

Aversive Treatment Procedures

A Special Educator's Guide to the Use of Aversive Treatment Procedures



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The Montana Office of Public Instruction does not advocate the use of aversive procedures to address behaviors exhibited by students with disabilities. However, we realize that some students with disabilities may exhibit behaviors that pose a danger to themselves, to other students, and to teachers and other school staff. Problem behaviors must be addressed by positive procedures that help students to develop the appropriate skills to become valued members of our society. For all students, behaviors must be addressed in the least restrictive manner appropriate to the individual student's needs and abilities.

This guide is intended for special educators who use aversive treatment procedures as defined in the special education rules of the state of Montana. The guide is not intended to answer every possible question regarding aversive treatment procedures, but to provide answers to general questions, as well as sample forms provided by the Office of Public Instruction. The guide does not address the development of functional behavior assessments or positive behavior interventions. For information on these topics, please contact your special education director or the Division of Special Education at 444-5661.

If you have questions regarding the use of aversive treatment procedures after reviewing this guide, please contact the Division of Special Education at 444-5661.

Suggestions regarding this guide may be sent to:

Aversive Treatment Procedures Guide Changes
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You may visit our website at:

www.metnet.state.mt.us/special/

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Text of the Administrative Rule on Aversive Treatment Procedures

10.16.3346 AVERSIVE TREATMENT PROCEDURES

(1) [Positive behavioral interventions](#) based on the results of a [functional behavioral assessment](#) shall serve as the foundation for any program utilizing aversive procedures to address the behavioral needs of students. Aversive treatment procedures may be appropriate for an individual student who exhibits behaviors which pose a risk of physical harm to the student or others, or a risk of significant damage to property, or significantly disruptive or dangerous behaviors which cannot be modified solely through the use of [positive behavioral interventions](#). Aversive treatment procedures must be designed to address the behavioral needs of an individual student, be approved by the IEP team, and may not be used as punishment, for the convenience of staff, or as a substitute for [positive behavioral interventions](#).

(2) Aversive treatment procedures are defined as:

(a) [physical restraint](#), other than as provided in [20-4-302](#), MCA, when the IEP team has determined that the frequency, intensity or duration of the restraint warrants an aversive treatment procedure; and

(b) [isolation time-out](#) which results in the removal of a student to an isolation room under the following conditions:

(i) the student is alone in the isolation room during the period of isolation;

(ii) the student is prevented from exiting the isolation room during the period of isolation;

(iii) the door to the isolation room remains closed during the period of isolation; and

(iv) the student is prohibited from participating in activities occurring outside the isolation room and from interacting with other students during the period of isolation.

(3) Any student in isolation time-out must be under the [direct constant visual observation](#) of a [designated staff person](#) throughout the entire period of isolation.

(4) The following procedures are [prohibited](#):

(a) any procedure solely intended to cause physical pain;

(b) isolation in a [locked room](#) or [mechanical restraint](#), except in residential treatment facilities and psychiatric hospitals as defined in

[20-7-436](#), MCA, when prescribed by a physician as part of a treatment plan and when implemented in compliance with relevant federal and state law;

(c) the withholding of a meal for a period of greater than one hour from its scheduled starting time; and

(d) [aversive mists](#), noxious odors, and unpleasant tastes applied by spray or other means to cause an aversive physical sensation; and

(e) [mechanical restraint](#) that physically restricts a student's movement through the use upon the student of any mechanical or restrictive device which is [not intended for medical reasons](#).

(5) Exclusion time-out is not considered an aversive treatment procedure. Exclusion time-out is defined as any removal of a student from a regularly scheduled activity for disciplinary purposes that does not result in placing the student in an isolation room under all of the conditions described in (2)(b).

(6) IEPs may include the use of aversive treatment procedures only when:

(a) [subsequent to](#) a [functional behavioral assessment](#), a [series](#) of no less than two written [positive behavioral intervention](#) strategies, which were [designed to target](#) the behavior to be changed, were previously implemented;

(b) the IEP team includes a person [trained and knowledgeable](#) about best practices in the application of [positive behavioral interventions](#), aversive treatment procedures and nonaversive alternatives for de-escalation of behaviors; and

(c) a [written behavioral intervention plan](#) using aversive treatment procedures is developed and incorporated as a part of the IEP.

(7) A behavioral intervention plan using aversive treatment procedures shall:

(a) include a [statement describing](#) no less than two [positive behavioral intervention](#) strategies previously attempted and the results of these interventions, as described in (6)(a);

(b) [describe](#) the target behavior(s) that will be consequented with the use of the aversive treatment procedure(s);

(c) [include](#) short-term objective(s) with measurable criteria stating the expected change in the target behavior(s);

(d) provide a written [description](#) of the aversive treatment procedure(s);

(e) specify a time limit for the use of the aversive treatment procedure [for any one instance](#);

- (f) include [data collection procedures](#) for recording each application of the aversive treatment(s);
 - (g) state when the IEP team will meet to review the ongoing use, modification or termination of the aversive procedure;
 - (h) designate an [individual](#) responsible for ongoing review and analysis of the data on the target behavior;
 - (i) state how the student's parents will be regularly informed of the progress toward the short-term objectives in the IEP at a frequency no less than is required in 34 [CFR 300.347](#); and
 - (j) state whether any standard school disciplinary measures are [waived](#).
- (8) When an aversive treatment plan is incorporated in the IEP, the parents must be [informed](#) that their consent to the IEP includes consent for the aversive treatment plan. Failure to obtain consent is subject to due process proceedings under ARM 10.16.3507 through 10.16.3523.

Common Questions About Aversive Treatment Procedures

10.16.3346 AVERSIVE TREATMENT PROCEDURES

(1) Positive behavioral interventions based on the results of a functional behavioral assessment shall serve as the foundation for any program utilizing aversive procedures to address the behavioral needs of students. Aversive treatment procedures may be appropriate for an individual student who exhibits behaviors which pose a risk of physical harm to the student or others, or a risk of significant damage to property, or significantly disruptive or dangerous behaviors which cannot be modified solely through the use of positive behavioral interventions. Aversive treatment procedures must be designed to address the behavioral needs of an individual student, be approved by the IEP team, and may not be used as punishment, for the convenience of staff, or as a substitute for positive behavioral interventions.

1. What are “positive behavioral interventions?”

Positive behavioral interventions are nonaversive treatment procedures used to address student problem behavior(s). Examples of positive behavioral intervention might include environmental changes, schedule changes, specific instructional methods and the use of reinforcement.

2. What is a “functional behavior assessment?” Are there requirements for the content and complexity of the functional behavioral assessment?

A functional behavior assessment (FBA) is a process used by a group of persons who know the student to review and analyze student behavior. The functional behavior assessment is used to form hypotheses of the relationships between events in a person’s environment and the occurrence of specific behaviors. There are many different tools for completing functional behavior assessments, but common components of a functional behavior assessment may include (but are not limited to):

- Description of the student
- Description of the target behaviors to be changed
- Identification and description of the antecedents and consequences of problem behaviors
- Hypotheses as to the functions of the behavior
- Suggested strategies for addressing the problem behaviors

The IEP team must determine if the functional behavior assessment was sufficient to develop written positive behavioral intervention strategies that were designed to target the behavior to be changed.

