Making the Wrong Call

The Emergency Removal of Students Exhibiting Disruptive Behavior Is an Unacceptable Substitute for Positive School-Based Mental Health Practices

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Executive Summary

- During the 2011-2012 school year, twenty students per day were removed from New York City public schools by ambulance and taken to psychiatric emergency rooms for disruptive behavior, not medical emergencies.

- In the vast majority of cases, students removed by ambulance for disruptive behavior do not receive emergency treatment on arrival at hospitals and are very rarely admitted.

- The inappropriate use of Emergency Medical Services runs counter to DOE interests in promoting education and reducing harm. Students exhibiting the behavioral effects of trauma face further traumatization, lose much-needed class time, and risk being pushed out of the educational system. Lacking control, parents may face financial and economic losses related to unnecessary EMS services and even ACS involvement.

- Culturally sensitive policies and protocols should be developed to give clear guidance on the circumstances that should give rise to the drastic remedy of removal by ambulance to prevent the overuse of Emergency Medical Services (EMS). Policies should be culturally competent and family centered, ensure parent notification, and require that data on emergency school removals be collected and reported. The collection and reporting of data would assist in tailoring the range of services appropriate for a given district.

- The range of school-based mental health services should be enhanced to meet the needs of affected students as well as the general student population. This may be accomplished by increasing access to School Based Mental Health Services programs, incorporating mental health services into existing school-based health clinics, developing affiliations with neighborhood providers and mobile crisis teams, and increasing the availability of on-site resources in innovative ways that have proven successful in the past.

- The State Education Law should be amended to require the adoption of disciplinary plans that decrease punitive approaches to emotional disturbances and/or behavioral issues related to disabilities or perceived disabilities and encourage restorative practices. Behavior intervention plans should be required when a suspension is imposed, and school personnel should receive training to identify and respond to behavioral problems, provide positive behavioral intervention and support, and de-escalate disruptive student behavior.

There can be no keener revelation of a society's soul
than the way in which it treats its children.

--- Nelson Mandela, May 8, 1995

Introduction

The New York City Department of Education (DOE) is the nation's largest system of public schools.[1] It includes over 1,700 schools serving 1.1 million students, nearly 700,000 of whom are in grades K-8, and approximately 160,000 of whom receive some form of special education services.[2]

During the 2011-2012 school year, school staff called New York City's Emergency Medical Services (EMS) for ambulances 13,967 times. Twenty-six percent of these (3,631 calls) were related to behavioral incidents, not to medical emergencies such as illness, accident, or suicidal ideation. In other words, for the school year, New York City schools averaged over twenty behavior-related EMS calls per school day.[3]

This practice of removing misbehaving students by EMS traumatizes students and deprives them of important class time, is counter-productive as a means modifying disruptive behavior, and is a costly waste of EMS and hospital resources. Yet, it has largely existed under the radar with little attention from education leaders and public policy makers. This paper summarizes what is now known about EMS removals from New York City schools and what additional information should be provided to the public and to policy makers about the practice. It concludes with concrete steps that can be taken to end the overuse of EMS in public schools and to create a better educational environment for children with behavioral challenges and for their peers.

1 NYC DOE, About Us. Retrieved at http://schools.nyc.gov/AboutUs.

2 NYC DOE, Statistical Summaries. Retrieved at http://schools.nyc.gov/AboutUs/Data/Stats. The special education services figure does not include students enrolled in NYC charter schools.

3 NYC DOE. (June 14, 2012). Responses to Questions Raised Following Joint Oversight Hearing of New York City Council Held on May 1, 2012.

Discussion

DE was a kindergartener during the 2011-2012 school year. Diagnosed with autism as a young child, DE had already had two years of pre-K when he started kindergarten at a new school in September 2011. Like many autistic children, DE has tantrums. Unlike his pre-K school, his new school called 911 and had DE removed by ambulance when he had tantrums. DE was taken a city hospital emergency room four times in the fall of 2011, even though he was calm by the time he was taken away each time and even though his mother or his aunt had been called and had arrived at the school prior to his removal. Each time, he was discharged without being admitted or treated. DE became terrified of going to school and his mother withdrew him from school in February 2012.

