Minnesota Journal of Law & Inequality

Volume 30 | Issue 2 Article 3

December 2012

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Introduction

No federal law in the United States prohibits school administrators from physically restraining or secluding students.[1] State laws diverge widely.[2] Unlike in medical, psychiatric, and law enforcement settings, where strict national standards govern the use of physical restraint and seclusion, many schools may have no, or inconsistent, guidelines to follow in deciding when the use of force upon students is appropriate.[3] This lack of industry-approved protocol and standardized training of school personnel makes restraint and seclusion susceptible to misapplication and abuse.[4]

Over a ten-year period in the 1990s, 142 restraint-related deaths were reported in the United States.[5] While restraints are dangerous even when used on adults, children face an especially

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1. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-09-719T, SECLUSIONS AND RESTRAINTS: SELECTED CASES OF DEATH AND ABUSE AT PUBLIC AND PRIVATE SCHOOLS AND TREATMENT CENTERS 3 (2009) [hereinafter GAO]; NANCY JONES & JODY FEDER, CONG. RESEARCH SERV., R 40522, THE USE OF SECLUSION AND RESTRAINT IN PUBLIC SCHOOLS: THE LEGAL ISSUES 1 (2010).

2. GAO, *supra* note 1; *see also* Daniel Stewart, *How Do the States Regulate Restraint and Seclusion in Public Schools? A Survey of the Strengths and Weaknesses in State Laws*, 34 HAMLINE L. REV. 531 (2011) (comparing and contrasting state laws governing the use of restraint and seclusion in public schools).

3. COUNCIL FOR CHILDREN WITH BEHAVIORAL DISORDERS, CCBD'S POSITION SUMMARY ON THE USE OF PHYSICAL RESTRAINT PROCEDURES IN SCHOOL SETTINGS 5–6 (2009).

4. *Id.* at 6.

5. *Id.* at 5.

high risk of death or serious injury.[6] The students who most often suffer the ill effects of restraint are children with disabilities, whose behaviors are often misunderstood and whose needs are often not accommodated.[7]

In the school environment, such misunderstanding and failure to accommodate contribute to students with disabilities receiving a disproportionate amount of seclusion and restraint.[8] For example, in one study, students with disabilities (as defined under the Individuals with Disabilities Education Act[9] and the Rehabilitation Act of 1973[10]) represented twelve percent of students in the sample, but comprised nearly seventy percent of the students who were physically restrained by adults in their schools.[11] When the Government Accountability Office (GAO) investigated the use of seclusion and restraint in U.S. public and private schools in 2009, it discovered hundreds of allegations of death and abuse over the prior twenty years.[12] Almost all of the reports the GAO received involved children with disabilities.[13] Many reports of death occurred following "prone restraints," in which a child is placed face down on a floor while being held by two or more adults.[14] In a 2009 investigation into the use of restraint and corporal punishment in U.S. schools, Human Rights Watch and the ACLU found that students with disabilities were punished at disproportionately high rates in almost every state that uses corporal punishment.[15] Although corporal punishment is theoretically distinct from the use of seclusion and restraint for student safety, the line between the practices is often blurred and researchers find that restraint and seclusion are being used for a

6. NAT'L DISABILITY RIGHTS NETWORK, SCHOOL IS NOT SUPPOSED TO HURT: INVESTIGATIVE REPORT ON ABUSIVE RESTRAINT AND SECLUSION IN SCHOOLS 7 (2009).

7. GAO, *supra* note 1, at 5. For a discussion of attempts to ensure the access to meaningful education for children with mental health disorders in the United States, see Sara J. Ruff & William Dikel, *Mental Health Related Services in IEPS*, INQUIRY & ANALYSIS, Nov. 2009, at 1, and Paul Ratwik & William Dikel, *Bridges and Firewalls: Contractual Relationships for Mental Health Services Provided in School Settings*, INQUIRY & ANALYSIS, Apr. 2009, at 4.

8. OFFICE FOR CIVIL RIGHTS, U.S. DEP'T OF EDUC., THE TRANSFORMED CIVIL RIGHTS DATA COLLECTION (CRDC) 5 (2012).

9. 20 U.S.C. § 1401(3) (2006).

10. 29 U.S.C. § 705(20) (2006).

11. OFFICE FOR CIVIL RIGHTS, *supra* note 8.

12. GAO, *supra* note 1, at 5.

13. *Id.*

14. *Id.* at 8–9.

15. HUMAN RIGHTS WATCH & ACLU, IMPAIRING EDUCATION: CORPORAL PUNISHMENT OF STUDENTS WITH DISABILITIES IN US PUBLIC SCHOOLS 29 (2009).

variety of purposes beyond ensuring safety.[16]

Restraint and seclusion did not originate in the school environment[17] and their current definitions are promulgated not by the Department of Education, but by the Centers for Medicare and Medicaid in their regulations on psychiatric facilities.[18] Seclusion is defined as "[t]he involuntary confinement of [an individual] alone in a room or area from which the [individual] is physically prevented from leaving."[19] The term restraint refers to "[a]ny manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of [an individual] to move his or her arms, legs, body, or head freely."[20] In U.S. schools, physical restraints are used most frequently, but school officials have also been reported to use crude mechanical restraints such as gagging students with duct tape or binding them to their chairs.[21]

In addition to the physical injuries that restraints can inflict on students, there are strong indications that they cause psychological injury as well, especially for children who have experienced prior abuse by adults.[22] The "trauma-informed care" literature recognizes that many children and adults with mental health disabilities have been subjected to some form of trauma resulting from abuse or neglect, and that coercive interventions often serve to retrigger or exacerbate underlying mental health illness symptoms.[23] Based in part on this premise, the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services, has developed strategies, resources, and a training center to reduce and prevent the use of restraint and seclusion.[24] Despite such recognition of the affirmative steps necessary to better protect against abusive practices, federal law remains silent on the matter.

