family ties

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Tristan: A Mom's Remembrance

One Family's Story

By Dr. Jean Allen

Note: This story ran previously in our Fall 2000 newsletter. We are running it again due to its relevance to this issue's theme of Seclusion and Restraint.

Tristan Michael joined our family in April 1982. He came as a foster baby and was supposed to stay with us only until a long-term institutional placement could be arranged. At ten months of age, Tristan was only functioning at about a 3 month-old developmental level. His large head with prominent forehead teetered on a small, flaccid body, and he appeared to a casual observer as an "out-of-proportion" little human being.

The moment the social worker handed him over to me, I bonded with this baby. He had dancing gray eyes and a crooked smile that melted my heart right away. His diagnosis was pervasive developmental delay and the prognosis given to me was that this baby was probably extremely retarded and that he might not ever walk or talk, but I saw more behind those intensely gray eyes.

I immediately began to try to convince the social workers not to pursue institutionalized placement, but to let him stay with us for a while to give his development a chance. It was a family effort, and we spent many hours each day exercising his arms and legs, providing visual and auditory stimulation, and giving him all the love and affection that we could. Tristan, the child who "might never walk or talk," took his first step at 15 months. It was a long uphill climb to achieve true mobilization, because he stumbled and fell with almost every step. A year or more of physical and occupational therapy helped his coordination and "the little guy with those gray eyes and crooked smile" learned to walk, run, ride a trike, climb a tree and play soccer. He seemed to be everywhere at once!

Tristan did not make typical baby noises. I knew he wasn't deaf because he would look up as jets flew overhead or as pots and pans crashed and banged. After testing by specialists, we learned that Tristan had a 40% hearing loss in both ears and the "speech-range of sounds" was not being processed. Tristan had surgery and miraculously began to make sounds within a few days. His speech initially had the monotone of a hard-or-hearing or deaf child and as we read and talked to him everyone exaggerated sounds and talked with hyper-inflections.

Tristan showed an early affinity to letters. As I introduced the alphabet to him and his brothers and sisters, he was fascinated by their shapes, their names, and their sounds. He began to see letter shapes in the clouds, to use sticks and rocks outside to form the letter shapes, to play in his cereal each morning and line up his Cheerios to form his ABCs. Once he learned the concept that letters formed words, words made sentences, and sentences made books, he was hooked. He read early and maintained an affinity for books until his death.

Schooling would become another real challenge for Tristan. His hyperactivity and poor social skills with his peers was a continual concern. But Tristan was lucky enough along the way to have some "true educators" who could see beyond the surface to the potential locked inside this boy with the crooked smile. Tristan did learn. His affinity to letters and words led him to be first runner up in the school spelling bee

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Wisconsin Family Ties announces

10th Annual Family Fun Day 2005

at Mt. Olympus Water and Theme Park
Tuesday, July 12, 2005

Please turn to page 9 of this issue for more details and to request tickets!

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Bringing hope to families that include children and adolescents with emotional, behavioral and mental disorders.

Advocates Support Bill to Limit the Use of Seclusion and Restraints in Wisconsin Schools

By Jeffrey Spitzer-Resnick
Managing Attorney, Wisconsin Coalition for Advocacy

As a result of numerous cases of inappropriate use of seclusion and restraint of children in many school districts in Wisconsin, the Wisconsin Coalition for Advocacy (WCA), working with parents and other advocacy organizations, put together a bill in the last legislative session, which reflected a combination of the best elements of other states' statutes and regulations which govern this area. Most recently, a two-part series on Madison's Channel 27 News featured a time out room in use at the Abraham Lincoln Elementary School in Monroe, which was locked and had no adult supervision. WCA is currently investigating that case. The Department of Public Instruction investigated the case and found numerous violations of both building safety codes and special education law.

Despite these investigations, Wisconsin currently has no laws or regulations which specifically govern the use of seclusion and restraint in our public schools, although the Depart-ment of Public Instruction (DPI) has issued draft guidelines on this topic. To view the guidelines, you may access them on the web at: www.dvi.state.wi.us/dvi/dlsea/een/doc/secrestrgd.doc.

The bill which WCA drafted and was introduced under the sponsorship of Rep. Mark Pocan, last session, was known as AB 765. Unfortunately, due to partisan politics, that bill never received a hearing last session. This session, WCA and others are working to get a Republican sponsor of the bill, which will hopefully give it a better chance of passage. If you support the idea of limiting the use of seclusion and restraints in public schools to last resort emergency situations in a safe and effective manner by trained school staff, you may contact your state representative to urge them to sponsor this bill. You may refer them to Jeff Spitzer-Resnick at the Wisconsin Coalition for Advocacy if they have any questions which you cannot answer, but it is important that legislators hear the real concerns of parents whose children may have experienced the inappropriate use of seclusion and restraint in our public schools.