3. Who determines when the use of aversive treatment procedures may be appropriate?

The student's IEP team, which includes the student (as appropriate), the student's parents, a special education teacher, a regular education teacher, an administrator and a person trained and knowledgeable about best practices in the application of positive behavioral interventions, aversive treatment procedures and nonaversive alternatives for de-escalation of behaviors.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

(2) Aversive treatment procedures are defined as:

(a) physical restraint, other than as provided in 20-4-302, MCA, when the IEP team has determined that the frequency, intensity or duration of the restraint warrants an aversive treatment procedure;

4. What is "physical restraint?"

Physical restraint is not defined in the Aversive Treatment Procedures rule. [ARM 37.34.1404](#) defines physical restraint as ". . . the restriction of a person's movement by one or more persons holding or applying physical pressure."

5. What are the relevant provisions of MCA 20-4-302?

[MCA 20-4-302](#) reads in part:

(4) (a) A person who is employed or engaged by a school district may use physical restraint, defined as the placing of hands on a pupil in a manner that is reasonable and necessary to:

- (i) quell a disturbance;
- (ii) provide self-protection;
- (iii) protect the pupil or others from physical injury;
- (iv) obtain possession of a weapon or other dangerous object on the person of the pupil or within control of the pupil;
- (v) maintain the orderly conduct of a pupil including but not limited to relocating a pupil in a waiting line, classroom, lunchroom, principal's office, or other on-campus facility; or
- (vi) protect property from serious harm.

6. Would an Aversive Treatment Plan be required if the IEP team has determined that the frequency, intensity or duration of the restraint does not warrant an aversive treatment procedure?

No. The determination as to whether the use of physical restraint warrants an aversive treatment procedure is left to the IEP team.

7. Is the development of an aversive treatment plan required if physical restraint is used more than one time under the provisions of [MCA 20-4-302](#)?

No. The determination as to whether the use of physical restraint warrants an aversive treatment procedure is left to the IEP team. However, the IEP team is required by CFR 300.346 (a)(2)(i) that “In the case of a child whose behavior impedes his or her learning or that of others, consider, if appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior.”

10.16.3346 AVERSIVE TREATMENT PROCEDURES

- (2) Aversive treatment procedures are defined as:
- (b) isolation time-out which results in the removal of a student to an isolation room under the following conditions:
 - (i) the student is alone in the isolation room during the period of isolation;
 - (ii) the student is prevented from exiting the isolation room during the period of isolation;
 - (iii) the door to the isolation room remains closed during the period of isolation; and
 - (iv) the student is prohibited from participating in activities occurring outside the isolation room and from interacting with other students during the period of isolation.

8. Are the following procedures considered isolation time-out: in-school suspension, study carrels, having the student stand in a corner of the classroom, having the student go outside of the classroom to a hallway, being in an isolation room with the door open?

To determine if a procedure is isolation time-out, answer the following questions:

- Is the student taken to another room?
- Is the student alone in that room?
- Is the student prevented from leaving that room?
- Is the door closed while the student is in that room?
- Is the student prohibited from participating in activities occurring outside the room and from interacting with other students during the period of isolation?

If the answer to any of these questions is “No,” the procedure is probably not considered to be isolation time-out. Section (5) of the rule provides a definition of exclusion time-out. If you are unsure if a procedure is isolation time-out, contact the Division of Special Education at 444-5661.

9. If school district personnel are in an isolation room with a student and the door is closed, is this isolation time-out?

No. The student must be alone in the isolation room with the door closed for the procedure to be isolation time-out.

10. Does the Office of Public Instruction have standards regarding the design of an isolation time-out room?

The OPI does not have specific standards regarding the design of an isolation time-out room. However, the room should be designed so that the student is unlikely to injure his or herself by inappropriately interacting with such items as grates, lighting fixtures, electrical outlets, doorknobs, door hinges, walls or the floor of the room. Exit from the time-out room may be prevented through the use of a system that requires the presence of staff to keep the door from opening, but will allow the door to be opened if the staff person is not actively engaging the system.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

(3) Any student in isolation time-out must be under the direct constant visual observation of a designated staff person throughout the entire period of isolation.

11. Can the use of a peephole, one-way glass or a video camera system meet the requirement for direct constant visual observation?

Yes, as long as the student is continually observed when using such a system. If the student is videotaped while in isolation time-out, the videotape would be considered to be a portion of the student's record and would be subject to the requirements of FERPA and state rules regarding the confidentiality of student records.

12. Who is the "designated staff person?"

The term "designated staff person" means the staff person who has been designated to provide direct constant observation of the student during the time that the student is in isolation time-out. The designation of this person is a district decision.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

- (4) The following procedures are prohibited:
- (a) any procedure solely intended to cause physical pain;
 - (b) isolation in a locked room or mechanical restraint, except in residential treatment facilities and psychiatric hospitals as defined in 20-7-436, MCA, when prescribed by a physician as part of a treatment plan and when implemented in compliance with relevant federal and state law;
 - (c) the withholding of a meal for a period of greater than one hour from its scheduled starting time; and
 - (d) aversive mists, noxious odors, and unpleasant tastes applied by spray or other means to cause an aversive physical sensation; and
 - (e) mechanical restraint that physically restricts a student's movement through the use upon the student of any mechanical or restrictive device which is not intended for medical reasons.

13. Can a parent provide permission for the use of a procedure that is prohibited by this rule?

No. Prohibited procedures may not be used under any circumstance.

14. What is a “locked room?”

The use of a locking system that does not require the presence of staff to keep the door from opening is considered a locked room. Any system used to prevent exit from the isolation time-out room must allow the door to be opened if a staff person is not actively engaging the system.

15. What are “aversive mists?” Would having a student take a shower be considered an aversive mist?

An example of the prohibited procedure of “aversive mists” could be the use of a spray bottle filled with water. The water would be sprayed in a child's face upon the occurrence of a target behavior, with the intended effect of reducing the rate of the target behavior. Taking a shower would not be considered an aversive mist unless the student was required to shower as a consequence to a target behavior and the shower was intentionally made aversive (i.e., no hot water, excessive water pressure).

16. What is “mechanical restraint”?

The use upon the student of any mechanical or restrictive device, that is not intended for medical reasons, that physically restricts a student's movement.

17. What is the definition of residential treatment facilities and psychiatric hospitals in MCA 20-7-436?

MCA 20-7-436 reads in part:

- (1) (a) "Children's psychiatric hospital" means a freestanding hospital in Montana that:
- (i) has the primary purpose of providing clinical care for children and youth whose clinical diagnosis and resulting treatment plan require in-house residential psychiatric care; and
 - (ii) is accredited by the joint commission on accreditation of healthcare organizations, the standards of the health care financing administration, or other comparable accreditation.
- (b) The term does not include programs for children and youth for whom the treatment of chemical dependency is the primary reason for treatment.
- (3) (a) "Residential treatment facility" means a facility in the state that:
- (i) provides services for children or youth with emotional disturbances;
 - (ii) operates for the primary purpose of providing residential psychiatric care to individuals under 21 years of age;
 - (iii) is licensed by the department of public health and human services; and
 - (iv) participates in the Montana medicaid program for psychiatric facilities or programs providing psychiatric services to individuals under 21 years of age; or
 - (v) notwithstanding the provisions of subsections (3)(a)(iii) and (3)(a)(iv), has received a certificate of need from the department of public health and human services pursuant to Title 50, chapter 5, part 3, prior to January 1, 1993.
- (b) The term does not include programs for children and youth for whom the treatment of chemical dependency is the primary reason for treatment.

18. How is the determination made that a mechanical or restrictive device is intended for medical reasons?

The determination that a mechanical or restrictive device is necessary for medical reasons should be made and documented by the student's IEP team, based on the advice of a medical professional. It is helpful if the IEP team has a record of the order or prescription for the use of the device. The IEP team may also wish to address the use of the device in an Individualized Health Care Plan. A form for this plan is included in the technical assistance manual "Serving Students With Special Health Care Needs" that is available from the Office of Public Instruction.

