Guidance on 704 KAR 7:170, Corporal Punishment

While corporal punishment is an allowable behavior resolution in Kentucky pursuant to KRS 503.110, changes made to KRS 158.4416 (part of the School Safety and Resiliency Act of 2019) requires districts to adopt trauma-informed discipline plans and approaches. Considering this, districts that choose to implement corporal punishment as a response to student behavior must do so in accordance with the rules outlined in 704 KAR 7:170.

This guidance document provides technical assistance to districts seeking to implement corporal punishment.

Corporal Punishment as a Classroom Management Strategy
Corporal punishment has been a disciplinary tool deployed in schools since the beginning of public schooling. As schooling has evolved, so too have the classroom management strategies available to educators.

In Kentucky, schools are required to implement trauma-informed discipline plans pursuant to KRS 158.4416. While corporal punishment remains an allowable discipline resolution under the law, corporal punishment is **not** a trauma-informed disciplinary practice and the Kentucky Department of Education (KDE) advises that it should not be deployed in Kentucky public schools.

Corporal punishment in school is harmful to the social, emotional and physical health of Kentucky's public school students. A resounding chorus of professional organizations have called for an end to the practice, including the:

- American Academy of Child and Adolescent Psychiatry,
- American Academy of Pediatrics,
- National Congress of Parents and Teachers,
- American Medical Association,
- National Education Association, and
- American Bar Association.

Research into the short-term and long-term effects of corporal punishment at school has documented its harmful effects. A research review conducted by the Global Initiative to End All Corporal Punishment of Children found more than 250 academic studies that demonstrated negative outcomes of inflicting corporal punishment, including:

- Direct physical harm to students;
- Negative impacts on mental and physical health;
- Poor moral internalization and increased antisocial behavior;
- Increased aggression in children;
- Increased violent and criminal behavior in adults;
- Damaged education;
- Damaged relationships; and

- Increased acceptance and use of other forms of violence.

Additionally, no studies were found to support the use of corporal punishment as a behavior deterrent. By contrast, actively prohibiting the use of corporal punishment has been shown to have positive effects. A recent report entitled "The positive impact of prohibition of corporal punishment on children's lives: messages from research," suggests that prohibitions on corporal punishment lead to lesser levels of violence and a greater acceptance of trauma informed practices by local populations.

KDE encourages all school districts in Kentucky to actively prohibit the use of corporal punishment. KDE is prepared to offer technical assistance, guidance and on-site training to districts seeking to transition corporal punishment out of their classroom management repertoire in favor of trauma-informed responses to student behavior and proactive, evidence-based approaches to preventing disruptions. More information about the resources available to districts can be found on KDE's School Safety and Resiliency Act webpage, including a tool for developing a Trauma-Informed Discipline Response and Behavior System.

A Harm Reduction Approach
As corporal punishment remains an allowable behavior resolution under KRS 503.110, KDE has applied a harm reduction framework in the crafting of 704 KAR 7:170. Harm reduction is a policymaking framework that acknowledges that while harmful behaviors cannot always be prohibited, policy steps can be taken to limit the risk of harm to individuals and to society.

In crafting 704 KAR 7:170, KDE adapted multiple principles of harm reduction as defined by the National Harm Reduction Coalition for a corporal punishment application:

- Accept, for better or worse, that corporal punishment is an allowable behavior resolution and choose to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understand that corporal punishment use is a complex, multi-faceted phenomenon that encompasses a continuum of behaviors and acknowledges that some ways of using corporal punishment are clearly safer than others.
- Ensure that people effected by corporal punishment have a real voice in the creation of programs and policies designed to serve them.
- Do not attempt to minimize or ignore the real and tragic harm and danger that is associated with corporal punishment.

These four elements of the harm reduction framework can be seen throughout the regulation and have informed KDE's technical assistance and guidance on this issue.

704 KAR 7:170, Corporal Punishment
The corporal punishment regulation includes seven sections designed to protect the health and safety of students that experience corporal punishment at school.