In order to better understand this issue, the rest of this article answers a few basic questions about the use of seclusion and restraint on children in public schools.

1. What are the effects of seclusion and restraint on children?

The effects of seclusion and restraint on children include but are not limited to the feeling of increased vulnerability, neglect, and a feeling of punishment while in seclusion. Additional effects of seclusion and restraint include "agitation, anger, fear, rejection, boredom, and claustrophobia."i Of course, children and staff may also be physically injured by inappropriate use of restraints. WCA has represented children who have had broken bones due to the inappropriate use of restraints. In Michigan, a student died due to being placed in an inappropriate restraint.

2. Why is the current law inadequate?

The current law is inadequate for three key reasons. First, county child abuse and child protection agencies rarely substantiate abuse in public schools, even though such techniques can be and often are abuse. Second, under the current law, despite being required to report abuse to counties, teachers rarely report when seclusion and restraint techniques occur to the parents of the child, the Wisconsin Department of Public Instruction, or counties. Third, the current law provides no specific guidance to schools on the proper and improper uses of seclusion and restraint techniques.

3. Is the problem of the overuse of seclusion and restraint occurring nationwide?

Yes, the overuse of seclusion and restraint is occurring in nursing homes and state mental facilities nationwide. A 50 State Survey conducted by the Hartford Courant in October of 1998 confirmed 142 deaths during or shortly after the use of restraint or seclusion techniques in the past decade.ii Due to these alarming statistics, many state and local governments passed laws limiting restraint and seclusion in nursing homes and other institutional settings. However, there are no specific laws restricting seclusion and restraint in public schools in Wisconsin, so we do not have good data on how big a problem this is in the state. That is one reason why the bill which WCA, parents and other advocates are promoting would require school staff to document use of seclusion and restraint on children. As indicated below, at least five other states have passed laws limiting the use of seclusion and restraint in public schools.

4. Where is this problem occurring in the State of Wisconsin?

WCA is aware that at least seven school districts, Oconto, Monroe, Marinette, Manitowoc, Fond du Lac, Eau Claire and Milwaukee have employed restraint and seclusion procedures. The number of school districts who use these practices are certainly greater than these seven school districts, but no definite study has been done to see if schools are improperly using seclusion and

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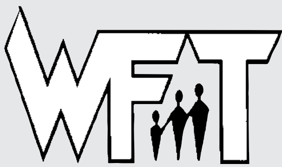

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Madison, WI 53703

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Tristan *Continued from page 1*

in the fourth grade.

School presented Tristan and us as a family with some of our darkest moments as well as a few times at the "top of the mountain." Children were cruel at times and Tristan's physical features provided fertile soil for the cultivation of rude comments and cruel pranks. However, I choose to remember the triumph - in the Spring of 1993 when Tristan delivered his self-composed address at the promotion ceremony for fifth graders at Alamance Elementary School. He cited each teacher he had had since kindergarten and thanked each one personally for some special thing that she had taught him. There was hardly a dry eye in the place. Those moments can never be forgotten!

Tristan had early on, since about third grade, exhibited severe mood swings and behavioral outbursts and had shown classic symptoms of bipolar disorder. A barrage of different medications and side effects put our family on a roller coaster of emotional ups and downs. Despite these difficulties, we tried to continue with a variety of family activities.

Adolescence, however, sent Tristan and our family reeling. We managed Tristan at home until his behavior warranted constant supervision to ensure that he did not hurt himself or our other children. We placed Tristan in an excellent residential facility, but the down side was that it was on the other side of the state from where we lived. There are very few facilities, especially very few good facilities, that are set up to handle children with severe emotional and behavioral disorders. There was no support group in our community and my husband and I felt we were sailing "uncharted seas with no compass" as we tried to find a good placement for our son.

Tristan did well at the residential placement and the caring, compassionate, and well-trained staff helped him with his behavior, as well as with academic and self-esteem issues. We traveled once or twice a month to the other side of the state for one-day visits. With all of our other family obligations and commitments, it was an exhausting ordeal; but Tristan was very firmly planted in our family and we were there for him.

Tristan was moved back to our home county in June of 1997. His transition to the new group home took some time, but it was great chatting with him on the phone almost everyday and taking him on family outings more regularly. During this time, Tristan had the opportunity to challenge himself on a variety of field trips and excursions. He hiked a portion of the Appalachian Trail, he studied the salt marshes on a camping expedition at the beach, and he faced and conquered his fears when he successfully completed a whitewater rafting trip! The young boy was becoming a man. His most important goal during this time was to complete high school and graduate as a part of the Class of2000. He wanted to get a job!

His passion for automobiles, which began as a toddler, remained strong. He could identify all makes and models of cars we passed on our family outings. He memorized the "stats" on the latest high-ticket luxury cars and delighted in sharing this knowledge with anyone who cared to listen. He loved to tell jokes and riddles and genuinely loved life. But Tristan had his darker moments, too. Events of his life and of the world caused him great anxiety and distress.

