorporated within training. Potential respondents were able to review the questionnaire in advance and were given the option of responding via telephone interview or in writing. If we did not receive a response within 1 month after initial contact we followed up. After we tabulated the information from the completed questionnaires and created tables, we sent the results to each respondent so that they could ver-

**Table 1. Crisis Intervention Training Programs**

Organization	Program Name	Phone Number	Web Site
Crisis Prevention Institute (CPI), Inc.	Nonviolent Crisis Intervention (NCI)	800-558-8976	www.crisisprevention.com
David Mandt and Associates	The Mandt System	800-810-0755	www.mandtsystem.com
Devereux National	Safe & Positive Approaches	610-542-3107	www.devereux.org
JKM Training, Inc.	Safe Crisis Management	866-960-4SCM	www.jkmtraining.com
NAPPI, International, Inc.	BESST	800-358-6277	www.nappi-training.com
Pro-ACT, Inc.	Professional Assault Crisis Training	949-489-5700	www.proacttraining.com
Quality Behavioral Solutions, Inc.	Safety-Care	866-429-9211	www.qbscompanies.com
Residential Child Care Project, Cornell University	Therapeutic Crisis Intervention (TCI)	607-254-5210	www.rccp.cornell.edu/TCI
Rocket, Inc.	Positive Behavior Facilitation (PBF)	301-980-2927	www.rocketinc.net
Satori Learning Designs, Inc.	Satori Alternatives to Managing Aggression	210-641-0955	www.satorilearning.com
Service Alternatives Training Institute, A Division of Service Alternatives, Inc.	RIGHT RESPONSE	800-896-9234	www.rghtresponse.org
Therapeutic Options, Inc.	Therapeutic Options	302-753-7115	www.therops.com
University of Oklahoma National Resource Center for Youth Services (OUNRCYS)	Managing Aggressive Behavior (MAB)	918-660-3700	www.nrcys.ou.edu/training.shtml

*Note.* The content of the programs reported in this article is copyrighted and may not be used or reproduced without permission from the individual programs. The names of most of these programs are trademarked and may not be used by others.

ify the accuracy of the information provided in this article and correct any inaccuracies.

Thirteen (60%) of the identified crisis intervention training programs voluntarily responded to the electronic survey. Table 1 provides organization, program name, and contact information for each of these programs. Although each organization's mission statement varies, the primary focus of all of the programs is to provide staff members who are working in hospital, school, residential facility, habilitation center, and community-based settings professional training on how to properly prevent and intervene in aggressive behavior. Although all of these programs focus on prevention of aggressive or out-of-control behavioral episodes, all except one program (i.e., Positive Behavior Facilitation) also offer instruction on the use of physical restraint procedures as a part of the training.

Many of these programs offer several levels of training courses, ranging from a basic practitioner level (the focus of this article) to more advanced train-the-trainer programs which certify participants to provide training to other staff members in their school or agency sites. Further information regarding other levels of training offered is available from the vendors. It should be noted that all the information regarding the content of training programs presented in this review is proprietary or copyrighted by the individual programs. Further, most of these programs provide training for a wide range of clients, including hospitals, residential treatment facilities, and other facilities, not just schools. For purposes of this review, we use terminology reflective of schools (e.g., *students* rather than *clients* or *patients*).

**Training Program Components**

To be able to distinguish how the various programs divided their emphases

in training, we asked vendors to provide the total amount of training time in their basic or initial training program and how much of that time addressed each of six specific components: (a) general information and definitions, (b) crisis antecedents and deescalation, (c) restraint procedures, (d) restraint monitoring procedures, (e) debriefing and follow up, and (f) other additional training topics (see Table 2). There was a wide range of answers among the 13 programs; "basic" training varied from 12 to 36 hours. Most of the programs spend a substantial amount of time on "crisis antecedents and verbal deescalation," with all but one program (i.e., Safe and Positive Approaches at 17.5%) indicating between 25% and 50% of time spent on this topic. In programs that included training in physical restraint, 10% to 32% of the total training time was devoted specifically to training in various restraint procedures. Only one program (i.e., Safe &