Emergency Medical Services (EMS) was called to New York City schools for behavioral incidents approximately twenty times a day during the 2011-2012 school year. While DOE does not appear to track what happens to the children after they a removed, the available data shows that experiences like DE's in which the hospital does not determine the child in need of treatment or admission are common. In a survey conducted by the co-chair of the New York City School Based Mental Health Committee, it was determined that at one hospital only 3% of students removed from schools by EMS were admitted for treatment. Of the four hospitals examined, the hospital that most often admitted students sent by EMS from schools declined to admit nearly two-thirds of the students sent to it.

DOE policy appropriately requires same-day risk assessment of any student who is deemed to pose a risk either to himself or to others.[4] However, it is evident from the available data that some students are being removed EMS for relatively minor disruptive behaviors which do not pose the sort of threat required to trigger mandatory same-day assessment and which would be better met with school-based behavioral intervention. Even in those cases where student behavior is genuinely threatening enough to appropriately trigger a referral for assessment, reliance on EMS removal to hospitals as a means to an assessment is a traumatizing, costly and unsustainable method, which should be a last resort rather than a standard practice.

The use of EMS to remove students from schools is inevitably traumatizing. After 911 is

[4] NYC DOE, Chancellor's Regulation A-412, Security in the Schools. Issued 11/8/2006. Retrieved at http://schools.nyc.gov/RulesPolicies/ChancellorsRegulations.

called, an ambulance arrives, and the often-restrained student is taken to a hospital Emergency Room to be assessed. A school staff member must accompany the student until a parent arrives. Though DOE policy requires parental notification when EMS is called, removal often takes place before parents can be contacted. Even when parents are reached and arrive before the removal, they are commonly not permitted to speak with their child, to intervene, or to decline the removal of their child to the hospital.

As noted above, in most cases, after spending hours in a hospital Emergency Room, the child is released without being admitted because Emergency Room staff determines that no treatable emergency exists. Often, the only outcome of the ordeal is a referral from the Emergency Room to a community based mental healthcare provider for an assessment. In the meantime, schools frequently refuse to permit the student to return to class until the assessment is completed and the mental healthcare provider writes a "psychiatric clearance letter" affirming that the child is fit to attend school. In such cases, EMS removal amounts to nothing more than an extraordinarily costly and traumatizing means of making a mental health care referral coupled with a de facto school suspension while the child waits to be seen for an assessment.

Students already exhibiting trauma, behavioral difficulties, and disabilities of the sort that lead to disruptive conduct can lose a great deal of critical class time, particularly when removal is coupled with the requirement of a psychiatric clearance letter. These students, some as young as five years old, may be so traumatized by the removal that they are unable to return to class even when they are cleared as not posing any risk. As the cycle repeats, these children risk being pushed out of the educational system altogether.

Overuse of EMS seems to be a natural outcome of the absence of clear regulatory or practice guideline on when EMS removal is warranted. Chancellor's Regulations on the topic state that 911 should be called "if an individual requires medical attention"[5] or when "a staff member has knowledge of a suicide attempt" or "where appropriate, if a staff member becomes aware of suicidal behavior or ideation."[6] Another regulation states that if a student's condition "warrants more emergency care than can be given in the school, 911 must be called."[7] However, the regulations are silent on when, if ever, emotional disturbance short of suicidal ideation or threats to others should be seen as requiring more emergency care than can be given at the school. The regulations also fail to offer concrete guidance on techniques for addressing emotional disturbance or disruptive behavior without resorting to EMS.

5 NYC DOE, Chancellor's Regulation A-412, Security in the Schools. Issued 11/8/2006. Retrieved at http://schools.nyc.gov/RulesPolicies/ChancellorsRegulations.
6 NYC DOE, Chancellor's Regulation A-755, Suicide Prevention/Intervention. Issued 8/18/2011. Retrieved at same.
7 NYC DOE, Chancellor's Regulation A-701, School Health Services. Issued 8/15/2012. Retrieved at same.

It is unclear how and to what extent data are tracked by schools and by DOE, and the resulting lack of transparency leaves important questions unanswered. For example, what proportion of EMS calls are made for students with acknowledged disabilities? How many students are sent to Emergency Rooms on more than one occasion, and how many actually require or receive treatment upon arrival? What proportion of students removed by EMS come from are of color or economically disadvantaged backgrounds? Which schools make the greatest number of EMS calls? As of yet, DOE has not made publicly available data on the schools which are most often using EMS in non-emergency cases, the reasons for these calls, the demographics of the students involved, or the outcomes of their emergency room visits.