"With all of his own problems, Tristan always worried and fretted over all the other children who, in his opinion, had problems more severe than his own."

A chain of events over the course of his last few months led to the depressive episode which on February 26, 1998, precipitated our placement of Tristan into a private psychiatric hospital because of his suicidal ideations. Tristan was dead six days later. Although there are disputes over his actual cause of death, the facts of a restraint and seclusion the evening of his death are not disputed.

Five staffers restrained Tristan face down on the floor and used a towel and a bed sheet wrapped around his mouth to prevent his spitting or biting. When we were notified, Tristan was already dead. An indictment was brought against one staff person who took part in the restraint; a jury found this individual not guilty.

With all of his own problems, Tristan always worried and fretted over all the other children who, in his opinion, had problems more severe than his own. He had a big heart and never lost his ability to lighten up a room with his crooked smile and dry wit.

Since Tristan's death, my husband, Richard, and I have continued to work to see that unsafe practices are changed and that laws are passed to regulate the use of restraints and seclusion in hospitals and treatment centers. We have met with Congressmen and I testified before a Senate committee in Washington, D.C.

June 25, 1999, would have been Tristan's eighteenth birthday and on that day, an administrative order came out of the White House which put into effect the following:

• **Eliminating the use of restraints except as a last resort.** These regulations prohibit the use of inappropriate physical or chemical restraints in acute care, psychiatric, rehabilitation, long-term care, and children's hospitals participating in the Medicare program, except when patients are in danger or are endangering the health and safety of others and only with a written order of a physician. The regulations also require staff to be educated and trained in the safe use of seclusion and restraints, as well as the techniques for handling behavior, symptoms, and situations that traditionally were treated through the use of restraints and seclusion.

• **New reporting requirements to hold providers accountable.** These regulations require providers to inform the Center for Medicare and Medicaid Services (CMS) of any death that occurs when it is reasonable to assume that the death was caused by the use of restraints or seclusion.

• **New efforts to educate patients and their families about their rights.** The regulations require hospitals to notify patients about their rights, including the right to be free from restraints and seclusion. Each patient must be informed of his or her right to request or refuse treatment and to be involved in the development and implementation of his or her plan of care.

National Trends in Seclusion and Restraint

By Lisa Mensink

When many of us were children, spanking was considered the discipline method of choice. This was sometimes true at schools as well as at home. One of my friends remembers how the teachers in his private school used to rap the knuckles of daydreaming children with rulers, to ensure attention to lessons. Today, spanking has gone the way of the dinosaur, and most experts in child development clearly agree that spanking is not a helpful or acceptable form of discipline, and can be considered abusive.

In this age when separate “time-out rooms” were supposed to replace spanking and are used regularly by TV's revered Supernanny, can it be that the use of seclusion as a method of controlling out-of-control children is also falling out of favor? In an era when almost every movie about a psychiatric institute or a difficult classroom situation involves at least one incident of restraint, are we finding a better way? As with spanking, seclusion and restraint methods can cross the line into abuse, and can be dangerous. As with spanking, using seclusion and/or restraint with an out-of-control child is not necessarily the best way to help a child calm down, or to ultimately change the child's behavior, especially in the long term.

Seclusion, defined as isolation in a locked room, can accelerate, rather than solve, the downward spiral of bad behavior, is demeaning and sometimes frightening to the child involved. Many experts say most seclusion use could be avoided by a better understanding of the child's situation and a thoughtful consideration of other solutions. In addition, seclusion and restraint can lead to physical injury of both children and staff involved, and even lead to death. The most recent federal legislation on seclusion and restraint was inspired to a large degree by a 1998 report by the Hartford Courant which related 142 deaths to the use of seclusion and restraint in the prior 10 years. Children accounted for more than 26% of those deaths (about twice the percentage of children in institutions). Furthermore, the 142 deaths were an understatement, since many deaths related to seclusion and restraint were not reported as such, due to lack of monitoring. The national trend is moving toward viewing the use of seclusion and restraint as a “failure of treatment,” and finding ways to avoid the use of these practices.

Restraint can run a gamut of practices, including: physical restraint, which can range from one person simply holding a child, to several people taking a struggling teen down to the floor; mechanical restraint, which includes straps to secure wrists and ankles to a bed, and “safety coats” which wrap around the child to hold the arms and hands securely; and chemical restraint, involving medication.

Seclusion and restraint can come into practice in several venues, each with its own set of rules or laws. The public school systems in Wisconsin are given guidelines on seclusion and restraint by the Wisconsin Department of Public Instruction, which works to ensure the requirements of state and federal special education laws are carried out by Wisconsin's schools. For more information on seclusion and restraint in Wisconsin public schools, see the article in this issue by Jeff Spitzer-Resnick. Other agencies may come into play in regulating seclusion and restraint. For example, seclusion practices may be restricted by the code requirements dealing with locked doors, reviewed by the Wisconsin Department of Commerce.