**Table 2. Crisis Intervention Training Components**

Program	General Information/Definitions	Crisis Antecedents & Deescalation	Restraint Procedures	Restraint Monitoring Procedures	Debriefing & Follow Up	Additional Training	Total Basic Training
Nonviolent Crisis Intervention® (NCI)	4% (.5 hr)	43% (5.75 hr)	25% (3 hr)	8% (1 hr)	15% (1.75 hr)	0%	100% (12 hr)
The Mandt System	2.5% (.4 hr)	25% (4 hr)	15% (2.4 hr)	2.5% (.4 hr)	2.5% (.4 hr)	52.5% (8.4 hr)	100% (16-24 hr) <sup>a</sup>
Safe & Positive Approaches	10% (2 hr)	17.5% (3.5 hr)	30% (6 hr)	2.5% (.5 hr)	2.5% (.5 hr)	37.5% (7.5 hr)	100% (20 hr)
Safe Crisis Management	5% (.9 hr)	40% (7.2 hr)	25% (4.5 hr)	5% (.9 hr)	10% (1.8 hr)	15% (2.7 hr)	100% (18 hr)
BESST	5% (.8 hr)	30% (4.8 hr)	25% (4 hr)	5% (.8 hr)	5% (.8 hr)	30% (4.8 hr)	100% (16-20 hr) <sup>a</sup>
Professional Assault Crisis Training (Pro-ACT)	10% (2 hr)	45% (9 hr)	10% (2 hr)	15% (3 hr)	15% (3 hr)	5% (1 hr)	100% (20 hr; 16-hr basic course, 4-hr restraint certification course)
Safety-Care	5% (.6 hr)	25% (3 hr)	25% (3 hr)	10% (1.2 hr)	10% (1.2 hr)	25% (3 hr)	100% (12 hr) <sup>b</sup>
Therapeutic Crisis Intervention (TCI)	5% (1.4 hr)	50% (14 hr)	30% (8.4 hr)	5% (1.4 hr)	10% (2.8 hr) Addnl 12-hr module available)	0	100% (28 hr)
Positive Behavior Facilitation (PBF)	50% (18 hr)	25% (9 hr)	0% (0 hr)	0% (0 hr)	0% (0 hr)	25% (9 hr)	100% (36 hr)
Satori-Alternatives to Managing Aggression	10% (1.2 hr)	50% (6 hr)	15% (1.8 hr)	5% (.6 hr)	5% (.6 hr)	15% (1.8 hr)	100% <sup>c</sup>
RIGHT RESPONSE®	2% (.28 hr)	31% (4.34 hr)	32% (4.48 hr)	5% (.7 hr)	5% (.7 hr)	25% (3.5 hr)	100% <sup>d</sup>
Therapeutic Options	10% (1.4 hr)	35% (4.9 hr)	20% (2.8 hr)	2% (.28 hr)	5% (.7 hr)	30% (3.5 hr)	100% (14 hr)
Managing Aggressive Behavior (MAB)	30% (3.9 hr)	25% (3.25 hr)	20% (2.6 hr)	5% (0.65 hr)	15% (1.95 hr)	5% (.65 hr)	100% (13 hr)

Note. Many programs offer multiple levels of training. The percentages were provided by the programs. Hours were calculated on the lowest level training offered.

<sup>a</sup>Percentage based on 16-hr training. <sup>b</sup>Core curriculum requires 12-16 hr. <sup>c</sup>Percentage based on 12-hr training. <sup>d</sup>Percentage based on 14-hr advanced certification program. <sup>e</sup>Offers 4 levels of training, ranging from 5-14 hr; each level adds additional layers of skills, depending upon the role and needs of the attendee.

Positive Approaches) spent more time on teaching restraint procedures than on antecedents and deescalation; two others (Safety-Care and RIGHT RESPONSE) indicated nearly equal time devoted to these topics.