The precise costs of this practice cannot be calculated without better data, but their scope should certainly be plain. City emergency services, already overburdened, are required to deal with an average daily influx of twenty extra students – costing hundreds of hours per day of EMS labor citywide. Depending on the insurance status of the students, the employment conditions of family members, and the extent of parental effort required to restore the student to class, this translates into millions of dollars in annual financial costs to taxpayers, hospitals, insurance providers, and to families. A school system that cannot spare an extra staff member to defuse an escalating situation or to remain with a child while he calms down surely cannot spare twenty staff members to remain with twenty students for the better part of a day in city Emergency Rooms.

On top of the direct costs of EMS removal, family members face serious additional difficulties as a result of the practice. Parents often face economic loss, ranging from the loss of half a day's wages for each removal to the loss of employment due to repeatedly having to leave work. Further, in cases where a parent cannot get to the Emergency Room before the school staff member must leave, parents may be subject to inquiry from the NYC Administration for Children's Services.

Conclusion and Recommendations

The removal of students with behavioral difficulties from schools, by ambulance, in non-emergency cases harms students and families, does not serve its intended purposes, and is costly. New York State, New York City and the Department of Education should redirect resources to effectuate the following policies that will positively address disruptive student behaviors and reserve EMS for appropriate emergency use.

1. Develop protocols for the use of Emergency Medical Services. DOE should adopt new Chancellor's Regulations clearly outlining policy and procedure for referrals to EMS. School officials should have detailed guidance in deciding which situations are so urgent that EMS intervention is warranted. In addition, the Regulations should:

- **Prioritize parental involvement.** Ensure that parental contact precedes EMS referrals whenever possible.
- **Involve appropriate school staff in the EMS decision-making process.** Involve those who know the child in any assessment of whether behavior constitutes a threat or emergency. Further, school nurses and, if available, school psychologists or social workers, should be involved in assessing when to use EMS.
- **Require annual disclosure of detailed data on usage of EMS and mental health referrals.** Disclosure by all school districts of EMS and mental health referral data by school and by reason for referral will allow policy makers to better identify schools with the greatest needs and direct tailored services to them.

2. Improve access to mental health services in schools. Children exhibiting disruptive behavior often have unmet mental health needs which are best addressed through culturally competent, family-centered interventions. Existing interventions range from school-based mental health services to behavioral interventions.

- **Increase funding for school-based mental health clinics.** School-based mental health services reduce the need for school removals and promote continuity in treating children with emotional disturbances.
- **Develop affiliations between schools and clinics.** School-linked clinical programs facilitate rapid and cost-effective referral of students in crisis into community mental health clinics.
- **Establish and develop mobile-response program affiliations** that bring mental health services to school sites that remain underserved, such as DOE's Mobile Response Team model and existing hospital-based mobile crisis teams.
- **Study the effects of innovative models** that have already been established and expanded in New York City schools, such as the DOE partnership with Turnaround,

which works with schools over a period of years to develop approaches tailored to fit individual schools that promote positive intervention strategies and academic performance.

3. Adopt policies that promote a positive school climate. Formalizing positive approaches such as restorative practices and positive behavioral interventions and supports (PBIS) fosters an environment that improves student behavior, reduces violence and bullying, enhances relationships among students, staff and parents, and creates a sense of community.

- **Amend Section 2801 of the State Education Law to require proportionate disciplinary interventions.** A disproportionate number of children who are suspended from New York City schools for disciplinary infractions are cognitively or emotionally disabled. Punitive approaches to school discipline contribute to a culture that discourages positive interventions. The Education Law should be amended to require proportionate penalties for disciplinary problems to reduce the prevalence of out-of-school suspensions.
- **Require districts to develop intervention plans that are less reliant on school removals.** The State Education Law should be amended to require districts to develop approached to school misconduct that reduce children's exposure to the criminal justice system and reduce the number of school removals including peer mediation and counseling.
- **Require behavior intervention plans** for all students removed from school for misconduct. School-based support teams or special education committees should recommend appropriate accommodations, interventions and services for students with disabilities who have significant behavioral difficulties.
- **Mandate training and professional development for school personnel** in de-escalation techniques and best practices for working with disruptive students so that disruptive behaviors can be appropriately and promptly addressed without unnecessary EMS interventions.