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16. NAT'L DISABILITY RIGHTS NETWORK, *supra* note 6, at 10 (identifying punitive purposes as the most common reasons for using restraint and seclusion).

17. COUNCIL FOR CHILDREN WITH BEHAVIORAL DISORDERS, *supra* note 3, at 7.

18. NAT'L DISABILITY RIGHTS NETWORK, *supra* note 6, at 5.

19. 42 C.F.R. § 482.13(e)(1)(ii) (2011).

20. *Id.* § 482.13(e)(1)(i).

21. GAO, *supra* note 1, at 10–13.

22. COUNCIL FOR CHILDREN WITH BEHAVIORAL DISORDERS, *supra* note 3, at 5.

23. GORDON R. HODAS, RESPONDING TO CHILDHOOD TRAUMA: THE PROMISE AND PRACTICE OF TRAUMA INFORMED CARE 5–6 (2006).

24. For a review of SAMHSA's efforts in this area, see NAT'L CENTER FOR TRAUMA-INFORMED CARE, http://www.samhsa.gov/nctic/about.asp (last visited Apr. 3, 2012). *See also* Charles C. Curie, *SAMHSA's Commitment to Eliminating the Use of Seclusion and Restraint*, 56 PSYCHIATRIC SERVICES 1139, 1139–40 (2005).

The international community has shown its concern for the dearth of regulation on restraint and seclusion not just in the United States, but globally. In 1991, the United Nations General Assembly addressed human rights abuses against persons with mental illness by adopting the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.[25] Principle 11.11 provides, in part:

> Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose.[26]

While addressing the situation of institutionalized patients in particular, Principle 11.11 echoes the requirements of necessity and proportionality that apply to restraint of schoolchildren as well, as set forth in a number of international human rights instruments. These instruments address the issue of restraint and seclusion in general terms, rather than creating specific protocols. Each instrument, with its principal focus on a particular human rights issue, contributes to the creation of international norms regarding seclusion and restraint in schools. Restraint of disruptive students, both with disabilities and those without disabilities, violates these international norms whenever excessive force is used.[27] The force used is excessive if it goes beyond the least intrusive measures possible to ensure safety or if it amounts to abuse.[28] In the case of children with disabilities, even restraint that does not use excessive force may violate their basic human rights if restraint is used in response to behaviors that directly result from the child's mental health disorder and that the State has failed to identify and reasonably accommodate.[29]

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25. Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, G.A. Res. 46/119, Annex, at 189, U.N. Doc. A/46/119 (Dec. 17, 1991).

26. *Id.* at 190, princ. 11.11.

27. Convention on the Rights of the Child art. 19, Nov. 20, 1989, 1577 U.N.T.S. 3.

28. *Id.*; European Convention for the Protection of Human Rights and Fundamental Freedoms arts. 2, 3, 8, Nov. 4, 1950, 213 U.N.T.S. 222 [hereinafter ECHR].

29. Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, Annex, art. 5, U.N. Doc. A/RES/61/106 (Dec. 13, 2006).

I. Why Schools Disproportionately Restrain and Seclude Students with Disabilities

The disproportionate use of restraint and seclusion on students with disabilities may be due in part to a failure to properly recognize the prevalence of these disabilities within a set of students. For instance, the majority of students who qualify for special education services under the emotional disability category (ED, also known in some states as EBD or SED) have psychiatric disabilities.[30] These particular disabilities are likely to manifest as behavioral issues.[31]

For instance, Déry, Toupin, Pauzé, and Verlaan surveyed 324 Canadian elementary school students receiving special education services for behavioral difficulties and found that 74.3% of the students met the criteria for attention deficit hyperactivity disorder (ADHD), 52.5% for oppositional defiant disorder, and 34.8% for conduct disorder.[32] Further, 13.8% of the students presented with a general anxiety disorder and 8% with a major depressive episode in the past year.[33] Hall, Bowman, Ley, and Frankenberger found a similar pattern in the United States.[34] In addition to comprising a majority of the ED category, students with psychiatric disabilities are prevalent in other categories of special education students as well. Schnoes, Reid, Wagner, and Marder found that students with ADHD, while constituting the majority of students in the ED category, also may be classified under the category of "other health impairment."[35] Because psychiatric disorders are noted in the majority of ED children, "other health impairment," and autism-spectrum-disorder categories of special education, when restraint and seclusion are applied to students in these categories, they are predominantly being applied to students with psychiatric disabilities.

The high proportion of children with psychiatric disabilities in the ED special education population exceeds that of many other

30. Michèle Déry et al., *Frequency of Mental Health Disorders in a Sample of Elementary School Students Receiving Special Educational Services for Behavioural Difficulties*, 49 CANADIAN J. PSYCHIATRY 769, 772 (2004).

31. *Id.* at 770.

32. *Id.* at 771.

33. *Id.* at 772.

34. *See* Kristina M. Hall et al., *Comorbid Diagnosis and Concomitant Medical Treatment for Children with Emotional and Behavioral Disabilities*, 21 INT'L J. SPECIAL EDUC. 96 (2006) (reporting a similar survey in which seventy-seven percent of students suffered from at least one psychiatric disorder).