For those programs that addressed restraint, from 2.5% to 15% of available time was devoted for each of the topics of restraint monitoring proce-

dures and debriefing. Such procedures typically include an evaluation of student and staff safety and breathing irregularities or other indicators of student safety and well-being during the restraint. All of the programs that teach physical restraint procedures also instruct participants how to monitor the restraint procedures, although some of these amounts of time were minimal

(2.5% to 10% of training time). The programs that teach restraint procedures also spend a portion of their training time (again, sometimes a rather minimal 2.5% to 15% of training time) providing participants with strategies for debriefing and following up with students and/or staff after administering a physical restraint.

**Table 3. Releases, Escorts, and Restraint Procedure Components**

Program	Protection and Releases	Physical Escorts	Standing Restraint	Seated Restraint	Pronc Floor Restraint	Supine Floor Restraint	Side Floor Restraint
Nonviolent Crisis Intervention® (NCI)	Examples of principle based personal safety (7)	Yes (1)	(4; includes transport position, counted in Escorts)	No	No <sup>c</sup>	No <sup>c</sup>	No
The Mandt System	Not specified	Not specified	Yes	Not specified	No	No	No
Safe & Positive Approaches	Yes (13)	Yes (4)	Yes (2)	Yes (6)	No	Yes (4)	No
Safe Crisis Management	Yes (2)	Yes (3)	Yes (8)	Yes (4)	Yes (3) <sup>a</sup>	Yes (3) <sup>a</sup>	Yes (1)
BESST	Not specified	Yes (2)	Yes (3)	Yes (2; for small bodies)	No	No	Yes (1)
Professional Assault Crisis Training (Pro-ACT)	Yes	Yes	Yes	Yes	Yes	Yes	Not specified
Safety-Care	Yes (7)	Yes (2)	Yes (2)	Yes (2)	Yes <sup>b</sup>	Yes <sup>b</sup>	No
Therapeutic Crisis Intervention (TCI)	Yes (10; protective interventions including releases)	Not specified	Yes (1)	Yes (2)	Yes (1)	Yes (1)	No
Positive Behavior Facilitation (PBF)	No	No	No	No	No	No	No
Satori Alternatives to Managing Aggression	Not specified	Yes (1)	Yes (2)	No	No	No	Yes (1)
RIGHT RESPONSE	Yes (14)	Yes (8)	Yes (7)	Yes (7)	Yes (3) <sup>a</sup>	No	No
Therapeutic Options	Yes	Yes (3) <sup>a</sup>	Yes (3)	Yes (1) <sup>a</sup>	No	Yes (1) <sup>a</sup>	No
Managing Aggressive Behavior (MAB)	Yes	No	Yes	No	No	No	No

Note. Number in parenthesis (e.g., 3) represents number of types of restraints taught for that category.

<sup>a</sup>Taught only on request, where legal. <sup>b</sup>Requires advanced training to perform. <sup>c</sup>Advanced training teaches transition from this to standing restraint.

**Types of Restraint Interventions**

The majority of crisis intervention programs provide training in one or more of the following areas: (a) protection and releases, (b) physical escorts, (c) standing restraints, (d) seated restraints, (e) prone floor restraints, (f) supine floor restraints, and (g) side floor restraints (see Table 3).

*Protection and Releases.* Releases are protection techniques that a staff mem-

ber can use to avoid physical injury from a physically aggressive student. Protection maneuvers allow staff members to avoid blows (e.g., punches or kicks) to the body; release maneuvers teach staff members how to escape from a student's grasp (e.g., student grabs staff member's hair) with minimal injury if they are unsuccessful in avoiding an attack. Most of the programs incorporate some training on protection and release techniques,

although three programs did not specify their content in this area (see Table 3). This type of training can be beneficial to those dealing with physically aggressive students because it trains staff how to deal with physical aggression in a manner that avoids injury to either the student or the staff member.

*Physical Escorts.* Physical escorts are interventions that staff members can utilize to transport a student from one setting (e.g., classroom) to another for

purposes of safety. Escorts are typically conducted using either one or two staff members. Five (38%) of the programs provide training on how to escort students (two programs did not provide training on this topic, and two did not specify their training here). It is important for staff to recognize that performing a physical escort risks escalating student aggression further given that it requires a staff member (a) to force a student to perform an action she or he does not desire, and (b) to physically place hands on an agitated student. Both of these actions may result in an escalation of aggressive behavior. Escorts in a school setting are typically used to remove a student from a classroom or to move a student to a seclusion or time-out environment.