Section One: Definitions

The corporal punishment regulation includes a list of definitions that will assist districts in maintaining compliance with the law:

- Corporal punishment: The deliberate infliction of physical pain by any means upon the whole or nay part of a student's body as a penalty or punishment for student misbehavior.
- Qualified mental health professional: A qualified mental health professional means:
    - A physician licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties;
    - A psychiatrist licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the practice of official duties, who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology Inc.;
    - A psychologist with the health service provider designation, a psychological practitioner, a certified psychologist or a psychological associate licensed under the provisions of KRS Chapter 319;
    - A licensed registered nurse with a master's degree in psychiatric nursing from an accredited institution and two years of clinical experience with mentally ill persons; or a licensed registered nurse with a bachelor's degree in nursing from an accredited institution who is certified as a psychiatric and mental health nurse by the American Nurses Association who has three years of inpatient or outpatient clinical experience in psychiatric nursing and is currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community program for mental health and individuals with an intellectual disability;
    - A licensed clinical social worker licensed under the provisions of KRS 335.100, or a certified social worker licensed under the provisions of KRS 335.080 with three years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community program for mental health and individuals with an intellectual disability;
    - A marriage and family therapist licensed under the provisions of KRS 335.300 to 335.399 with three years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community program for mental health and individuals with an intellectual disability;
    - A professional counselor credentialed under the provisions of KRS Chapter 335.500 to 335.599 with three years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or

forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community program for mental health and individuals with an intellectual disability; or

- A physician assistant licensed under KRS 311.840 to 311.862, who meets one of the following requirements:
  - Provides documentation that he or she has completed a psychiatric residency program for physician assistants;
  - Has completed at least 1,000 hours of clinical experience under a supervising physician, as defined by KRS 311.840, who is a psychiatrist and is certified or eligible for certification by the American Board of Psychiatry and Neurology Inc.;
  - Holds a master's degree from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant or its predecessor or successor agencies, is practicing under a supervising physician as defined by KRS 311.840, and:
    - Has two years of clinical experience in the assessment, evaluation and treatment of mental disorders; or
    - Has been employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community program for mental health and individuals with an intellectual disability for at least two years; or
  - Holds a bachelor's degree, possesses a current physician assistant certificate issued by the board prior to July 15, 2002, is practicing under a supervising physician as defined by KRS 311.840, and:
    - Has three years of clinical experience in the assessment, evaluation and treatment of mental disorders; or
    - Has been employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community program for mental health and individuals with an intellectual disability for at least three years.

- Dangerous instrument: Any instrument, including parts of the human body when a serious physical injury is a direct result of the use of that part of the human body, article or substance which, under the circumstances in which it can be used, attempted to be used, or threatened to be used, is readily capable of causing death or serious physical injury.
- Deadly weapon: Any of the following:
  - A weapon of mass destruction;

  - Any weapon from which a shot, readily capable of producing death or other serious physical injury, may be discharged;
  - Any knife other than an ordinary pocket knife or hunting knife;
  - Billy, nightstick or club;
  - Blackjack or slapjack;
  - Nunchaku karate sticks;
  - Shuriken or death star; or
  - Artificial knuckles made from metal, plastic or other similar hard material.
- Physical injury: Substantial physical pain or any impairment of physical condition.
- Serious physical injury: Physical injury which creates a substantial risk of death or which causes serious and prolonged disfigurement, prolonged impairment of health or prolonged loss or impairment of the function of any bodily organ. For a child 12 years of age or less at the time of the injury, a serious physical injury includes but is not limited to the following:
  - Bruising near the eyes or on the head, neck or lower back overlying the kidneys;
  - Any bruising severe enough to cause underlying muscle damage as determined by elevated creatine kinase levels in the blood;
  - Any bruising or soft tissue injury to the genitals that affects the ability to urinate or defecate;
  - Any testicular injury sufficient to put fertility at risk;
  - Any burn near the eyes or involving the mouth, airway or esophagus;
  - Any burn deep enough to leave scarring or dysfunction of the body;
  - Any burn requiring hospitalization, debridement in the operating room, IV fluids, intubation or admission to a hospital's intensive care unit;
  - Rib fracture;
  - Scapula or sternum fractures;
  - Any broken bone that requires surgery;
  - Head injuries that result in intracranial bleeding, skull fracture or brain injury;
  - A concussion that results in the child becoming limp, unresponsive or results in seizure activity;
  - Abdominal injuries that indicate internal organ damage regardless of whether surgery is required;
  - Any injury requiring surgery;
  - Any injury that requires a blood transfusion; and
  - Any injury requiring admission to a hospital's critical care unit.
- Trauma-informed approach: Incorporating principles of trauma awareness and trauma-informed practices, as recommended by the federal Substance Abuse and Mental Health Services Administration, in a school in order to foster a safe, stable and understanding learning environment for all students and staff and ensuring that all students are well known by at least one adult in the school setting.
- Evidence-based: The proposed project component is supported by one or more of strong evidence, moderate evidence, promising evidence or evidence that demonstrates a rationale.