35. Connie Schnoes et al., *ADHD Among Students Receiving Special Education Services: A National Survey*, 72 EXCEPTIONAL CHILD. 483, 489 (2006).

comparator populations.[36] At 70.2%, it is higher than that of children and adolescents seen in the alcohol/drug treatment (60.3%), child welfare (41.8%), juvenile justice (52.1%), and even mental health (60.8%) systems.[37] Additionally, the underlying mental health disabilities among special education students are complex—often not limited to a single disorder. The Hall study revealed that 76.8% of 617 students studied were identified as having one or more psychiatric disorders and 21.2% of students were identified as having been diagnosed with multiple psychiatric disorders.[38] "Approximately 65% of the elementary students in ED programs were identified as receiving psychiatric medication for the treatment of one or more psychiatric disorders. . . . Fifteen percent of students were identified as receiving combinations of medications, and 6.2% were identified as receiving three or more medications concurrently."[39]

Instead of receiving the individualized treatment necessary to respond to such complex mental health disabilities, many ED students who possess such disabilities face a high risk of seclusion or restraint due to their behavior problems.[40] For many of these students, these behaviors initially led to their special education placement.[41] Although the majority of students in the ED category have psychiatric disabilities, the federal criteria for that category focus on behavior and not diagnosis.[42] As a result, the underlying psychiatric disability may not be directly addressed and its symptoms may not be appropriately accommodated.[43] Interventions are primarily based on behavioral concepts. Assuming that the student's behaviors are functional and based on factors such as work avoidance, attention seeking, or gaining tangibles, these interventions are unlikely to succeed if the behaviors are, in fact, direct clinical manifestations of the student's psychiatric disorder.[44] Despite such indications that restraint and seclusion are frequently misapplied to students with psychiatric disabilities,

36. Ann F. Garland et al., *Prevalence of Psychiatric Disorders in Youths Across Five Sectors of Care*, 40 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 409, 413 (2001).

37. *Id.*

38. Hall et al., *supra* note 34, at 96.

39. *Id.*

40. *See* William Dikel & Daniel Stewart, *Emotional/Behavioral Disorders and Special Education: Recommendations for System Redesign of a Failed Category*, 34 HAMLINE L. REV. 589, 596–97 (2011).

41. *See id.* at 595.

42. *See id.* at 590.

43. *See id.* at 599.

44. *Id.* at 596.

much about their use remains unknown as there is no federal restraint- or seclusion-use reporting law.[45] Only in March of 2012 did the Office for Civil Rights begin collecting data on restraint and seclusion use from a national sample of American schools.[46]

School personnel are likely to maintain that they need to provide a safe environment regardless of the underlying clinical causes of behaviors (e.g., psychiatric illness or brain tumors), and that schools are educational and not clinical institutions. Furthermore, schools may find that the student has received multiple diagnoses from multiple providers over the years, with no agreement on the nature of the student's disabilities. These inconsistencies can lead school personnel to question the usefulness of diagnosis in educational planning. School staff generally have limited training on mental health issues, including how psychiatric disorders manifest in an educational setting. As the majority of students who have mental health disorders never receive mental health services, and because school staff cannot rely upon all psychiatrically disabled students being correctly diagnosed and treated, behavioral interventions are often relied upon to maintain order and safety.

Schools' difficulty in adequately identifying psychiatric disabilities is compounded by the severe limitations in access to child psychiatric and other mental health services encountered by parents when they seek treatment services for their children. The majority of providers of mental health services are primary care physicians, many of whom have limited training in the diagnosis and treatment of psychiatric disorders.[47] Many students' families lack insurance coverage, or have policies with high copays and deductibles. School districts are mandated by the Individuals with Disabilities Education Act (IDEA) Special Education Law to be financially responsible for services deemed necessary for the provision of a free, appropriate, public education.[48] Whether such accommodations, which could include mental health services, are considered necessary depends on whether the team planning a child's individual education plan (IEP), deems them necessary in the IEP.[49] Such an IEP team includes multiple representatives

45. *See* GAO, *supra* note 1.

46. *See* OFFICE FOR CIVIL RIGHTS, *supra* note 8.

47. NAT'L INST. FOR HEALTH CARE MGMT. RESEARCH AND EDUC. FOUND., CHILDREN'S MENTAL HEALTH: AN OVERVIEW AND KEY CONSIDERATIONS FOR HEALTH SYSTEM STAKEHOLDERS 13–14 (2005).

48. *See* 34 C.F.R. § 300.101 (2011).

49. *Id.* § 300.320 (defining IEP).

from the child's school.[50] This process results in the reluctance of many school programs to directly recommend mental health diagnostic or treatment services in a child's IEP.

Schools, unlike treatment programs, do not have the option to deny services, and are obligated to educate all students including those individuals who have been discharged from correctional or mental health programs where they displayed severe aggressive tendencies. Health maintenance organizations (HMOs) and counties are becoming increasingly reluctant to provide intensive mental health services to children and adolescents. This reluctance has resulted in schools being required to fund programs for very severely disturbed students who previously were served in settings such as residential treatment programs. Hence, the psychiatrically disabled student who is being secluded or restrained may be the victim of a chain of numerous deprivations, including lack of health care coverage, lack of access to quality diagnostic and treatment services, misdiagnosis, lack of protection against medical neglect, and lack of insurance or county-authorized payment for intensive services. As discussed below, under a number of instruments, such deprivations may violate international human rights norms.

II. The Civil and Political Covenant and the Convention Against Torture

The International Covenant on Civil and Political Rights (Civil and Political Covenant), ratified by the United States on June 8, 1992, governs excessive restraint in schools through its prohibition on the use of cruel, inhuman, or degrading treatment or punishment under Article 7.[51] The Human Rights Committee (HRC), which is authorized to interpret and monitor implementation of the Civil and Political Covenant, emphasizes that the prohibition on the use of cruel, inhuman, or degrading treatment or punishment "must extend to corporal punishment, including excessive chastisement ordered . . . as an educative or disciplinary measure."[52] It clarifies that the "prohibition in article 7 relates not only to acts that cause physical pain but also to acts that cause

50. *Id.* § 300.321 (mandating inclusion of not less than one special education teacher and one regular education teacher on an IEP team).