**Standing Restraints.** Standing physical restraints typically entail one or more staff members using their hands and bodies to immobilize a student from the standing position. Most standing restraint procedures attempt to control the student's arms while maintaining him in an unbalanced position to prevent him from being able to strike a staff member with his legs. All 12 (100%) of the training programs that teach restraints teach a standing restraint hold. There are numerous variations of standing restraint procedures and, as can be seen in Table 3, up to eight variations of standing restraints may be taught. Selection of a specific method is often determined based on the size of the student and number of staff available. Standing restraints do pose a reduced risk of death due to asphyxia because all parties are standing up, and with the exception of wall restraints, prevent staff from placing weight on the student's back or chest.

**Seated Restraints.** Seated physical restraints are also discussed in most (8) of the training programs. The student is in a seated position, typically with arms interlocked to prevent hitting. Mechanical restraints are sometimes used to secure students to their own wheelchairs or other positioning equipment such as Rifton chairs. Because of the close proximity required for seated restraints, staff members

may be at risk for head butts, punches, or kicks.

**Prone or Supine Floor Restraints.** Floor restraints including prone (face down), supine (face up), and side restraints can be very dangerous and have resulted in death (National Disability Rights Network, 2009). Injuries can occur while trying to administer these restraints (e.g., tackles, falls to the ground) and also as a result of excessive pressures on the body (chest, lungs, sternum, diaphragm, back, neck, or throat) once the student is placed in the restraint (Council for Children With Behavioral Disorders, 2009). This risk emphasizes the importance of training programs teaching some sort of restraint monitoring procedure. Ongoing safety is a major concern with such restraints. The dangers associated with this type of restraint (i.e., they have been associated with the most injuries and deaths) may also explain why 58% (7 of the 12 which teach restraints) of the training programs reviewed do not currently teach prone restraints. Approximately 50% (6 of the 12 which teach restraints) do not teach supine restraints, probably because this position has much of the same potential for injury or death.

**Side Floor Restraints.** Only three of the programs include training in side floor restraints, where the student is placed on one side on the floor. Although intended to be less dangerous than prone or supine restraints, these positions may still pose some of the same dangers as described for prone and supine restraints, and may be hard to maintain without several staff members being involved.

#### **Safety Procedures**

Several types of safety procedures can be considered in training programs that employ physical restraint including (a) having a time limit on the restraint, (b) having more than one person involved in the restraint, (c) monitoring the student's physical state for symptoms of distress, and (d) monitoring the student's emotional state. These topics are addressed for the responding programs in Table 4.

**Time Limits.** Physical restraint procedures should only be utilized as long as necessary to prevent a student from injuring themselves or others. Obviously the time required to achieve this goal may vary based on both the circumstances and individual being restrained. Nevertheless, maintaining a restraint after danger of injury has passed could not only be viewed as unnecessary and therefore abusive, but may also extend the potential for injury. Currently, there do not appear to be any commonly agreed time guidelines. Six of the programs did not set a time limit or even make a recommendation regarding length of time for continuing physical restraints. One program set a limit of 3 minutes, with 4 programs making recommendations that restraints be conducted for 5 minutes or less. One program (i.e., Therapeutic Crisis Intervention) provided the longest time limit recommendation (15 minutes).

**Requiring Involvement of More Than One Person.** Another potential safety factor is a requirement that more than one staff member be involved in a restraint. This permits additional staff to manage the restraint, thus reducing the risk of injury by providing more control of the student's body. In addition, it permits more than one person to monitor the student's physical and emotional state. Three of the programs appeared to require that more than one staff member be involved; four other programs recommended more than one staff member. All programs may recognize situations where physical restraint may be necessary, whether or not more than one staff member is available.

**Provisions for Monitoring Physical State and Symptoms of Physical Distress.** Given the potential for injuries and deaths due to restraint procedures, all 12 of the training programs indicated that they train staff members to monitor students for symptoms of physical distress. Although exactly what symptoms are monitored and how training is accomplished varied; nevertheless, this appeared to be a universal component across programs.