19. If a student uses a brace or belt-type support in order to maintain posture while seated in a wheelchair, chair or bus seat, would the device be considered a mechanical restraint?

If the use of the mechanical device is for medical reasons, the device would not be considered a mechanical restraint. The determination that the device is necessary for medical reasons should be documented by the student's IEP team. It is helpful if the IEP team has a record of the order or prescription for the use of the device.

20. If a student’s movement is physically restricted by a mechanical or restrictive device while the student is being transported by bus or car, would this be considered a mechanical restraint?

Not if the device is used for the safety and protection of the student and others while being transported by bus or car. The use of the device should be identified by the IEP team as specialized equipment used during transportation. The use of a standard seat belt or built-in device that prevents a wheelchair from moving during transport is not considered a mechanical restraint or specialized equipment.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

(5) Exclusion time-out is not considered an aversive treatment procedure. Exclusion time-out is defined as any removal of a student from a regularly scheduled activity for disciplinary purposes that does not result in placing the student in an isolation room under all of the conditions described in (2)(b).

(6) IEPs may include the use of aversive treatment procedures only when:

(a) subsequent to a functional behavioral assessment, a series of no less than two written positive behavioral intervention strategies, which were designed to target the behavior to be changed, were previously implemented;

21. Must the aversive treatment procedures be written on the IEP forms or can these be included as an attachment to the IEP?

The rule states that the IEP must include the aversive treatment procedures. This may be accomplished by attaching the completed Aversive Treatment Plan as a part of the IEP.

22. Must the two written positive behavioral intervention strategies be implemented before or after the functional behavior assessment is developed?

They must be implemented after the functional behavior assessment is developed.

23. What is meant by “a series of no less than two” positive behavioral intervention strategies?

At least two positive behavioral intervention strategies must have been implemented in sequence; that is, first one strategy, then a second strategy.

24. Is there a minimum period of time for which the positive behavioral intervention strategies must be implemented?

No. The determination as to whether the strategies were implemented for a sufficient length of time is left to the IEP team that is considering the use of aversive treatment procedures.

25. What documentation is required of the written positive behavioral intervention strategies previously implemented?

The dates of implementation, a description of the strategies, the rate of the target behavior(s) prior to the implementation of the strategies and the effect of the strategies on the rate of the target behavior(s) and a copy of the functional behavioral assessment on which the positive behavioral intervention strategies were based are required. The IEP team may determine the need for additional documentation.

26. Can the aversive treatment procedures only address the behaviors that were targeted to be changed by the two written positive behavioral intervention strategies?

Yes. However, behaviors that have a similar topography (e.g., scratching and pinching) and antecedent(s) may be included in an existing aversive treatment plan at the discretion of the IEP team.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

- (6) IEPs may include the use of aversive treatment procedures only when:
 - (b) the IEP team includes a person trained and knowledgeable about best practices in the application of positive behavioral interventions, aversive treatment procedures and nonaversive alternatives for de-escalation of behaviors; and
 - (c) a written behavioral intervention plan using aversive treatment procedures is developed and incorporated as a part of the IEP.

27. Who determines that the IEP team includes a person trained and knowledgeable about best practices in the application of positive behavioral interventions, aversive treatment procedures and nonaversive alternatives for de-escalation of behaviors?

The IEP team determines if a member or members of the team is trained and knowledgeable in these areas. There is no certification or licensure that specifically addresses this requirement.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

- (7) A behavioral intervention plan using aversive treatment procedures shall:
 - (a) include a statement describing no less than two positive behavioral intervention strategies previously attempted and the results of these interventions, as described in (6)(a);
 - (b) describe the target behavior(s) that will be consequented with the use of the aversive treatment procedure(s);

28. Must the target behaviors be discrete individual behaviors (hit, kick, bite) or can they be “classes” of behavior (self-abuse, physical aggression)?

The target behaviors must be described so that members of the IEP team understand which target behaviors will be consequented by aversive treatment procedures and the persons implementing the plan will document and consequent the target behaviors in a consistent manner. This is best done through describing discrete behaviors.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

- (7) A behavioral intervention plan using aversive treatment procedures shall:
 - (c) include short-term objective(s) with measurable criteria stating the expected change in the target behavior(s);

29. Must the short-term objectives in the aversive treatment plan be included in the student’s IEP?

Yes. The IEP must include short-term objective(s) with measurable criteria stating the expected change in the target behavior(s). The IEP team may choose to develop additional measurable criteria of progress as part of the aversive treatment plan.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

- (7) A behavioral intervention plan using aversive treatment procedures shall:
 - (d) provide a written description of the aversive treatment procedure(s);

30. How detailed must the written description of the aversive treatment procedure(s) be?

The description must be sufficiently detailed so that all members of the IEP team, as well as those persons implementing the aversive treatment procedures, are able to understand the actual procedures and under which circumstances they will be implemented. Examples are included in the section, Examples of Aversive Treatment Plan.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

- (7) A behavioral intervention plan using aversive treatment procedures shall:
 - (e) specify a time limit for the use of the aversive treatment procedure for any one instance;

31. Can the IEP team establish additional limits for the use of aversive treatment procedures such as maximum amount of time per day in isolation time-out or how many times per day a student can be restrained?

Yes. The IEP team should also determine and document what actions will be taken when a maximum limit is reached.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

- (7) A behavioral intervention plan using aversive treatment procedures shall:
 - (f) include data collection procedures for recording each application of the aversive treatment(s);

32. What data should be collected for each application of the aversive treatment procedures?

This data could include antecedents to the target behavior, attempted intervention or redirection strategies other than aversive treatment procedures, the target behavior(s) that the student exhibited, the time at which the physical restraint/isolation time-out began, the student's behavior while in physical restraint/isolation time-out and the time at which the student was released from physical restraint/isolation time-out.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

- (7) A behavioral intervention plan using aversive treatment procedures shall:
 - (g) state when the IEP team will meet to review the ongoing use, modification or termination of the aversive procedure;
 - (h) designate an individual responsible for ongoing review and analysis of the data on the target behavior;
 - (i) state how the student's parents will be regularly informed of the progress toward the short-term objectives in the IEP at a frequency no less than is required in 34 CFR 300.347;

33. Who should be the individual responsible for ongoing review and analysis of data on the target behavior?

This individual should be someone who is able to review and analyze the data on the target behavior on an ongoing basis and interpret data, if necessary, to team members. This individual does not have to be a member of the IEP team, but may be designated by the team.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

- (7) A behavioral intervention plan using aversive treatment procedures shall:
- (j) state whether any standard school disciplinary measures are waived.

34. How specific must the IEP team be in stating whether any standard school disciplinary measures are waived?

The IEP team should be as specific as possible in referencing the measures to be waived. The IEP team may wish to review and include a copy of the standard school disciplinary measures as a part of any IEP at which these measures are discussed or waived.

35. Can an IEP team waive standard school disciplinary procedures if the school district does not agree?

[MCA 20-5-201](#) requires that “a pupil shall be subject to the control and authority of the teachers, principal, and district superintendent while the pupil is in school or on school premises, on the way to and from school, or during intermission or recess.” A school district may determine that waiving a standard school disciplinary measure(s) would be in conflict with the above administrative rule. In this instance, the IEP team may choose to use informal dispute resolution through the Office of Public Instruction Early Assistance Program.

10.16.3346 AVERSIVE TREATMENT PROCEDURES

- (8) When an aversive treatment plan is incorporated in the IEP, the parents must be informed that their consent to the IEP includes consent for the aversive treatment plan. Failure to obtain consent is subject to due process proceedings under ARM 10.16.3507 through 10.16.3523.