51. International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter Civil and Political Covenant].

52. United Nations, Human Rights Comm., General Comment 20, Article 7 (Forty-Fourth Session, 1992), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, ¶ 5, U.N. Doc. HRI/GEN/1/Rev.1 (July 29, 1994) [hereinafter General Comment 20].

mental suffering to the victim."[53] Such acts, which inflict mental as well as physical suffering, could include restraints.[54] The HRC's comments note that Article 7 applies to the excessive use of seclusion as well, stating that "prolonged solitary confinement of the detained or imprisoned person may amount to acts prohibited by article 7."[55]

The language of the Civil and Political Covenant's Article 7 is mirrored in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), which was ratified by the United States on October 21, 1994.[56] Article 16 of the Convention against Torture similarly establishes a ban on "cruel, inhuman or degrading treatment."[57] The Committee against Torture, responsible for interpreting this Convention, has indicated that the "continuing application" of corporal punishment "could constitute in itself a violation in terms of the Convention."[58] This statement suggests that restraint and seclusion, if regularly misused as corporal punishment rather than as emergency interventions, could violate the Convention against Torture.[59]

In 2009, Manfred Novak, the United Nations's Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, reaffirmed that these provisions of the Civil and Political Covenant and the Convention against Torture are applicable to the school context:

> Since corporal punishment in all its forms . . . whether imposed by State authorities or by private actors, including schools and parents, has been qualified by all relevant intergovernmental human rights monitoring bodies as cruel, inhuman or degrading punishment, it follows that, under present international law, corporal punishment can no longer be justified, not even under the most exceptional situations.[60]

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53. *Id.*

54. COUNCIL FOR CHILDREN WITH BEHAVIORAL DISORDERS, *supra* note 3, at 5.

55. General Comment 20, *supra* note 52, ¶ 6.

56. *Convention against Torture: Status as at: 14-04-2012*, UNITED NATIONS TREATY COLLECTION (Apr. 14, 2012), http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9&chapter=4&lang=en.

57. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, 1465 U.N.T.S. 113 (1984) [hereinafter Convention against Torture].

58. Rep. of the Comm. against Torture, ¶ 169, U.N. Doc. A/50/44, GAOR, 50th Sess., Supp. No. 44 (1995).

59. HUMAN RIGHTS WATCH & ACLU, *supra* note 15, at 59–60.

60. Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Promotion and Protection of All Human Rights, Civil, Political, Economic, Social, and Cultural Rights, Including the Rights to*

The Special Rapporteur also specifically condemned the excessive use of restraint and seclusion on children and adults with disabilities. He noted that "there can be no therapeutic justification for the prolonged use of restraints, which may amount to torture or ill-treatment."[61] Furthermore, "persons with disabilities are often held in seclusion or solitary confinement as a form of control or medical treatment, although this cannot be justified for therapeutic reasons, or as a form of punishment" and it "may constitute torture or ill-treatment."[62]

III. Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child (CRC), which went into force in September 1990, sets forth the human rights of children, including access to education, and the rights of children with disabilities.[63] The CRC has been ratified by 194 countries—nearly every nation in the world—with the exception of the United States and Somalia.[64] The CRC contains a number of provisions that restrict the use of restraint and seclusion for students with disabilities. Like the Civil and Political Covenant and the Convention against Torture, the CRC includes a duty on states to protect children from "torture or other cruel, inhuman or degrading treatment or punishment."[65] The CRC, however, also offers specific protections to schoolchildren and children with disabilities.

Article 2 of the CRC creates an obligation on state parties to prevent discrimination of any kind against children within their jurisdiction, and makes explicit mention of disability as a prohibited ground for discrimination.[66] This express inclusion of disability reflects the fact that "children with disabilities belong to one of the most vulnerable groups of children."[67] While Article 2

Development, ¶ 37, U.N. Doc. A/HRC/10/44 (Jan. 14, 2009).

61. Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment*, ¶ 55, U.N. Doc A/63/175 (July 28, 2008).

62. *Id.* ¶ 56.

63. Convention on the Rights of the Child, *supra* note 27, at arts. 19, 23, 28.

64. *Convention on the Rights of the Child: Status as at: 26-04-2012*, UNITED NATIONS TREATY COLLECTION (Apr. 26, 2012), http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en.

65. Convention on the Rights of the Child, *supra* note 27, at art. 37(a).

66. *Id.* at art. 2.

67. United Nations, Comm. on the Rights of the Child, General Comment No. 9: The Rights of Children with Disabilities, ¶ 8, U.N. Doc. CRC/C/GC/9 (Feb. 27, 2007) [hereinafter General Comment No. 9].

demands that states prevent harmful discrimination against children with disabilities, Article 23 requires that states sometimes recognize the different capacities of children with disabilities and take action to ensure the maximum inclusion of those children into society.[68] This requirement, that children who are situated differently deserve to be treated differently, demands that states provide appropriate care and assistance to disabled children "free of charge, whenever possible" in order to "ensure that the disabled child has effective access to and receives education, training, health care services, [and] rehabilitation services, . . . in a manner conducive to the child's achieving the fullest possible social integration and individual development."[69] Article 24 echoes the obligation of states to provide to all children "the highest attainable standard of health," including providing children with disabilities the care they need.[70] These provisions create a duty on states to provide reasonable accommodation to students with disabilities.[71] This duty is breached—and the State is guilty of discrimination—when students with disabilities, who are not given appropriate care and assistance, are restrained or secluded by school personnel as a result of behavior directly arising from their disabilities.[72]

Reinforcing this standard is CRC Article 28, which directly addresses discipline issues in school.[73] The Article provides, "States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention."[74] Article 28 also reaffirms a state's duty to make a variety of forms of education accessible to all children.[75]

Although the CRC does not specifically address restraint and seclusion, Article 19 can be used to encourage states to protect

68. Convention on the Rights of the Child, *supra* note 27, at art. 23 ¶ 1; General Comment No. 9, *supra* note 67, ¶ 11.