**Table 4. Safety Procedures for Restraint Procedures**

Program	Time Limits	Requires More Than One Person	Provisions for Monitoring Physical State	Training Includes Symptoms of Physical Distress	Provisions for Monitoring Emotional State
Nonviolent Crisis Intervention® (NCI)	No	Yes	Recommends team interventions; one team member not involved in restraint should monitor student's physical state.	Yes	Staff members are taught to continually assess for signs of deescalation and opportunities to use a less restrictive means of intervention; auxiliary team members monitor emotional and physical safety of individual.
The Mandt System	3 Minutes	No	Follows recommendations of Child Welfare League of America	Yes	Yes
Safe & Positive Approaches	Position of student in restraint should be changed in accordance with time-limits, (e.g., at least every 5 min).	Recommended	Staff not involved in restraint should observe and document student's physical and emotional condition in accordance with established time-limits, (e.g., at least every 5 min); recommend that all staff members involved in restraints be trained in first aid and CPR.	Yes	Yes; staff are taught specific observational monitoring techniques.
Safe Crisis Management	5 min for prone; 10 min for all others	Recommended	Utilizes assessment recommendations of Child Welfare League of America. Recommends an observer for all physical restraints.	Yes	Yes
BESST	No	Yes	Techniques designed with respect to range of motion, avoidance of head and neck areas, maintain upright posture; recommends CPR certification for all direct-care employees.	Yes; breathing mechanics and kinesiology	No, but staff are taught that restraints cause emotional distress and therefore should be ended as soon as possible.
Professional Assault Crisis Training (Pro-ACT)	No	Recommended	Staff are taught physiological indicators of breathing and circulation.	Yes	Yes; staff are taught specific indicators of emotional trauma.
Safely-Care	No	Recommended	Yes; recommends a licensed medical professional monitor each restraint.	Yes	Yes; deescalation procedures continue during restraint.
Therapeutic Crisis Intervention (TCI)	No (decision whether to continue should be made by staff within 15 min)	Yes	Yes; recommends a health care professional be present to monitor each restraint.	Yes	Yes; staff are taught to assess level of agitation and listen to what student is saying.
Positive Behavior Facilitation (PBF)	N/A	N/A	N/A	N/A	N/A

*continues*

**Table 4. Continued**

Program	Time Limit	Requires More Than One Person	Provisions for Monitoring Physical State	Training Includes Symptoms of Physical Distress	Provisions for Monitoring Emotional State
Satori Alternatives to Managing Aggression	No, but recommend less than 5 min	Required for Floor Restraint	Yes	Yes	Yes, through the use of the Assisting Process.
RIGHT RESPONSE	No	No	Yes, staff are taught safety protocols.	Yes	Yes
Therapeutic Options	Left up to local school policy and state law	Yes, when possible; supine hold requires 3 people	Yes; nurses are summoned when available; nonmedical staff monitor in the absence of medical staff.	Yes	Yes; sensitivity to traumatization and retraumatization is a focus; stresses the importance of maintaining the helping relationship.
Managing Aggressive Behavior (MAB)	Recommend 5 min	No, but recommended	Yes; staff are taught to monitor student for risk factors of restraint and comfort.	Yes	Yes, through check-ins and assurances.

\*Symptoms that may be monitored include but are not limited to breathing, circulation, color of skin and nail beds, skin temperature, and bladder control.

*Provisions for Monitoring Emotional State.* In addition to monitoring physical state, the student's emotional state is potentially a strong indicator of when physical restraint procedures should be discontinued. All except one program suggested monitoring the emotional state, but all indicated that conflict deescalation procedures should be continued during the restraint and that the restraint should be ended or a less restrictive intervention attempted as soon as the student's emotional state permitted. At least some of the programs also provided training regarding the retraumatization of students, acknowledging that the use of restraint may trigger in some clients emotional responses based on prior experiences with physical or sexual abuse or other trauma.