36. How does a school district inform the parents that their consent to the IEP includes consent for the aversive treatment plan?

By developing the aversive treatment plan as part of the IEP process and document.

37. If the student’s parents do not attend the IEP meeting at which consent is needed for the aversive treatment plan, how is consent for the IEP and aversive treatment plan obtained?

A meeting may be conducted without a parent in attendance if the public agency is unable to convince the parents that they should attend. In this case the public agency must have a record of its attempts to arrange a mutually agreed on time and place for the meeting.

When parental consent for the IEP has not been obtained and has not been specifically refused or revoked, the district shall informally attempt to obtain consent from the parent. If parental consent cannot be obtained within a reasonable time, the district shall send written notice to the parent requesting approval and stating that the student with disabilities shall be provided special education and related services according to the student's IEP as developed by the district 15 days from the date of the notice. If no response from the parent is obtained, the district shall provide the student special education and related services according to the student's IEP, including the aversive treatment plan, without parental consent subject to the parent's right to an impartial due process hearing under ARM 10.16.3507 through 10.16.3523.

[ARM 10.16.3505 Parental consent](#)

[CFR 300.345 Parent participation](#)

Additional Questions

38. Does this rule apply to students who have not been identified as students with disabilities under IDEA?

No. The rule only applies to students who have been identified as IDEA-qualified students.

39. If a student transfers between school districts in Montana with an existing aversive treatment plan, must the receiving district conduct a functional behavior assessment and implement two written positive behavioral intervention programs before the aversive treatment plan can be implemented?

No. When an IDEA-eligible student moves to a new school district within the state and the student's current IEP is available, the new school district shall ensure that there is no interruption of special education and related services.

If a student with an aversive treatment plan transfers from another state, contact the Office of Public Instruction for guidance.

[ARM 10.16.3342 Transfer students: intrastate and interstate](#)

40. What is a public agency's responsibility if the parents refuse to consent to the use of aversive treatment procedures?

The IEP team should work toward consensus, but the public agency has ultimate responsibility to ensure that the IEP includes the services that the child needs in order to receive FAPE. It is not appropriate to make IEP decisions based upon a majority "vote." If the team cannot reach consensus, the district must provide the parents with prior written notice of the agency's proposals or refusals, or both, regarding the child's educational program, and the parents have the right to seek resolution of any disagreements by initiating an impartial due process hearing.

Every effort should be made to resolve differences between parents and school staff through voluntary mediation or some other informal step without resorting to a due process hearing.

[10.16.3505 Parental consent](#)

41. If a child's IEP includes behavioral strategies to address a particular behavior, can a child ever be suspended for engaging in that behavior?

Yes. [MCA 20-5-201](#) states that a pupil who continually and willfully shows open defiance of the authority vested in school personnel, defaces or damages any school building, school grounds, furniture, equipment, book belonging to the district, or harms or threatens to harm another person or the person's property is liable for punishment, suspension, or expulsion. Whether suspension is ever appropriate for behavior that is addressed in a child's IEP will have to be determined on a case-by-case basis in light of the particular circumstances of that incident.

42. Must the parents be notified each time aversive treatment procedures have been used?

No; however, the IEP team may include this practice in the aversive treatment plan.

43. Is parental consent required and must a district provide notice of and obtain permission for evaluation before conducting a functional behavior assessment for the purpose of developing an aversive treatment plan?

Yes. If the purpose of a functional behavior assessment is to determine the nature and extent of the special education and related services that the child needs, informed parental consent must be obtained unless the evaluation is administered to all children.

[CFR 300.500 General responsibility of public agencies; definitions](#)

[CFR 300.503 Prior notice by the public agency; content of notice](#)

Aversive Treatment Plan
(ARM 10.16.3346)

Aversive Treatment Procedure: Physical Restraint Isolation Time-out

Student Name: _____ School: _____

Date of IEP Meeting(s): _____

Initial Date of Plan: _____

Revision Dates: _____

Member of the student’s IEP Team who is trained and knowledgeable about best practices in the application of positive behavioral interventions, aversive treatment procedures and nonaversive alternatives for de-escalation of behaviors:

Name: _____ Position: _____

Describe the series of no less than two written positive behavioral intervention strategies implemented subsequent to a functional behavioral assessment, which were designed to target the behavior to be changed, that were previously implemented: (Attach the functional behavior assessment and two written positive behavioral intervention strategies.)

Additional materials attached - _____

Describe the results of these interventions:

Additional materials attached - _____

Describe the target behavior(s) that will result in the use of the aversive treatment procedure(s):

Additional materials attached - _____

Short-term objective(s) with measurable criteria stating the expected change in the target behavior(s) are listed in Annual Goal(s) number _____ of the IEP dated _____. (IEP must be attached to this plan)

Describe the aversive treatment procedure(s):

Additional materials attached - _____

Specify a time limit for the use of the aversive treatment procedure(s) in any one instance:

Describe the data collection procedures for recording each application of the aversive treatment procedure(s):

Additional materials attached - _____

When will the IEP Team meet to review the ongoing use, modification or termination of the aversive treatment procedures?

Who is responsible for ongoing review and analysis of the data on the target behavior(s)?

How will the student's parents be regularly informed of the progress toward the short-term objectives in the IEP at a frequency no less than is required in 34 CFR 300.347?

Are any standard school disciplinary measures waived? YES NO

If "YES," please describe the measures waived:

Additional materials attached - _____

The student's parents have been informed that their consent to the IEP includes consent for the aversive treatment plan:

Date on which parents were informed: _____

Date(s) of IEP(s) incorporating aversive treatment plan: _____

This aversive treatment plan must be developed and incorporated as part of an Individualized Education Program.

Common Questions About the Aversive Treatment Plan

44. What changes in the aversive treatment plan require an IEP team meeting?

The following changes in the aversive treatment plan require an IEP team meeting:

- Adding or removing target behaviors that will be consequented by aversive treatment procedures
- Changing the short-term objectives stating the expected change in the target behaviors
- Adding or removing aversive treatment procedures (isolation time-out or physical restraint)
- Changing the time limit for the use of the aversive treatment procedures in any one instance
- Discontinuing any data collection procedure
- Changing the frequency of IEP team meetings to review the ongoing use or modification of aversive treatment procedures
- Changing the frequency of the reporting of the progress toward the short-term objectives
- Changes in standard school disciplinary procedures that are waived
- Terminating the use of aversive treatment procedures

45. How should changes to the aversive treatment plan be documented?

Changes which require the approval of the IEP team should be documented in the student's IEP. Depending on the changes being made in the Aversive Treatment Plan document, it may not be necessary to rewrite the entire Aversive Treatment Plan. On a new Aversive Treatment Plan, complete the portion(s) of the ATP which are being changed (be sure to note the IEP Date and Revision Date on page 1) and attach a copy of the revisions to the IEP at which the revisions are approved.

Aversive Treatment Procedures Checklist

Date: _____ Student Name: _____

Aversive Treatment Procedure: Physical Restraint Isolation Time-out

THE IEP MUST DOCUMENT EACH OF THE FOLLOWING:

Yes No**

No less than two written positive behavioral intervention strategies were previously implemented.

The intervention strategies above were designed to target the behavior to be changed by the aversive treatment procedures.

The intervention strategies above were implemented subsequent to a functional behavior assessment.

The IEP team includes a person trained and knowledgeable about best practices in the application of positive behavioral interventions, aversive treatment procedures and nonaversive alternatives for de-escalation of behaviors.