69. Convention on the Rights of the Child, *supra* note 27, at art. 23 ¶ 3.

70. *Id.* at art. 24.

71. *See* General Comment No. 9, *supra* note 67, ¶ 65.

72. *See id.* (obligating states, in order to prevent discrimination in education for children with disabilities, to provide "personal assistance, in particular, teachers trained in methodology and techniques, including appropriate languages, and other forms of communication, for teaching children with a diverse range of abilities capable of using child-centred and individualised teaching strategies, and appropriate and accessible teaching materials, equipment and assistive devices, . . . to the maximum extent of available resources").

73. Laura C. Hoffman, *A Federal Solution that Falls Short: Why the Keeping All Students Safe Act Fails Children with Disabilities*, 37 J. LEGIS. 39, 78–79 (2011).

74. Convention on the Rights of the Child, *supra* note 27, at art. 28 ¶ 2.

75. *Id.* at art. 28 ¶ 1(a)–(d).

against the dangers these harmful practices present.[76] This Article obligates states to take all measures necessary to "protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."[77] The Committee on the Rights of the Child, charged with monitoring compliance with the CRC, issued General Comment No. 8, in which it found that Article 19 "does not leave room for any level of legalized violence against children" and that "[s]tates must take all appropriate legislative, administrative, social and educational measures to eliminate [any cruel and degrading forms of punishment]."[78]

The Committee acknowledged that "there are exceptional circumstances in which teachers and others, e.g. those working with children in institutions and with children in conflict with the law, may be confronted by dangerous behaviour which justifies the use of reasonable restraint to control it."[79] The Committee stated, however, that "[t]he principle of the minimum necessary use of force for the shortest necessary period of time must always apply."[80] In light of the Committee's General Comment No. 8, the Article 19 duty to protect should be interpreted to apply to the use of restraint and seclusion in schools.[81]

IV. Convention on the Rights of Persons with Disabilities

In December 2006, the United Nations adopted the Convention on the Rights of Persons with Disabilities,[82] which has since been ratified by 112 nations.[83] The United States has signed the Convention but not yet ratified it.[84] Despite the United States's reluctance to become a party, the Convention reflects a "'paradigm shift' in the way we think about and treat persons with

76. Hoffman, *supra* note 73.

77. Convention on the Rights of the Child, *supra* note 27, at art. 19 ¶ 1.

78. United Nations, Comm. on the Rights of the Child, General Comment No. 8: The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment, ¶ 18, U.N. Doc. CRC/C/GC/8 (Mar. 2, 2007).

79. *Id.* ¶ 15.

80. *Id.*

81. COUNCIL FOR CHILDREN WITH BEHAVIORAL DISORDERS, *supra* note 3, at 5–6.

82. Convention on the Rights of Persons with Disabilities, *supra* note 29.

83. *Convention on the Rights of Persons with Disabilities: Status as at: 26-04-2012*, UNITED NATIONS TREATY COLLECTION (Apr. 26, 2012), http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en.

84. *Id.*

disabilities."[85] Its creation of a universal standard for the human rights of persons with disabilities advances international norms that have potential to increase the protection of students with disabilities in the United States.[86]

The Convention marks the first treaty specifically focused on the rights of persons with disabilities that creates enforceable obligations for party governments.[87] The purpose of the Convention is to guarantee persons with disabilities the same rights enjoyed by others, including the right to health and the right to education.[88] As such, the Convention does not recognize any new rights of persons with disabilities, but rather seeks to clarify the duties of states to protect rights recognized in previous instruments—such as the Civil and Political Covenant and the Covenant on Economic, Social and Cultural Rights—as they apply to persons with disabilities.[89]

The Convention does not define "disability," acknowledging that the concept of disability is evolving.[90] The Convention, however, does say that "disabled persons" includes "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."[91] This approach differs from the definitions used in previous instruments in that it explicitly endorses the social model of disability, identifying disabled persons in terms of the obstacles they face to full participation in society, rather than in medical terms.[92] The Convention also "reconceptualizes mental health rights as disability rights,"[93] thereby including in its coverage children with mental disabilities who may be more prone to suffer restraint and seclusions in school.

The Convention contains a number of provisions that are implicated when a child with a disability is restrained or secluded in school instead of being given appropriate accommodations for his or her disability. Article 5 requires states to take all

85. MICHAEL L. PERLIN, INTERNATIONAL HUMAN RIGHTS AND MENTAL DISABILITY LAW: WHEN THE SILENCED ARE HEARD 144 (2012).

86. *Id.*; HUMAN RIGHTS WATCH & ACLU, *supra* note 15, at 58–59.

87. PERLIN, *supra* note 85, at 145.

88. *Id.* at 144–47.

89. Convention on the Rights of Persons with Disabilities, *supra* note 29, at pmbl. ¶ d.

90. *Id.* ¶ e.

91. *Id.* at art. 1.

92. *Id.* at art. 1, pmbl. ¶ e; PERLIN, *supra* note 85.