“Seclusion, defined as isolation in a locked room, can accelerate, rather than solve, the downward spiral of bad behavior...”

Seclusion and restraint are also used in both state and private mental health institutes, whose policies are set by the Wisconsin Department of Health and Family Services (DHFS) as well as federal agencies. In 1999, the Health Care Financing Administration (HCFA, now known as the Centers for Medicare and Medicaid Services, CMS) created new regulations regarding patient's rights for hospitals that receive Medicare and Medicaid, including regulations on seclusion and restraint. The requirements affect both adult and child inpatient psychiatric units.

The Child Health Act, Public Law 106-310 was passed in October, 2000. This law established national standards that restrict the use of restraint and seclusion in all psychiatric facilities that receive federal funds and in “non-medical community-based facilities of children and youth.” To help implement this law, the Centers for Medicare and Medicaid Services (CMS) developed the 2001 Interim Final Rules on “Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Provid-ing Inpatient Psychiatric Services to Individuals under Age 21.” This rule only applies to clients in residential facilities that are funded under Medicaid's “Psychiatric Services Under 21” benefit. The federal law will not preempt more protective laws and regulations, such as those by CMS, or state laws.

Under the law, involuntary seclusion and restraint may only be used to ensure the physical safety of a patient, not as punishment or for staff conve-nience. Medication that is used to control behavior and is not part of the standard treatment for the child's condition is considered a form of restraint. The CMS rules include a “one hour rule” which requires a face to face evaluation by a licensed psychiatric professional within one hour of a seclusion or restraint incident. Facilities must report any death that occurs within 24 hours of a patient's removal from seclusion or restraint. Reports must also be made to state protection and advocacy agencies. Wisconsin's advocacy agency for citizens with disabilities is the Wisconsin Coalition for Advocacy.

Non-medical facilities for children may only use seclusion and restraint to protect the immediate physical safety of the child or others. The seclusion and restraint may only be imposed by certi-fied practitioners who have been trained in the impacts of seclusion and restraint, in how to monitor physical signs of distress, and in methods of avoiding the use of seclusion and restraint. Time-out and physical escorts are not considered seclusion or restraint under these require-ments. These facilities may not use mechanical restraints or drugs, and seclusion can only be used if a staff member is continuously monitoring face-to-face.

CMS issued, in December 2003, guidance for state survey agencies on their responsibility to enforce the re-straint and seclusion regulations. (See www.cms.hhs.gov/medicaid/ survev-cert/sc0413.pdf).

The Joint Commission on Accredi-tation of Healthcare Organizations (JCAHO) has standards for non-Medi-care/Medicaid facilities that differ from the one-hour CMS rule. In these facili-ties, the juvenile patients in seclusion or restraint must see a physician or licensed practitioner within two hours if the patient is 17 and under, and one hour if the patient is under age

Eliminating Restraints:

A Case Study

By Jennifer Harris, MD.

Mike, an 8-year-old boy with significant cognitive limitations and a history of witnessing domestic violence, is an inpatient on a child psychiatric unit. He walks up to a member of the milieu staff and begins pulling on her arm. The staff member gently asks him to please stop, as this is hurting her. Instead of stopping, he gets more and more agitated, pulling at her more and more forcefully, ignoring verbal redirection. What should the next intervention be?

I recently had the privilege of spending four months on the Child Assessment Unit (CAU) at Cambridge Hospital, a 13-bed unit for children ages two to 13, which has managed to eliminate the use of physical, chemical, and mechanical restraints, as well as locked-door seclusion. My time there made me rethink many of my assumptions about the purpose of inpatient care, as well as behavioral interventions. I left convinced that this unit is at the vanguard of a revolution in how we treat agitated and aggressive patients in child psychiatry.

I had heard a great deal about the changes taking place on this unit prior to starting there. As an adult psychiatry resident at Cambridge Hospital, I heard the child psychiatry fellows talking about the transition to a new model of care with great trepidation and concern. How could you keep staff and kids safe if you couldn't restrain someone? How could kids learn to behave properly if they never got consequences for bad behavior? How could you run a unit without the ultimate in limit setting (restraints) as an option? Isn't the purpose of an inpatient unit safety and containment? As a former day care teacher, I believed in the importance of minimal but consistent limit setting.

The answer to these questions starts with rethinking the core mission of an inpatient unit. When the leaders of the CAU started to think about these changes, their first step was to change the mission from safety and containment to nurturance and teaching. On a practical level, this meant the end of formal visiting hours. Parents can (and. do) come on to the unit any time of day or night, and may even spend the night with their children, if they desire. They also allow more physical contact between staff and patients. Staff not only give kids high fives and return hugs, they even sometimes initiate them. Walking through the CAU, one immediately notices this difference. Instead of feeling like a structured, contained, even cold environment, it feels warm, friendly, and relaxed.