A written behavioral intervention plan using aversive treatment procedures is developed and incorporated as a part of the IEP.

NOTES: _____

** For any item which has a "No" response, the item must be completed and checked "Yes" before aversive treatment procedures can be implemented.

Continued on next page

The behavior intervention plan using physical restraint or isolation time-out:

Yes No**

Includes a statement describing no less than two positive behavioral intervention strategies previously attempted and the results of these interventions and a copy of the two written positive behavioral intervention strategies previously implemented.

Describes the target behavior(s) that will be consequented with the use of the aversive treatment procedure(s).

Includes short-term objective(s) with measurable criteria stating the expected change in the target behavior(s).

Provides a written description of the aversive treatment procedure(s).

Specifies a time limit for the use of the aversive treatment procedure for any one instance.

Includes data collection procedures for recording each application of the aversive treatment(s).

States when the IEP team will meet to review the ongoing use, modification or termination of the aversive procedure.

Designates an individual responsible for ongoing review and analysis of the data on the target behavior.

States how the student's parents will be regularly informed of the progress toward the short-term objectives in the IEP at a frequency no less than is required in 34 CFR 300.347.

States whether any standard school disciplinary measures are waived.

The parents have been informed that their consent to the IEP includes consent for the aversive treatment plan.

Common Question About the Aversive Treatment Procedures Checklist

46. Is it necessary to complete the Aversive Treatment Procedures Checklist if an Aversive Treatment Plan has been completed?

No. The Aversive Treatment Procedures Checklist is intended to serve as an additional means of documenting that the requirements of the administrative rule on Aversive Treatment Procedures have been met. If the Aversive Treatment Plan form developed by the Office of Public Instruction has been completed correctly, it is not necessary to use the Aversive Treatment Procedures Checklist.

If an Aversive Treatment Plan form other than the one developed by the Office of Public Instruction has been used, the OPI Aversive Treatment Procedures Checklist may be used to document that the requirements of administrative rule have been addressed. In either instance, if the Aversive Treatment Procedures Checklist was used, it should be included in the IEP that includes the Aversive Treatment Plan.

Aversive Treatment Plan - Example **(ARM 10.16.3346)**

Aversive Treatment Procedure: Physical Restraint Isolation Time-out

Student Name: ___Robert Hund___ School: ___Jefferson Elementary___

Date of IEP Meeting(s): ___Initial 1/30/01_____

Initial Date of Plan: ___1/31/01___ Revision Dates: _____

Member of the student's IEP Team who is trained and knowledgeable about best practices in the application of positive behavioral interventions, aversive treatment procedures and nonaversive alternatives for de-escalation of behaviors:

Name: ___Dan Wilson_____ Position: ___School Psychologist___

Describe the series of no less than two written positive behavioral intervention strategies implemented subsequent to a functional behavioral assessment, which were designed to target the behavior to be changed, that were previously implemented: (Attach the functional behavior assessment.)

1/8/01 - 1/23/01 - Environmental Changes : We moved Robert's desk closer to Jake, who Robert likes and usually has good behavior around. This only decreased the rate of hitting for the first two days. We gave him headphones and a radio to calm him down during high noise activities, but he took them off each time.

1/10/01 - 1/30/01 - Schedule Changes: We began using a picture schedule to show Robert his schedule. He ripped it up the first three times so we put it on the wall. This lead to a slight decrease in the hitting when given a cue to go to another area.

1/15/01 - 1/30/01 - Reinforcement: We began a reinforcement schedule with Robert where he was given a smelly sticker on a card for each activity in which he did not hit. When he had three stickers, he could have 15 minutes to draw or do another activity of his choosing. This did not decrease the rate of hitting.

A graph of the number of hits per day and Antecedent/Behavior sheets for each episode of hitting from 12/4/00 through 1/30/01 are attached.

Additional materials attached - Graphs, ABC Sheets

Describe the results of these interventions:

Robert's overall rate of hitting remained the same at 12-15 times per day. We saw slight decreases in the situations noted above. A graph of the number of hits per day and Antecedent/Behavior sheets for each episode of hitting from 12/4/00 through 1/30/01 are attached.

✓ Additional materials attached - Graphs, ABC Sheets

Describe the target behavior(s) that will result in the use of the aversive treatment procedure(s):

Hitting - striking another person with a hand or fist so as to cause a red mark or cause an exclamation of pain. This includes attempts to hit that are dodged or blocked.

Additional materials attached - _____

Short-term objective(s) with measurable criteria stating the expected change in the target behavior(s) are listed in Annual Goal(s) number _1_ of the IEP dated _1/30/01_. (IEP must be attached to this plan)

Describe the aversive treatment procedure(s):

Each time Robert hits (as described above) another person, he will be restrained until he has been calm (no struggling or shouting) for 2 minutes. All staff working with Robert have been trained in the restraint procedure. A description of the restraint procedure are attached.

✓ Additional materials attached - Restraint procedure description

Specify a time limit for the use of the aversive treatment procedure(s) in any one instance:

20 minutes. If, after 5 minutes of restraint, Robert has not met the requirement for two minutes of calm (no struggling or shouting), the criteria for release from the restraint will be lowered to 90 seconds of calm. After 10 minutes of restraint, the criteria will be lowered to one minute of calm. After 15 minutes, the criteria will be lowered to 30 seconds. If Robert is still

in restraint after 20 minutes, he will be given the cue to be calm and will be released from restraint when he has been calm for two seconds.

Describe the data collection procedures for recording each application of the aversive treatment procedure(s):

Antecedent/Behavior/Consequence (ABC) data sheets will be kept for each occurrence of hitting. These sheets will record 1. The date and time when the hit occurred, 2. The setting (where in the school the hit occurred) 3. Antecedent and Setting Events (Antecedent - what Robert was doing when he hit. If Robert hit when he was asked to do something, note what he was asked to do. Setting Events - note if Robert was agitated over something that had happened earlier, the environment was noisy, etc.), 4. Behavior (which target behavior occurred, who Robert hit), 5. Consequence (what you did as a consequence to the behavior), 6. Response (how Robert responded to the consequence), 7. The staff person who delivered the consequence.

Aversive Treatment Procedure Documentation sheets will be used each time Robert is restrained. These will record 1. The date, start time and end time of each restraint, 2. The total time in restraint, 3. Observations (what Robert did while he was restrained (struggled, shouted, attempted to slide to the floor, etc.) and what Robert did when he was released from the restraint.

✓ Additional materials attached - Sample ABC and ATP Documentation Sheets

When will the IEP team meet to review the ongoing use, modification or termination of the aversive treatment procedures?

1. Every two months. 2. If Robert has 5 hits or fewer per day (average) for eight consecutive days. 3. If Robert hits more than 20 times per day for 3 or more consecutive days.

Who is responsible for ongoing review and analysis of the data on the target behavior(s)?

Mrs. Left Hand

How will the student's parents be regularly informed of the progress toward the short-term objectives in the IEP at a frequency no less than is required in 34 CFR 300.347?

1. Daily behavior log between home and school will list number of restraints and number of reinforcers earned. 2. Parents will be given a copy of the ABC sheets every 10 days, 3. Monthly data reports to IEP team, 4. At bimonthly IEP meetings, the IEP team will state if they feel Robert is making progress toward the short-term objectives in the IEP, 5. Mid-semester and end of semester reports.