93. PERLIN, *supra* note 85.

appropriate steps to ensure that reasonable accommodations are provided to persons with disabilities.[94] Article 7 obligates states to take "all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children."[95] Articles 14, 15, and 17 of the Convention on the Rights of Persons with Disabilities protect the liberty and security of the person; freedom from cruel, inhuman, or degrading treatment; and the integrity of the person, respectively, echoing a number of provisions from the Civil and Political Covenant, the Convention against Torture, and the Convention on the Rights of the Child.[96]

Article 24 of the Convention on the Rights of Persons with Disabilities addresses education, including a number of provisions that call upon states to take appropriate action to accommodate students' disabilities, rather than resort to harmful practices like restraint and seclusion. The Convention instructs that states should ensure that children's impairments are identified early and that interventions and services are provided to minimize further disabilities.[97] In order to ensure fulfillment of disabled persons' right to education, Article 24 calls upon nations to avoid excluding disabled persons from compulsory education systems based on their disabilities, and to provide "the support required, within the general education system, to facilitate their effective education."[98] Governments should also ensure that "effective individualized support measures are provided in environments that maximize academic and social development."[99] These standards explicitly require states not only to provide mental health services to children with disabilities, but also to do so in conjunction with education. Exactly which services nations must provide, however, is subject to the caveat that each state is only required to "take measures to the maximum of its available resources."[100]

94. Convention on the Rights of Persons with Disabilities, *supra* note 29, at art. 5.

95. *Id.* at art. 7.

96. *Id.* at arts. 14, 15, 17.

97. *Id.* at art. 25 ¶ b.

98. *Id.* at art. 24 ¶ 2.

99. *Id.* ¶ 2(e).

100. *Id.* at art. 4 ¶ 2.

V. International Covenant on Economic, Social and Cultural Rights

The International Covenant on Economic, Social and Cultural Rights, which entered into force in 1976, has been ratified by 160 countries and signed but not ratified by 6 others, including the United States.[101] The Covenant addresses the rights of children with disabilities through its protection of "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,"[102] and "the right of everyone to education."[103] In 1995, the Committee on Economic, Social and Cultural Rights issued a General Comment on persons with disabilities.[104] General Comment No. 5 noted that, although the Covenant never explicitly mentions persons with disabilities, they are still entitled to the rights found in the treaty, including the right to health and the right to education, and that governments are obligated to take necessary measures, to the greatest extent possible, to ensure disabled persons full enjoyment of those rights.[105] Based on the Committee's interpretation of the treaty, governments are required not only to ensure that disabled persons within their jurisdiction are treated the same as everyone else, but also to provide special services, when possible, to allow disabled persons to exercise their rights to the greatest extent possible.[106]

Despite the Committee's General Comment, the lack of specific reference to disabled persons in the Covenant on Economic, Social and Cultural Rights may impede the protection of persons with disabilities.[107] Governments occasionally choose not to include information on the treatment of persons with mental health disorders or other disabilities in their periodic reports to the Committee on Economic, Social and Cultural Rights or other international bodies, choosing instead to treat conditions

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101. International Covenant on Economic, Social and Cultural Rights, Jan. 3, 1976, 993 U.N.T.S. 3; *International Covenant on Economic, Social and Cultural Rights: Status as at: 14-04-2012*, UNITED NATIONS TREATY COLLECTION (Apr. 14, 2012), http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en.

102. *Id.* at art. 12 ¶ 1.

103. *Id.* at art. 13 ¶ 1.

104. United Nations, Comm. on Econ., Social and Cultural Rights, General Comment No. 5: Persons with Disabilities (Eleventh Session, 1994), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 (May 12, 2003) [hereinafter General Comment No. 5].

105. *Id.* ¶ 5.

106. *Id.* ¶ 9.

107. *See id.* ¶ 6.

of disabled persons as a domestic matter and making monitoring of human rights violations difficult.[108]

Although such weaknesses arise from its failure to specifically refer to children with disabilities, the Covenant's requirement that nations meet the "highest attainable standard of physical and mental health" directly implicates their rights.[109] The Committee on Economic, Social and Cultural Rights clarified the meaning of the right to health in 2000 in its General Comment No. 14, including antidiscrimination measures relevant to people with disabilities.[110] The General Comment defines the right not as the right to be healthy but to have access to health care and other necessities for a healthy lifestyle and to be free from discrimination in access to health care and other health-related resources.[111] The Comment states that Articles 2.2 and 3 of the Covenant explicitly proscribe discrimination in the provision of health care means and entitlements toward people with physical or mental disabilities.[112]

In addition to the right to health, the Covenant provides protection to children with disabilities through its guarantee of "the right of everyone to education."[113] The right to education obligates governments to provide compulsory, free, primary education; to ensure access to secondary and higher education as well as technical and vocational education to the greatest extent possible; and to prevent discrimination within the educational system.[114]

This universal right to education without discrimination creates a duty to protect against neglect, exclusion, or separation based on disability that would prevent children from exercising their economic, social, and cultural rights on an equal basis with

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108. *See* Comm. on Econ., Social and Cultural Rights, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Slovakia, ¶ 32, U.N. Doc. E/C.12/1/Add.81 (Dec. 19, 2002); Debra Benko, *The Application of Universal Human Rights Law to People with Mental Disabilities*, HUM. RTS. BRIEF, Fall 2001, at 9.

109. International Covenant on Economic, Social and Cultural Rights, *supra* note 101, at art. 12.

110. United Nations, Comm. on Econ., Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Twenty-Second Session, 2000), ¶¶ 12(b), 18, 22, 26, U.N. Doc. HRI/GEN/1/Rev.6 (Aug. 11, 2003).

111. *Id.* ¶¶ 8, 12(b).

112. *Id.* ¶ 18.