But the most dramatic changes that were made had to do with the behavior plan – it was eliminated. Instead of an elaborate points system, in which patients had to earn privileges by good behavior, it was assumed that kids would be allowed off the unit once they had been there 24 hours, unless some very good reason otherwise existed. Perhaps most remarkably, there was no set list of consequences for certain behaviors. Every situation was judged independently, at the moment, and interventions were tailored to a particular child at a particular moment.

The unit adopted Ross Greene's concept of Collaborative Problem Solving. Greatly simplified, this program focused on avoiding strict limit setting in favor of compromise and negotiation to help kids understand the reasons for their behavior and practice better ways to get what they need. This has required a far more detailed understanding of each child, what drives his or her behavior, and what helps. Instead of just looking at what a kid is doing, one must understand why. Such an approach forces all the clinicians (from milieu staff to attendings) to formulate cases deeply and to tailor interventions accordingly.

Another staff member approaches and comments that she saw Mike on the phone asking his mother to pick him up at the hospital. It appeared his mother had hung up on him. The two staff members start to talk to Mike about other things he could do if he's feeling upset. Many suggestions are offered, and Mike starts to relax his grip. Eventually Mike agrees that getting out a stuffed animal to hold onto might help. He lets go, and they go to the closet together and pick one out.

This is just one example of the types of interactions I witnessed daily on the CAU during my four months there. It is, however, an excellent example. On a unit more focused on behaviors than the reasons behind them, this could easily have escalated into a restraint. Instead, staff used their knowledge of this child's limitations, his history, and recent events to tailor their intervention in a way that not only de-escalated the situation, but also more directly attended to his needs. I hope that my work as a child psychiatrist will be similarly nurturing, responsive, and effective.

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Trends *Continued from page 4*

nine. If released within the time limit, the child must be evaluated face-to-face within 24 hours. The order to continue restraint or seclu-sion can be made by a registered nurse or other qualified trained and authorized individual. However, a licensed indepen-dent practitioner must perform an in-person reevaluation at least every 4 hours. These standards do not apply to seclusion in an unlocked room.

What is the future for the use of seclusion and restraint for controlling children? The Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS), whose mission is “to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness,” has allocated $2.5 million to support implementation of a National Action Plan to reduce and ultimately eliminate seclusion and restraint from treatment and rehabilita-tion settings. The plan focuses on identifying evidence-based practices, developing training models, providing technical assistance for staff and enforc-ing rights protection to safeguard con-sumers.

What can we do to further progress in this area? Contact your legislator to make your views known (see box on page xx). Talk to the staff members and administrators who educate and treat your children and set policy, to see what their practices are. Most important, educate yourself on best practices so that you will know what the alternatives are.

Resources on Seclusion and Restraint

Alliance to Prevent Restraint, Aversive Interventions, and Seclusion (APRAIS)

Contact Jamie Ruppmann
TASH
29 W. Susquehanna, Suite 210
Baltimore, MD 21204
410-828-8274, x104
APRAIS, a newly formed coalition of the nation's major disability advocacy organizations, has the following vision: “All children should grow up free from the use of restraint, seclusion, and aversive practices to respond to or control their behavior, and from the fear that these practices will be used on themselves, their siblings, or their friends.”

American Academy of Child and Adolescent Psychiatry (AACAP)

www.aacap.org
The American Academy of Child and Adolescent Psychiatry is a professional medical organization comprised of child and adolescent psychiatrists. For a look at their position on seclusion and restraint, see: http://www.aacap.org/publications/policy/Ps44.htm

American Academy of Physician Assistants (AAPA)

www.aapa.org/gandp/restraint.html
This page on the AAPA website, “Patients' Rights: Seclusion and Restraint,” also has links to other S/R pages, including AAPA's policy on S/R.

The Bazelon Center for Mental Health Law.

www.bazelon.org
The Bazelon Center is a national legal advocate for people with mental disabilities, using litigation, policy coalitions, publications, and the media to advance their cause. Click on the “search” link to search the site for information on seclusion or restraint. Contains up-to-date information on legislation and court decisions affecting the use of seclusion and restraint in psychiatric facilities. Bazelon believes restraint and seclusion should be used only as a last resort in emergency safety situations involving immediate physical danger, and that its use should be time-limited and subject to a physician's order and oversight and to constant monitoring by qualified professional staff.

Child Welfare League of America

www.cwla.org/advocacy/seclusionrestraints.htm
This page on the CWLA website has links to numerous articles on seclusion and restraint. Check out their bibliography of seclusion and restraint studies:
www.cwla.org/programs/behavior/samshabib.pdf

National Association of State Mental Health Program Directors (NASMHPD)

www.nasmhpd.org
Click on the search tab to search for information on seclusion and restraint, such as publications, symposia, position statement, info on laws and regulations. The Summer 1999 issue of Networks newsletter online focuses on seclusion and restraint.