On a monthly basis, the following data will be sent to all team members: 1. Graph of number of hits per day. 2. A percentage breakdown of who Robert hit (staff or student). 3. A percentage breakdown of where the hits occurred (playground, classroom, lunchroom, hallway, etc.). 4. A percentage breakdown of antecedents. These will be described as a. cues to start doing a desk activity, b. cues to stop doing an activity (example - drawing on book), c. cues to go to another activity (example - go to Mrs. Left Hand's desk for spelling), d. told to come in from recess, e. cues to leave the classroom to go to lunch, f. other (give examples).

Are any standard school disciplinary measures waived? YES NO

If "YES," please describe the measures waived:

Robert will not be sent to the principal's office or in-school suspension for hitting other students or staff. A copy of the school discipline policy was reviewed by the team and is included with each copy of this IEP.

Additional materials attached - School discipline policy

The student's parents have been informed that their consent to the IEP includes consent for the aversive treatment plan:

Date on which parents were informed: 1/30/01

Date(s) of IEP(s) incorporating aversive treatment plan: 1/30/01

This aversive treatment plan must be developed and incorporated as part of an Individualized Education Program.

Example Description of Restraint Procedure

After Robert has hit someone, he will be told, “Robert, when you hit someone you have to be restrained until you are calm.” The staff person will, while standing behind Robert, gently push Robert’s left elbow forward. The staff person will reach between Robert’s right arm and body, grasping Robert’s left wrist with the staff person’s right hand and holding Robert’s left arm loosely against Robert’s body. The staff person will reach between Robert’s left arm and body and place his or her left hand on Robert’s left forearm below the elbow.

If necessary, the staff person will grasp Robert’s right wrist with the staff person’s left hand, holding Robert’s right arm and wrist loosely against Robert’s body. Robert will be restrained until he has been calm (no struggling or shouting) for two minutes.

If, after 5 minutes of restraint, Robert has not met the requirement for two minutes of calm (no struggling or shouting), the criteria for release from the restraint will be lowered to 90 seconds of calm. After 10 minutes of restraint, the criteria will be lowered to one minute of calm. After 15 minutes, if Robert is still in restraint, he will be given the cue to be calm and will be released from the restraint when he has been calm for two seconds.

Example Description of Isolation Time-out Procedure

After Seth has hit someone, he will be told, “Seth, when you hit someone you have to go to time-out.” He will be escorted to the isolation time-out room using the least assistance possible. If it is necessary to restrain Seth to take him to the isolation-time out room, he will be restrained as described in his aversive treatment plan.

Once Seth has entered the isolation time-out room, he will be told, “Seth, you have to stay in the time-out room until you are calm* for three minutes.” The staff person will then leave the isolation time-out room and close the door. Seth will be under the direct constant visual observation of a staff person while he is in the isolation time-out room.

If, after 10 minutes of isolation time-out, Seth is not has not met the requirement for three minutes of calm, the criteria for release from the isolation time-out will be lowered to 90 seconds of calm. After 15 minutes of isolation time-out, the criteria will be lowered to one minute of calm. If Seth is still in isolation time-out after 20 minutes, he will be given the cue to be calm and the isolation time-out room door will be opened when he has been calm for two seconds.

When Seth has met the criteria for calm, the staff person will open the door of the isolation time-out room and tell Seth that time-out is over. If, after one minute, Seth has not left the isolation time-out room, the staff person will follow the prompting procedures in his behavior intervention plan.

*(Calm is defined as not hitting or kicking the walls and not talking in a voice that can be heard outside of the isolation time-out room.)

Administrative Rules and Statutes of Montana Cited:

ARM 37.34.1404 AVERSIVE PROCEDURES: DEFINITIONS (reads in part)

(29) "Physical restraint" means the restriction of a person's movement by one or more persons holding or applying physical pressure.

ARM 10.16.3342 TRANSFER STUDENTS: INTRASTATE AND INTERSTATE

(reads in part)

(1) When an IDEA eligible student moves to a new school district within the state and the student's current IEP is available, the new school district shall ensure that there is no interruption of special education and related services. If the current IEP is not available, or if the new school district or the parent believes that the IEP is not appropriate, the new school district must develop a new IEP through appropriate procedures within a short time (normally within one week) after the student enrolls in the new school district. Before the new IEP is finalized, the new school district may provide interim services agreed to by both the parents and the new school district. If the parents and the new school district are unable to agree on an interim IEP and placement, the new school district must implement the former IEP to the extent possible until a new IEP is developed and implemented. To the extent that implementation of the former IEP is impossible, the new school district must provide services that approximate, as closely as possible, the former IEP.

ARM 10.16.3505 PARENTAL CONSENT (reads in part)

(3) (b) When parental consent for annual placement has not been obtained and has not been specifically refused or revoked, the local educational or public agency shall informally attempt to obtain consent from the parent.

(i) If parental consent cannot be obtained within a reasonable time, the local educational or public agency shall send written notice to the parent requesting approval and stating that the student with disabilities shall be provided special education and related services according to the student's individualized education program (IEP) as developed by the local educational agency 15 days from the date of the notice.

(ii) If no response from the parent is obtained, the local educational or public agency shall provide the student special education and related services according to the student's IEP without parental consent subject to the parent's right to an impartial due process hearing under ARM 10.16.3507 through 10.16.3523.

(c) When parental consent for annual placement is refused or revoked, the local educational or public agency shall informally attempt to obtain consent from the parent. If, after exhausting informal attempts, the local educational agency is unable to obtain consent or resolve the disagreement, the local educational agency shall:

(i) provide the parent written notice as required by 34 CFR 300.503; and

(ii) if the local educational agency believes its proposed annual placement is necessary to ensure a free appropriate public education, it may file a request for special education due process hearing in accordance with ARM 10.16.3507 through 10.16.3523.

MCA 20-4-302 Discipline and punishment of pupils -- definition of corporal punishment -- penalty -- defense

- (1) A teacher or principal has the authority to hold a pupil to a strict accountability for disorderly conduct in school, on the way to or from school, or during intermission or recess.
- (2) For the purposes of this section, "corporal punishment" means knowingly and purposely inflicting physical pain on a pupil as a disciplinary measure.
- (3) A person who is employed or engaged by a school district may not inflict or cause to be inflicted corporal punishment on a pupil.
- (4) (a) A person who is employed or engaged by a school district may use physical restraint, defined as the placing of hands on a pupil in a manner that is reasonable and necessary to:
 - (i) quell a disturbance;
 - (ii) provide self-protection;
 - (iii) protect the pupil or others from physical injury;
 - (iv) obtain possession of a weapon or other dangerous object on the person of the pupil or within control of the pupil;
 - (v) maintain the orderly conduct of a pupil including but not limited to relocating a pupil in a waiting line, classroom, lunchroom, principal's office, or other on-campus facility; or
 - (vi) protect property from serious harm.
- (b) Physical pain resulting from the use of physical restraint as defined in subsection (4)(a) does not constitute corporal punishment as long as the restraint is reasonable and necessary.
- (5) A teacher in a district employing neither a district superintendent nor a principal at the school where the teacher is assigned has the authority to suspend a pupil for good cause. When either a district superintendent or a school principal is employed, only the superintendent or principal has the authority to suspend a pupil for good cause. Whenever a teacher suspends a pupil, the teacher shall notify the trustees and the county superintendent immediately of the action.
- (6) A teacher has the duty to report the truancy or incorrigibility of a pupil to the district superintendent, the principal, the trustees, or the county superintendent, whichever is applicable.
- (7) If a person who is employed or engaged by a school district uses corporal punishment or more physical restraint than is reasonable or necessary, the person is guilty of a misdemeanor and, upon conviction of the misdemeanor by a court of competent jurisdiction, shall be fined not less than \$25 or more than \$500.
- (8) A person named as a defendant in an action brought under this section may assert as an affirmative defense that the use of physical restraint was reasonable or necessary. If that defense is denied by the person bringing the charge, the issue of whether the restraint used was reasonable or necessary must be determined by the trier of fact.