**Documentation of incidents**

Seven of the training programs included procedures for documenting the use of restraint procedures (see Table 5). In most cases this included specific formats or templates for recording data about the incident. However, most of the programs did not include specific documentation of injuries occurring as a result of a restraint. At least a couple

of programs simply indicated that injuries be discussed as a part of the debriefing procedure. One program (i.e., Mandt) indicated that injuries to students should be reported to local protection and advocacy organizations.

**Certification and Recertification of Trainees**

All but one of the programs provide some form of time limited certification for completing basic training, but the requirements for recertification varied (see Table 5). Several had annual recertification, and a few biannual recertification. Others were not specific about their recertification requirements. It appeared that all of the programs had recurrent training and certification requirements for "trainers."

**Limitations**

Of the original crisis training programs we identified, nine elected not to participate in the study and some did not respond to our request. Some programs requested that they have final approval of any mention of their program in this article prior to publication, which we declined, with the result that these programs did not participate. There may very well be additional deescalation

training programs and other less formal training programs that local school systems may have developed or adopted for their own training purposes; so our findings may not reflect all of the training programs that might be available.

Even when training programs did respond, our questionnaire may not have permitted sufficient detail to adequately address program content or other details. This is particularly problematic because most of these programs are providing training that they view as proprietary, and thus may not be willing to share detailed content information for fear that the content may be stolen by others. In addition, these programs compete with each other and therefore do not want their proprietary information being shared even inadvertently with their competitors.

Finally, although we believe that the data for this article was accurate at the time that it was gathered (summer and fall 2009), the curriculum and content of these training programs may change over time. This is particularly true given the media and public attention on this topic, and given the deaths and injuries caused by some restraint holds or procedures.

**Table 5. Documentation, Complaints, and Certification Information**

Program	Type of Documentation	Procedure for Investigating Complaints or Injuries Related to Restraint	Certification/Recertification of Training
Nonviolent Crisis Intervention® (NCI)	Incident reports; data collection templates provided.	Injuries and complaints should be documented and discussed during debriefing.	Basic training: Annual refresher training recommended. Trainers: Annual recertification; testing every 2 years; renewal course every 4 years.
The Mandi System	Training provided on documentation requirements.	Recommend complaints or injuries be reported to state protection and advocacy organization.	Basic training: Annual certification. Trainers: Biannual certification.
Safe & Positive Approaches	Training provided on documentation requirements. Documentation includes antecedents, personnel involved, date and time, location, interventions, outcome, duration, injuries or damages, and events following incident.	Yes, during postintervention assessment and debriefing.	Basic training: Annual certification. Trainers: Annual certification.
Safe Crisis Management	Provides policy recommendations for recordkeeping, including model forms.	Provides policy recommendations, but no specific procedures.	Trainers: Annual recertification.
BESST	Provides recommendations for recordkeeping.	No.	Basic training: Annual recertification.
Professional Assault Crisis Training (Pro-ACT)	Provides training on documentation.	No.	Trainers: Annual training requirements.
Safety-Care	Provides training in documentation of all restraints and crisis incidents.	No.	Core curriculum: Annual certification. Trainers: Annual recertification.
Therapeutic Crisis Intervention (TCI)	Provides information that should be included in documentation reports.	Yes; separate course for investigating allegations of abuse and use of physical restraint.	Basic training: Refresher course required every 6 months.
Positive Behavior Facilitation (PBF)	N/A.	N/A.	Trainers: Recertification every 3 years.
Satori Alternatives to Managing Aggression	No, but encourages agencies to maintain data on use of restraints.	Recommends review of assisting process.	No recertification. Facilitators may lead "micro sessions" to keep skills fresh.
RIGHT RESPONSE	Recommends recordkeeping for purpose of data analysis.	Recommends documentation through incident reports.	Biannual recertification for Elements, Elements + Level; annual recertification for advanced level. Trainers: Annual or biannual recertification.
Therapeutic Options	No; left up to facility's internal requirements and those of the state system governing the program.	Not a formal part of the program, but manual recommends formal investigation of any incident involving injury.	Annual recertification for staff.
Managing Aggressive Behavior (MAB)	No.	No.	Basic training: Annual recertification.