Positive Education Program (PEP)

www.pepcleve.org/re-ed.htm
Check out PEP's 12 principles of reeducation, developed by Nicholas Hobbs, and used by this special education/mental health program.

Substance Abuse & Mental Health Services Administration (SAMHSA)

www.samhsa.gov/Matrix/matrix_seclusion.aspx
SAMHSA has allocated $2.5 million to support implementation of a National Action Plan to reduce and ultimately eliminate seclusion and restraint from treatment and rehabilitation settings. Check out their summary report on eliminating S/R, including the “What Works!” section:
http://alt.samhsa.gov/seclusion/SRMay5report2.htm

Wisconsin Coalition for Advocacy

16 N. Carroll St., Suite 400
Madison, WI 53703
608-267-0214
www.w-c-a.org
WCA is currently sponsoring Wisconsin legislation to limit seclusion and restraint in Wisconsin schools. See article on page 2.

How to Contact Your Legislator

By Phone

To find out who your legislators are, or to state your opinion by phone, call the Wisconsin Legislative Hotline:
Outside of Madison: 1-800-362-9472
In Madison: 266-9960

By Email

Go to the legislature's web page, www.legis.state.wi.us. The link “Who Are My Legislators?” allows you to search by address or municipality for your legislators on the Wisconsin State Senate, Wisconsin State Assembly, U.S. Senate, and U.S. House of Representatives. Follow the links for each legislator.

By Mail

To your State Senator:
P.O. Box 7882
Madison, WI 53707

To your State Representative:
Last name A through L
P.O. Box 8952
Madison, WI 53708

Last name M through Z
P.O. Box 8953
Madison, WI 53708

To contact the Governor
Room 115 East, Capitol
Madison, WI 53702
608-266-1212
or email from: www.wisgov.state.wi.us/contact.asp

Conferences *and* Workshops

June 23-25 - Building on Family Strengths Conference

Portland, Oregon. Portland State's Research & Training Center (RTC) conference is entitled Assets and Evidence: Positive Strategies for Reducing Disparities and Transforming Children's Mental Health. Visit www.rtc.pdx.edu/pgConference.shtml for program and registration or call Lyn Gordon at 503-725-4114; gordon1@pdx.edu.

June 29 - New Developments in Special Education Law: The Impact of the Individuals with Disabilities Education Improvement Act of 2004

Sheraton Hotel, Madison. 800-930-6182 or www.nbi-sems.com.

July 19-21 - Children Come First Conference: Working Together Works for Everyone

Radisson Paper Valley Hotel, Appleton.
Call Lisa Carlson at 608-284-0580, ext. 304; www.wccf.org.

July 20 - Challenging Behaviors

Easter Seals KindCare, 1016 Milwaukee Avenue, Milwaukee, 9-noon; $45. 414-571-5566, x 406
sally@eastersealskindcaresewi.com.

Aug 2-6 - Association on Higher Education & Disabilities National Conference

Midwest Airlines Center, Milwaukee. Contact 781-788-0033 to register; www.ahead.org.

Aug 8-11 - 2005 State Prevention Conference - Weaving a Tapestry of Health: Promoting Change through Action

Hotel Mead & Conference Center, Wisconsin Rapids. Presented by the Wisconsin Clearinghouse. www.uwsp.edu/extension/conferences and then WI State Prevention Conference or call 1-800-898-9472, ext. 3 to register.

Sept 15-16 - 9th Annual Crisis Intervention Conference: The Many Faces of Crisis

Marriott Hotel Middleton. Contact the SE WI Area Agency on Aging at 262-821-4444 for information. Program information available in June.

Sept 26 - CESA #2 Early Childhood Program presents Conscious Discipline with Jeannette French

CESA #2 Conference Center, Milton. For more information on Conscious Discipline check out www.consciousdiscipline.com. For conference early registration ($85), contact Susan Donahoe, 608-758-6232, x323 or sdonahoe@cesa2.k12.wi.us with workshop content questions.

Nov 9-12 - TASH International Conference on Inclusion

Milwaukee Midwest Express Center. www.tash.org.

Nov 18-20 - Federation of Families for Children's Mental Health 17th Annual Conference: Transforming Systems Through Youth and Family Leadership

Renaissance Hotel, Washington DC. For information, go to www.ffcmh.org or contact the WFT office.

Bill *Continued from page 2*

restraint and DPI does not track this data.

5. What can be done about this problem?

WCA, many parents, and other advocates believe that Wisconsin needs to pass legislation that only allows the safe use of seclusion and restraint techniques to be used in emergency situations. Too often, over-stressed teachers (with increasingly growing numbers of students) are frustrated or unable to control a child who is having a behavioral problem. Instead of finding a positive solution to the problem, the teacher often locks the child in a confined space isolating him from his classmates and the learning experience. If this bill passes, teachers will no longer be allowed to use seclusion and restraint unless other methods have failed or an emergency situation has taken place. In addition, seclusion and restraint techniques, when used, will need to be done safely.