MCA 20-5-201 Duties and sanctions (reads in part)

- (1) A pupil shall:
 - (a) comply with the policies of the trustees and the rules of the school that the pupil attends;
 - (b) pursue the required course of instruction;
 - (c) submit to the authority of the teachers, principal, and district superintendent of the district; and
 - (d) be subject to the control and authority of the teachers, principal, and district

superintendent while the pupil is in school or on school premises, on the way to and from school, or during intermission or recess.

(2) A pupil who continually and willfully disobeys the provisions of this section, shows open defiance of the authority vested in school personnel by this section, defaces or damages any school building, school grounds, furniture, equipment, book belonging to the district, or harms or threatens to harm another person or the person's property is liable for punishment, suspension, or expulsion under the provisions of this title. When a pupil defaces or damages school property the pupil's parent or guardian is liable for the cost of repair or replacement upon the complaint of the teacher, principal, superintendent, or any trustee and the proof of any damage.

MCA 20-7-436 Definitions

For the purposes of 20-7-435 and this section, the following definitions apply:

(1) (a) "Children's psychiatric hospital" means a freestanding hospital in Montana that:

- (i) has the primary purpose of providing clinical care for children and youth whose clinical diagnosis and resulting treatment plan require in-house residential psychiatric care; and
- (ii) is accredited by the joint commission on accreditation of healthcare organizations, the standards of the health care financing administration, or other comparable accreditation.

(b) The term does not include programs for children and youth for whom the treatment of chemical dependency is the primary reason for treatment.

(2) "Eligible child" means a child or youth who is less than 19 years of age, who is emotionally disturbed as defined in 20-7-401, and whose emotional problem is so severe that the child or youth has been placed in a children's psychiatric hospital or residential treatment facility for inpatient treatment of emotional problems.

(3) (a) "Residential treatment facility" means a facility in the state that:

- (i) provides services for children or youth with emotional disturbances;
- (ii) operates for the primary purpose of providing residential psychiatric care to individuals under 21 years of age;
- (iii) is licensed by the department of public health and human services; and
- (iv) participates in the Montana medicaid program for psychiatric facilities or programs providing psychiatric services to individuals under 21 years of age; or
- (v) notwithstanding the provisions of subsections (3)(a)(iii) and (3)(a)(iv), has received a certificate of need from the department of public health and human services pursuant to Title 50, chapter 5, part 3, prior to January 1, 1993.

(b) The term does not include programs for children and youth for whom the treatment of chemical dependency is the primary reason for treatment.

Code of Federal Regulations (CFR) Cited:

CFR 300.345 Parent participation (reads in part)

(a) Public agency responsibility—general. Each public agency shall take steps to ensure that one or both of the parents of a child with a disability are present at each IEP meeting or are afforded the opportunity to participate, including—

(1) Notifying parents of the meeting early enough to ensure that they will have an opportunity to attend; and

(2) Scheduling the meeting at a mutually agreed on time and place.

(c) Other methods to ensure parent participation. If neither parent can attend, the public agency shall use other methods to ensure parent participation, including individual or conference telephone calls.

(d) Conducting an IEP meeting without a parent in attendance. A meeting may be conducted without a parent in attendance if the public agency is unable to convince the parents that they should attend. In this case the public agency must have a record of its attempts to arrange a mutually agreed on time and place, such as -

(1) Detailed records of telephone calls made or attempted and the results of those calls;

(2) Copies of correspondence sent to the parents and any responses received; and

(3) Detailed records of visits made to the parent's home or place of employment and the results of those visits.

CFR 300.346 Development, review, and revision of IEP (reads in part)

(2) Consideration of special factors. The IEP team also shall -

(i) In the case of a child whose behavior impedes his or her learning or that of others, consider, if appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior;

CFR 300.347 Content of IEP (reads in part)

(a) General. The IEP for each child with a disability must include—

(7) A statement of -

(i) How the child's progress toward the annual goals described in paragraph (a)(2) of this section will be measured; and

(ii) How the child's parents will be regularly informed (through such means as periodic report cards), at least as often as parents are informed of their nondisabled children's progress, of:

(A) Their child's progress toward the annual goals; and

(B) The extent to which that progress is sufficient to enable the child to achieve the goals by the end of the year.

CFR 300.500 General responsibility of public agencies; definitions

(reads in part)

(2) **Evaluation** means procedures used in accordance with §§300.530-300.536 to determine whether a child has a disability and the nature and extent of the special education and related services that the child needs;

CFR 300. 503 Prior notice by the public agency; content of notice (reads in part)

(1) Written notice that meets the requirements of paragraph (b) of this section must be given to the parents of a child with a disability a reasonable time before the public agency—

(i) Proposes to initiate or change the identification, evaluation, or educational placement of the child or the provision of FAPE to the child;

Antecedent - Behavior - Consequence Sheet

Student Initials: _____

Date	Time	Place	Antecedents and Setting Events	Behavior	Consequence	Response	Staff

Aversive Treatment Procedures Application Documentation

(To be completed for each application of Physical Restraint Isolation Time-out)

Student Initials: RTH

Date	Start Time	End Time	Total Time	Aversive Procedure	Observations	Staff Person
2/1/01	11:17	11:30	13 min.	Restraint	Robert struggled for the first 5 minutes then would calm down for 1 minute to 90 seconds but would begin to struggle and ask to be released. After release he went back to math class and worked OK.	Dave
2/1/01	12:32	12:35	3 min.	Restraint	Robert was restrained in the lunchroom after hitting me while in line. For the first minute of restraint he kept saying, "I want to eat lunch." I told him that he had to be calm for two minutes before he could eat lunch. He calmed down for two minutes and then went to get his lunch. The line was shorter and he only had to wait for 30 seconds to get his food.	Deirdre
2/2/01	8:25	8:43	18 min.	Restraint	I restrained Robert by the fence when he hit me after I tried to guide him into the school after the bell. He kept trying to sit down. He would calm down for one minute, then start struggling and telling me to let go. He finally calmed down and then went inside.	Deirdre
2/2/01	12:28	12:39	11 min.	Restraint	I took Robert out of the lunchroom to restrain him. He kept struggling, then would calm down for 30 - 45 seconds, then would say he wanted to go to lunch. I finally told him he had to calm down until the hand on my watch went around twice. He calmed down and watched my watch. After I released him, he said, "I don't like waiting in line!"	Mrs. Left Hand

Aversive Treatment Procedures Application Documentation

(To be completed for each application of Physical Restraint Isolation Time-out)