113. International Covenant on Economic, Social and Cultural Rights, *supra* note 101, at art. 13 ¶ 1.

114. *Id.* at art. 13 ¶ 2(a)–(d).

persons without disabilities.[115] Hence, the Covenant obligates states to provide reasonable accommodations in schools to children with disabilities, including accommodations that are appropriately responsive to behaviors associated with their disabilities for which school staff might otherwise be unprepared.[116] In the United States, these accommodations would likely be described among strategies to be used to support the student in a student's IEP, a requirement for students with disabilities under IDEA.[117] A failure to provide such accommodations would likely contravene the norms established by the Covenant on Economic, Social and Cultural Rights.

VI. The European Convention on Human Rights

Although the United States is not a party to it, the European Convention on Human Rights (ECHR) further reinforces the international norms prohibiting excessive physical restraint of schoolchildren. Article 2 of the ECHR, which covers the right to life, could be construed to protect against any restraint that could cause death.[118] Article 3 echoes the numerous treaties that prohibit subjecting any person to inhuman or degrading treatment or punishment.[119] Article 14 prohibits denying an individual the rights in the ECHR because of the individual's protected status.[120]

Article 5 establishes a right to liberty and security, and prohibits the unlawful deprivation of freedom that would arise in an unnecessary restraint.[121] Important limits to the amount of force used in restraints are provided by ECHR Article 8, which establishes a right to physical integrity and requires that any action that interferes with this right should be: (1) in accordance with established law and guidelines; (2) for a legitimate purpose; and (3) necessary for and proportionate to that purpose.[122] To be

115. *See* General Comment No. 5, *supra* note 104, ¶ 15.

116. *Id.*

117. 20 U.S.C. § 1414(d); GAO, *supra* note 1.

118. ECHR, *supra* note 28, at art. 2.

119. *Id.* at art. 3; *see* Convention on the Rights of Persons with Disabilities, *supra* note 29, at art. 15; Convention on the Rights of the Child, *supra* note 27, at art. 37; Convention against Torture, *supra* note 57, at art.16; Civil and Political Covenant, *supra* note 51, at art. 7.

120. ECHR, *supra* note 28, at art. 14. Article 14 specifically prohibits "discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status." *Id.*

121. *Id.* at art. 5.

122. *Id.* at art. 8; *see* JOINT COMM. ON HUMAN RIGHTS, *Physical Restraint and Seclusion*, *in* THIRD REPORT, ¶ 224, ¶ 232 (2004), *available at* http://www.

proportionate, a physical intervention must be the least intrusive measure possible.[123] Intervention should be a last resort, applied with the minimum force necessary and for the shortest time necessary to ensure safety.[124]

The ECHR's principles of proportionality and necessity are reflected in decisions of the European Court of Human Rights, which provides a valuable source of case law on international human rights.[125] In *Winterwerp v. Netherlands*,[126] the court articulated the requirements that must be met before a state may involuntarily detain persons with disabilities.[127] The *Winterwerp* standard requires a diagnosis of a medically recognized mental disorder by objective medical experts, a determination that the disorder is of a kind or degree warranting compulsory confinement, and demands that detention is only permissible for as long as the disorder persists.[128]

The court established further constraints on the State's treatment of persons with disabilities in *Keenan v. United Kingdom*,[129] in which the court condemned the use of excessive restraints on persons with mental disabilities.[130] The court stated that "in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3 [of the ECHR]."[131] The *Keenan* case, which concerned a mentally ill man's suicide while in punitive seclusion, also clarified that seclusion can violate the right to be free from inhuman or degrading treatment or punishment under ECHR Article 3.[132]

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publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1511.htm (interpreting the ECHR for the government of the United Kingdom); URSULA KILKELLY, THE RIGHT TO RESPECT FOR PRIVATE AND FAMILY LIFE: A GUIDE TO THE IMPLEMENTATION OF ARTICLE 8 OF THE EUROPEAN CONVENTION ON HUMAN RIGHTS 31–32 (2003) (describing factors taken into account when deciding proportionality of interventions).

123. ECHR, *supra* note 28, at art. 8; JOINT COMM. ON HUMAN RIGHTS, *supra* note 122.

124. JOINT COMM. ON HUMAN RIGHTS, *supra* note 122.

125. Paul Hunt & Judith Mesquita, *Mental Disabilities and the Human Right to the Highest Attainable Standard of Health*, 28 HUM. RTS. Q. 332, 338–39 (2006).

126. 47 Eur. Ct. H.R. (ser. A) (1981).

127. *Id.* at 4–6.

128. *Id.*

129. 2001-III Eur. Ct. H.R. 94.

130. *Id.* at 134–35.

131. *Id.* at 135.

132. *Id.* at 135–36.

Another leading case on restraints on persons with disabilities from the European Court of Human Rights is *Price v. United Kingdom*.[133] In *Price*, a woman who did not have use of her four foreshortened limbs and who suffered kidney disease, was bound to her wheelchair while in detention, became dangerously cold, and was unable to use the bathroom without assistance or to reach emergency call buttons.[134] The European Court of Human Rights found that, despite the absence of any intention to humiliate the prisoner, these conditions constituted degrading treatment contrary to Article 3 of the ECHR.[135] The judgment established that the failure to treat differently a person whose situation is significantly different can itself be degrading.[136] While an important judgment in support of reasonable accommodations, commentators have cautioned the court might not be as willing to declare that a failure to accommodate constitutes degrading treatment when it occurs outside of an institution.[137]

There is, however, potential for expanding the rights of persons with disabilities beyond the institutional context.[138] The court constrained the corrective measures that may be taken against students with disabilities in *Tyrer v. United Kingdom*.[139] The court found that under ECHR Article 3, severe corporal punishment of any child is inhumane, regardless of the setting and even if committed by the child's parents.[140] In *D.H. v. Czech Republic*,[141] the Grand Chamber of the European Court of Human Rights clarified the responsibilities of school administrators when it found that the disproportionate segregation in the special

133. App. No. 33394/96, 34 Eur. H.R. Rep. 1285 (2002); Davíd Pór Björgvinsson, *The Protection of the Rights of Persons with Disabilities in the Case Law*, *in* THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: EUROPEAN AND SCANDINAVIAN PERSPECTIVES 141, 145 (Oddný Mjöll Arnardóttir & Gerard Quinn eds., 2009).