®Requirements or recommendations for continued certification for staff and trainers.

### Implications for Practice

The amount of time for basic training varied considerably, although most of the training programs required about 12 to 16 hours for basic training. There did not appear to be a consensus regarding the length of basic training needed, although this may reflect varying levels of detail provided by different training programs. This variation raises the question of how much training should minimally be provided to educators regarding these topics in order to be effective. There is little

### One of the most significant differences among the program had to do with the relative emphasis placed on restraints versus crisis antecedents and conflict deescalation.

information or research to guide a decision on this important issue.

Although some of the major topics for training are consistent across vendors providing this training, it is clear that there are major variations in what is emphasized. One of the most significant differences among the programs had to do with the relative emphasis placed on restraints versus crisis antecedents and conflict deescalation. There may be a widespread need in educational settings to provide training to all or certain staff members on conflict deescalation; the need for all educators to be trained in physical restraint is much less clear. However, it can be argued that for the relatively few educators who need to be trained in using restraint procedures, a more thorough training may be necessary than can be accomplished in the relatively small amounts of time provided by some programs. This raises a question: Which type of training should be provided to whom? No guidelines exist regarding the amount of time needed to provide proficiency on these topics.

Future research might examine whether any vendors provide training that is specifically designed for children, particularly young children. Techniques used on an adult may be inappropriate for a child, particularly a small child.

Another growing concern is that these physical restraint techniques may retraumatize students already sensitive to touch due to previous physical/sexual abuse or sensory issues (e.g., autism). We did not determine whether these programs provided any information to trainees regarding *trauma informed care* or information specific to a disability or diagnosis.

Still another issue is whether training should be differentiated for educators versus care providers at psychiatric hospitals, detention facilities, correctional facilities, and so forth. Certainly,

the mission of schools is substantially different than these other institutions. In addition, schools often serve larger populations, are physically different (e.g., schools are typically not locked or secure facilities to the degree that other institutions are), and perhaps serve more diverse populations. Should the training provided to educators, for example, focus on educational antecedents (e.g., providing dynamic instruction, keeping students engaged in meaningful learning tasks) in addition to more traditional behavioral antecedents? Should training adopt or include more elements of a positive behavior supports approach to prevention, such as supervision, verbal acknowledgment of appropriate behavior, or environmental design?

Another topic not addressed in this analysis is the cost of basic training. We did not determine if programs had a standard cost for basic training, and obviously the cost would depend on a variety of factors. Many of these programs appear to offer advanced training to local "trainers" who are then "licensed" to do local training as a way to reduce school district costs.

Schools may be able to identify or develop sources for training related to the prevention and deescalation of aggressive behaviors beyond the commercial vendors surveyed in this report. As mentioned earlier, several

such programs already exist. If schools were to rely more on preventive programs, they may be less dependent on the vendors described in this study for training on those topics.

It seems likely, however, that the vendors described in this report will still be among the likely providers of training specifically addressing physical restraint for students in schools, as these vendors have collectively the largest set of experience and expertise related to this topic. They also have track records in providing this type of training. Although it is beyond the scope of our study to address standards for content of crisis intervention training programs, either the federal government or individual states may choose to identify content standards for training on these topics. Creating independent standards would provide an opportunity for further examination of the content of training provided regardless of the source of the training. Further research should explore establishing content standards and standards for quantity as well as quality of training, and compare individual training programs against these standards.

### Final Thoughts

The use of restraint procedures in public schools will likely continue to be a controversial issue for years to come, especially given the injuries, deaths, and litigation associated with its use. Training will continue to be a key point of discussion related to this topic, and school leaders will need additional information about the content and characteristics of available training in order to make decisions about training needs. This preliminary examination should provide a springboard to more detailed discussion of training needs related to physical restraint.

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Amy Hartmann, a special education teacher at Simon Middle School in Hays Consolidated I.S.D. in Texas, and Jenni Huber, a postdoctoral student at Arizona State University, both made important contributions to the development of this manuscript. These contributions are gratefully acknowledged.

TEACHING Exceptional Children, Vol. 42, No. 5, pp. 6-17.

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