6. How much will it cost to fix the problem?

No state funds are requested in the bill which WCA, parents and other advocates are promoting. Any training costs must be borne by the local school districts.

7. What are some current statutes and regulations that deal with seclusion and restraint?

- Massachusetts 603 CMR 46.00
- Texas Statute 37.0021
- Maryland Proposed Regulation Title 12 A Chapter 4
- Illinois Public Act 91-600
- California Inglewood California Regulation 5 CCR 3052

Notes:

i. Martinez, Grimm, & Adamson, 1999; Meehan, Vermeer, & Windsor, 2000 study of *The Experience of Seclusion from the Patient's Perspective.* Reprinted in part in Journal of Child and Adolescent Psychiatric Nursing

ii Weiss, E. Deadly Restraint: A Hartford Courant Investigative Report October 11, 1998 courant.ctnow.com/ projects/restraint

The author wishes to credit his former law clerk, Nicki VanderMeulen for her assistance in drafting AB 765, and for an earlier version of this article.

The following poem was published in our Winter 2005 newsletter. We regret that the dedication was partially omitted.

Hush My Child

By Janet de Terville

Hush my child, it is time for bed
Hush my child, please rest your head
No one is going to hurt you now
No one is going to steal you now.

Here is a tissue, dry your eye
Hush my child, there is no need to cry
Say no more, your mom is home
Relax my child, you are not alone.

Dream my child of wondrous days
Playing and dancing in the sunlight's rays
No one is going to neglect you now
Mom is here to protect you now.

Forget those harsh words that you heard
As if you did not hear a word
Come my child, you are free at last
Come my child, your hurt has passed.

For now my child, the night must end
And trust that I will be your friend
No one is going to haunt you now
No one is going to hurt you now.

Hush my child, it is time for bed
Hush my child, rest your weary head
I will fight to protect you now
I will show you happiness now.

The author wrote this poem for her daughter, who was diagnosed with Attachment Disorder 4 1/2 years ago.

Federation of Families Director to Keynote at *Children Come First* Conference

Sandra Spencer, Executive Director of the Federation of Families for Children's Mental Health (FFCMH) will be a featured keynote speaker at the 2005 Children Come First Conference to be held at the Radisson Paper Valley Hotel in Appleton, July 20-21. Ms. Spencer became the leader of the Federation as a result of her steadfast love of and dedication to her own family first, and then beyond, to all of our families. She knows systems of care development from the ground up and has worked for many years to provide training and technical assistance to family-run organizations like Wisconsin Family Ties.

Ms. Spencer has commanded respect from national policy and program leaders, family members, youth, and children for more than a decade. Sandra has navigated a highly visible career path through local family organizing, state-level systems of care development, advocacy, national meeting planning for both the Federation of Families for Children's Mental Health and the Technical Assistance Partnership, and providing training and technical assistance to family-run organizations. But, in addition to her successes, Sandra's struggles have led to the deepest ways of knowing and learning. Sandra has been homeless and on welfare. She has spent sleepless nights protecting her son from the symptoms of his emotional disorder. She has developed and managed resources to raise her children alone, in a home she owns, and in an environment of unconditional love and support. Those are the real skills and abilities Sandra brings to her position.

Steve Hornberger, Director of Behavioral Health for the Child Welfare League of America, will also keynote. Mr. Hornberger's work to promote family-driven support and wraparound services in New York City is praiseworthy.

Pre-Conference Wraparound Training

Other features of this year's CCF Conference entitled "Working Together Works for Everyone," is a pre-conference training on Tuesday, July 19, for those interested in expanding their knowledge and skills of wraparound principles. "Wraparound: Beyond the Basics" will be tailored to meet the needs of the audience and will include practical applications to common challenges encountered in the working relationships of the wraparound team members – children, families, and child-serving professionals.

Youth Program

For a second year the conference will provide a free Children's Program to involve and entertain youth with exceptional needs and their siblings. This program will run for the two days of the conference (not during the pre-conference) and be geared to children six and older. The planners have given careful consideration to age-appropriate activities: Children will be divided into groups aged 6-10 and 11 and older.

Workshops and Awards Luncheon

Conference attendees will also enjoy the opportunity to attend five different workshop sessions during the two-day conference. As in other years, the problem will be which workshop to choose! The conference brochure gives a full listing, so study it closely and choose what fits your needs the most.

The CCF Conference concludes with an awards luncheon this year. The Wisconsin Council on Children and Families (WCCF) is seeking nominations in four categories: Family Member; Child, Individual-Professional or Volunteer; and Organization/Agency/School. You may nominate on line at www.wccf.org/CCF, or by mailing the form in the CCF Conference brochure.