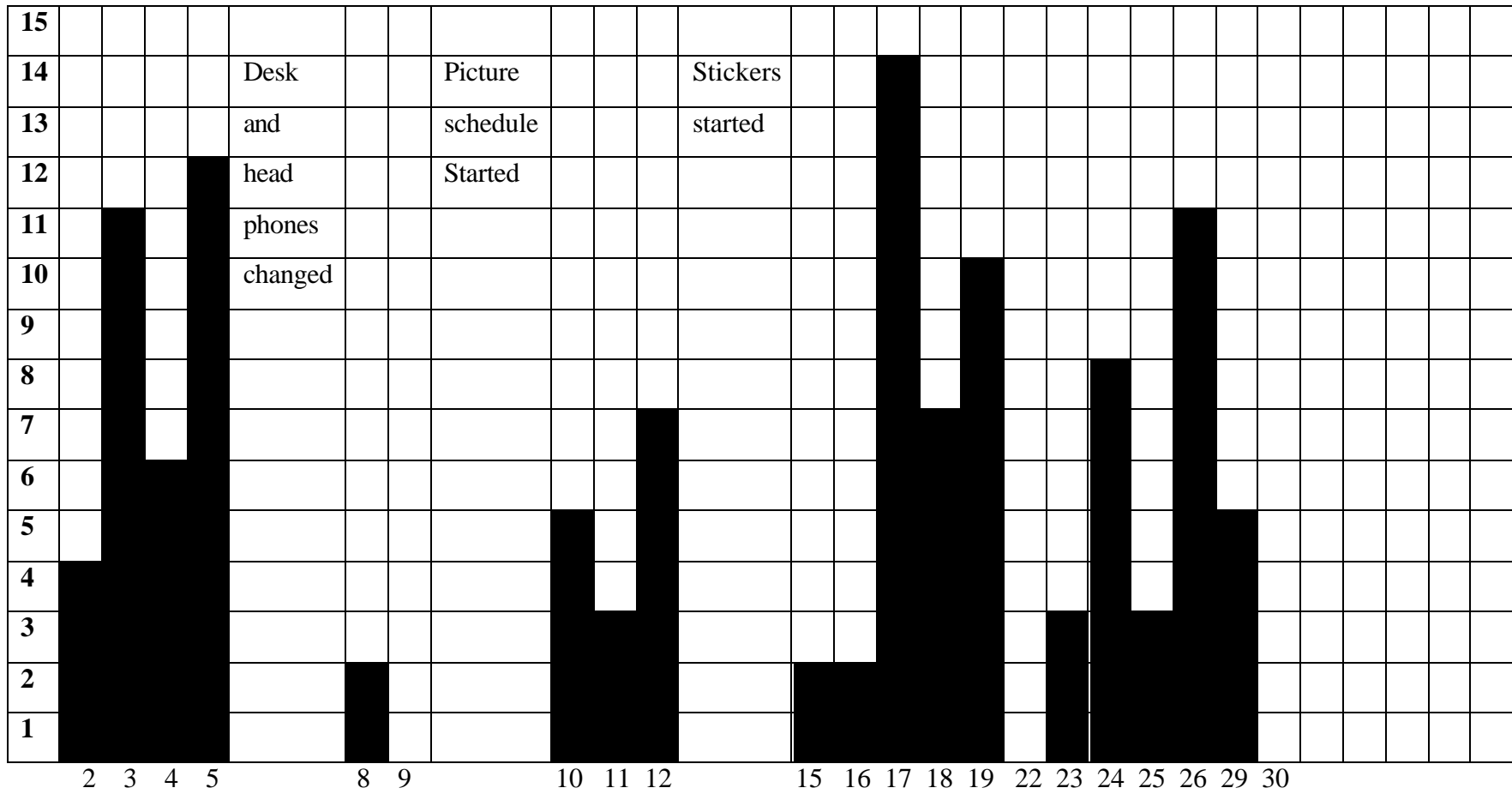
Student Initials: _____

Date	Start Time	End Time	Total Time	Aversive Procedure	Observations	Staff Person

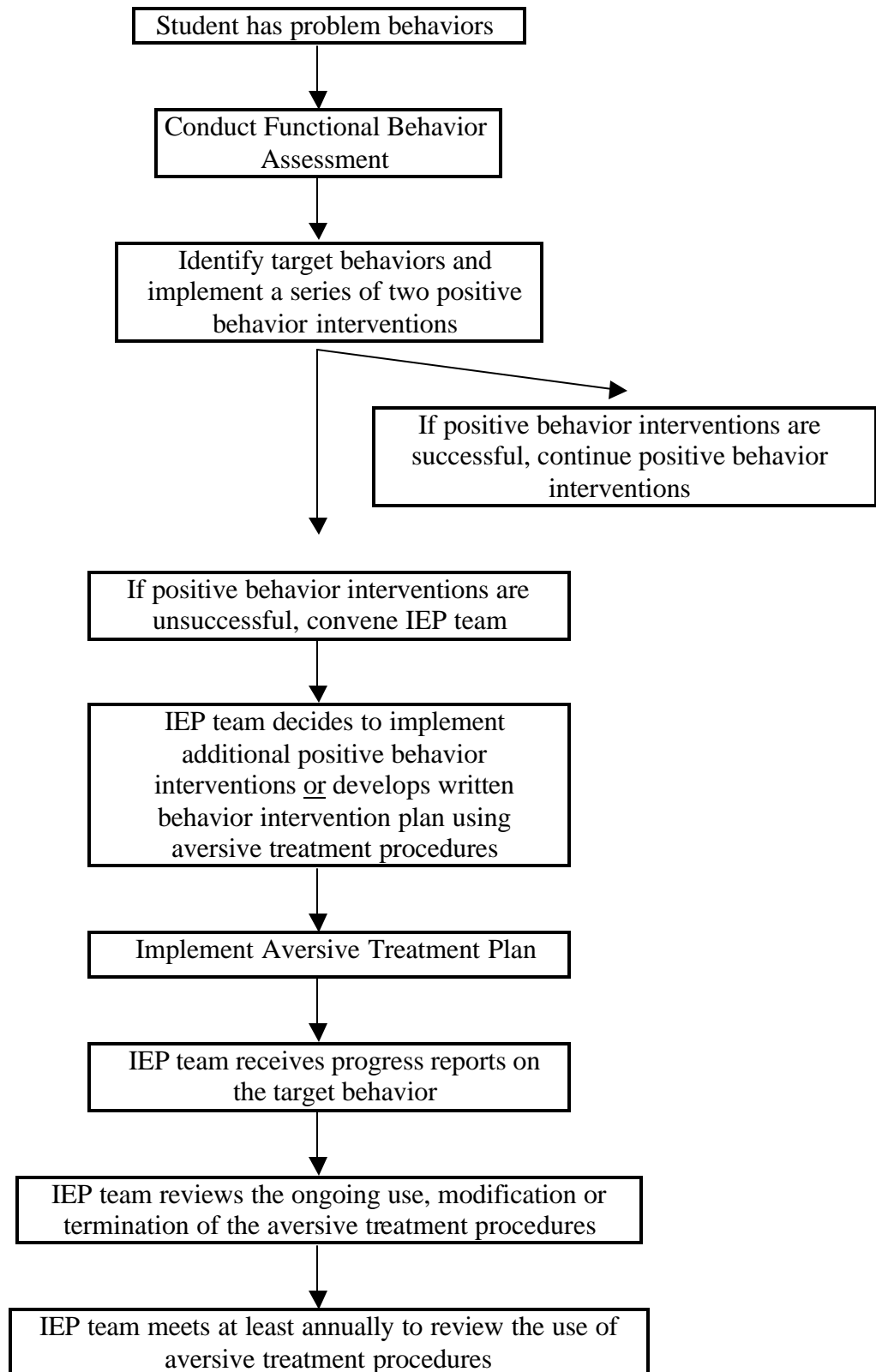
Robert Hund

Number of hits per day 1/2/01 - 1/30/01

Mrs. Left Hand



Flowchart of Aversive Treatment Procedures Development



Technical Assistance guides are developed by the Division of Special Education to provide guidance to schools, parents and advocates regarding eligibility for and the implementation of services to students with disabilities under the Individuals with Disabilities Education Act, the Administrative Rules of Montana, and Montana statutes.

This document contains recommended practices and procedures that may enhance the services to children and youth with disabilities. All policy statements regarding the delivery of special education and related services are contained in the current *Montana State Plan Under the Individuals with Disabilities Education Act*.