134. *Price*, 34 Eur. H.R. Rep. at 1294.

135. *Id.*

136. Oliver De Schutter, *Reasonable Accommodations and Positive Obligations*, *in* DISABILITY RIGHTS IN EUROPE: FROM THEORY TO PRACTICE 35, 54 (Anna Lawson & Caroline Gooding eds., 2005).

137. *Id.* at 55.

138. Colm O'Cinneide, *Extracting Protection for the Rights of Persons with Disabilities*, *in* THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: EUROPEAN AND SCANDINAVIAN PERSPECTIVES, *supra* note 133, at 141, 145.

139. 26 Eur. Ct. H.R. (ser. A) at 17 (1978).

140. *See id.* at 15–17 (describing the scope of Article 3's protection of children). *But see* Costello-Roberts v. United Kingdom, 247 Eur. Ct. H.R. 47, 60 (1993) (finding that the striking of a student three times with a soft-soled shoe by a teacher in a private school did not constitute inhumane treatment).

141. App. No. 57325/00, 47 Eur. H.R. Rep. 59 (2008).

education system of Roma students constituted active discrimination by the government, in violation of ECHR Article 14.[142] The court reasoned that the statistics used by the applicants to show the extent of racial segregation placed the burden on the Czech government to prove a nondiscriminatory justification, which it failed to do.[143] This willingness of the court to examine the impact of exclusionary treatment could open the door for systematic discrimination claims, including those claims based on disability.[144]

Commentators forecast further potential of the court to expand protection under ECHR Articles 3, 8, and 14 by scrutinizing resource allocation decisions in terms of their effect on persons with disabilities.[145] While the court's judgments do not carry the same binding status on the United States as an international treaty, they provide interpretive guidance that should be used to add specificity to understanding corresponding treaty-based rights.[146]

Conclusion and Recommendations

The United States, as a party to both the Civil and Political Covenant and Convention against Torture, is obligated to guard against any restraint or seclusion of school children that violates their common prohibition on cruel, inhuman, or degrading treatment or punishment.[147] International norms establish further expectations for protection of children in schools, particularly those children with disabilities. The Convention on the Rights of Persons with Disabilities imposes extensive obligations on the State to accommodate children with disabilities to prevent discrimination and provide them educational opportunities that are equal with those provided to other children.[148] Additionally, both the Convention on the Rights of the Child and the Covenant on Economic, Social and Cultural Rights establish duties to accommodate students with disabilities and provide them the highest attainable standard of health.[149] When, as in the United

142. *Id.* at 125.

143. *Id.* at 69–73.

144. O'Cinneide, *supra* note 138, at 185.

145. *Id.* at 186; De Schutter, *supra* note 136, at 45–53.

146. Hunt & Mesquita, *supra* note 125, at 338–39.

147. Convention against Torture, *supra* note 57, at art. 16; Civil and Political Covenant, *supra* note 51, at art. 7.

148. Convention on the Rights of Persons with Disabilities, *supra* note 29.

149. Convention on the Rights of the Child, *supra* note 27, at arts. 23, 24 (encouraging the extension of special assistance to disabled children to provide effective access to education); General Comment No. 5, *supra* note 104, ¶¶ 32, 35

States, physical restraint and seclusion are imposed disproportionately, repeatedly, or excessively on students with disabilities, the government is failing to meet the basic human rights of these students and thus violates international norms.[150]

The United States can rely on international human rights norms from the Civil and Political Covenant, the Convention against Torture, the Convention on the Rights of the Child, the Covenant on Economic, Social and Cultural Rights, and the European Convention on Human Rights, as well as current research literature, to develop legislation on a national level.[151] To reflect such international standards and research, legislation should focus on accountability through required documentation and regular reviews of the use of restraint and seclusion on individual and systemic levels.[152] It should mandate appropriate training for school employees, stricter standards on when restraint or seclusion is permitted, procedures to ensure restraint or seclusion are being applied safely, and prevention and reduction strategies. This legislation must also prohibit unjustifiable procedures, require reasonable accommodations to ensure access to education, and prevent discrimination. By enacting such laws in defense of human rights, the United States can halt the disproportionate infliction of trauma and ill-treatment on some of its most vulnerable citizens.

(entitling children with disabilities to special protection and requiring, under Articles 13 and 14, that the necessary equipment and support be made available to bring persons with disabilities up to the same level of education as their nondisabled peers).

150. HUMAN RIGHTS WATCH & ACLU, *supra* note 15, at 62–63.

151. For a review of trauma-informed care practices and research, see GORDON HODAS, RESPONDING TO CHILDHOOD TRAUMA: THE PROMISE AND PRACTICE OF TRAUMA INFORMED CARE (2006), *available at* http://www.dpw.state.pa.us/ucmprd/groups/public/documents/manual/s_001585.pdf.

152. For a comprehensive review of state laws existing in 2009 and recommendations for a comprehensive approach to restraint and seclusion, see Daniel Stewart, *supra* note 2, at 539–43.