Scholarship Information ,

A word about scholarships: WCCF has conference registration scholarships; Wisconsin Family Ties has limited scholarships available for lodging, meals, transportation and childcare. You must be registered for the conference in order to receive a WFT scholarship. Email us for a Parent Scholarship Request Form at info@wifamilyties.org, or request the form by calling 1-800-422-7145. Leave a message with your name and address and we will send you the form by mail.

If you do not receive a CCF Conference brochure by mail, you may request one by calling WCCF's Lisa Carlson at 608-284-0580, ext. 304, or go to www.wccf.org/CCF. Those who have attended the Children Come First Conference in the past know what a well-planned and worthwhile experience it is. Think about joining us this year to reinforce in your own mind the concept that "Working Together Works for Everyone." We believe it's the only way we can hope to see progress.

Wisconsin Family Ties announces

Family Fun Day 2005

10th Annual Family Fun Day at
Mt. Olympus Water and Theme Park

Tuesday, July 12, 2005
1701 Wisconsin Dells Parkway
Wisconsin Dells, WI

Every year it gets better and this year's event promises to give new thrills and spills. So set aside July 12 and expect to meet families like yours from all over the state when we gather in the Dells for the 10th annual Wisconsin Family Ties Family Fun Day! But don't be confused with the new name - Family Land Water Park is now Mt. Olympus Water and Theme Park. This "mega-park" has joined several other resorts and parks, including Family Land, into one large fun-filled Dells attraction.

We'll gather at the same place as in previous years, and we'll play in the same Family Land Park area. But we'll enjoy two additional family raft rides and six new slides in the updated environs! Will you be brave enough to raft Triton's Fury and Triton's Rage or ride one of the six slides comprising Triton's Challenge?

Last year nearly 600 people attended Family Fun Day. The weatherman predicted thunderstorms, but fortunately we enjoyed the warmth of the sun for the entire time. Even if it rains, the indoor pool and slide area are available, so you need not worry about getting your money's worth.

As before, the tickets for the WFT Family Fun Day are steeply discounted and include a picnic lunch. Ticket costs will remain at $10 for WFT Family Fun Day guests. The entrance to the park (1701 Wisconsin Dells Parkway) and the parking area remain the same as before, although there will be a different look. . Turn in at the Treasure Island Resort entrance and after parking, meet us at the Group Sales building (the one with a blue awning) at about 9 a.m. or whenever you can make it.

To save yourself a call, clip the form below and send it today with your check. Or call us at 800-422-7145. If staff is busy and you must leave a message, please state your name, address, telephone, and the number of tickets you want. Then send us your payment. Whichever way you choose to register, please do so well before the deadline. Your tickets will be sent to you only upon receipt of your check. Deadline for receiving payment is **Wednesday, July 6.**

Gather your kids, swimming suits and towels and head for the Dells on July 12. We look forward to seeing you at Mt. Olympus Water and Theme Park for Wisconsin Family Ties Family Fun Day!

Mt. Olympus Water and Theme Park Ticket Request

Please complete (print clearly), detach and mail with payment to: WFT, 16 N. Carroll, Ste. 640, Madison WI 53703

MUST BE RECEIVED IN OUR OFFICE NO LATER THAN ***WEDNESDAY, JULY 6.***

First Name ______________________ Last Name: ______________________

Address: ______________________ City: ______________ State _______ Zip: ______________

Phone: ______________________ Number of Tickets Requested: _____ (ages 3 to adult $10/ticket)

_____ (ages 2 and under free)

Payment by Personal Check, Money Order or Cashier's Check Only

Met Life and Local Businesses Donate to Northern Family Fun Day

Thanks to generous donations from Metropolitan Life and many local businesses and organizations, Wisconsin Family Ties' Northern Family Fun Day at THE WATERS of Minocqua was a huge success and fees were kept affordable for families.

Over 60 people attended the April 17th event, including families and volunteers from Oneida, Vilas, Iron, Price & Ashland counties. A pizza lunch was provided along with many door prizes, including a free night, two-day stay at THE WATERS donated by THE WATERS of Minocqua and a $500.00 off coupon for an Estate Plan donated by Hooper Law Offices.

WFT Family Advocate Jackie Baldwin, along with volunteers, plan to host another Fun Day on Sunday, November 6th, also at THE WATERS. The November event will include workshops for parents and volunteers. Childcare will be provided.

family ties

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Wisconsin Family Ties (WFT) is a statewide organization run by families for families that include children and adolescents with emotional, behavioral, and mental disorders. An Equal Opportunity Employer, WFT is funded by individuals, corporations, grants, and an a llocation from Community Shares of Wisconsin. Contributions to WFT are tax deductible.

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❑ Check here to update address. Correct name and address in space above and fax to 608.267.6801 or email changes to info@wifamilyties.org

❑ Check here to remove your name from WFT's mailing list and fax to 608.267.6801 or email request to info@wifamilyties.org.

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