Section Two: Student Exceptions

As corporal punishment is not considered a trauma-informed discipline approach and research has shown that it is a trauma provoking event for students, 704 KAR 7:170 excepts students who are at high risk of trauma exposure from experiencing corporal punishment. The following groups of students may not experience corporal punishment at school under any circumstances:

- Students with an Individual Education Program (IEP) pursuant to 707 KAR Chapter 1;
- Students with a 504 plan pursuant to Section 504 of the Rehabilitation Act of 1973; and
- Homeless children or foster care youth pursuant to 704 KAR 7:090.

Section Three: Parental Notification and Consent

To increase parental agency and control over corporal punishment, the regulation requires two rounds of parental notification before corporal punishment may be deployed.

Within the first five days of enrollment, districts that wish to use corporal punishment must receive affirmative, written consent from the legal guardian of the student. The written consent document must:

- Include information about how to access the student code of conduct;
- Describe the types of conduct violations which may result in a corporal punishment; and
- Include a notification that consent may be withdrawn at any point during the school year.

In addition to the three required elements, KDE recommends that parental notification forms include a copy of the district's corporal punishment policy, a description of the procedures the district will use to deploy corporal punishment and a warning statement acknowledging the inherent risks of using corporal punishment.

Corporal punishment may only be used with students who have a written consent form on file.

The second required parental notification occurs immediately before administering a corporal punishment. A school representative must contact the child's legal guardian and receive affirmative verbal consent to administer the punishment. This requirement acknowledges the diverse ways that parents choose to discipline their children at home. Not all families that use corporal punishment choose to do so in the same way. The verbal consent requirement ensures that parents have the opportunity to opt their child out of a corporal punishment for infractions that may not meet the threshold for a corporal punishment in their home.

Section Four: Trauma-Informed Response

As the harm of corporal punishment has been well documented, schools are required to attempt to remedy problematic behavior using evidence-based practices consistent with a trauma-informed approach before deploying corporal punishment. Resources to assist schools in the identification of trauma-informed disciplinary resolutions can be found on KDE's School Safety and Resiliency webpage.

Section Five: Student Privacy

To protect student privacy and limit the social and emotional harm of corporal punishment, the regulation provides limitations as to who may administer, witness or observe/hear a corporal punishment.

Only the principal or assistant principal may administer corporal punishment, and they must do so in the presence of at least one additional certified staff member who is the same gender as the child. It is recommended that the certified witness be a staff member who has no connection to the child.

As was previously discussed, research has demonstrated that experiencing corporal punishment harms the relationship between the child and the adult. Measures to prevent the student's current or potential future teachers from engaging in the enactment of corporal punishment ensures that the punishment does not create a relationship barrier that could negatively impact learning. Additionally, KDE recommends that staff in emotional support roles – such as the school counselor, Family Resource and Youth Service Center coordinator or other mental health positions – not be involved in the administration of corporal punishment.

To protect students and staff from vicarious trauma, corporal punishment must be performed in a location where another student, staff member (other than the witness) or adult visitor to the school cannot see or hear the corporal punishment being administered. Additionally, no staff member shall be compelled to administer or witness a corporal punishment.

Vicarious trauma is described by the American Counseling Association as "the emotional residue of exposure" to trauma. Students, staff and visitors to the building may experience vicarious trauma when exposed to corporal punishment. This exposure may create a mentally unsafe and unstable future environment for the individual or may trigger post-traumatic reactions to previous abuse. Districts must take steps to mitigate vicarious exposure.

Section Six: Post-Administration Requirements

After administering a corporal punishment, the school is required to ensure that the student receives a minimum of 30 minutes of counseling provided by the school counselor, school social worker, school psychologist or other qualified mental health professional no later than the end of the next school day. Through this interaction, the counselor should seek to uncover underlying concerns that may have contributed to the student or staff behaviors that prompted corporal punishment and work to develop an action plan to prevent the recurrence of corporal punishment in the future.

Schools also must document the corporal punishment in Kentucky's Student Information System (KSIS), known as Infinite Campus. In addition to the usual documentation of a behavior event outlined in the Behavior Data Standards, schools also must record the following information for each corporal punishment administration:

- The time and date the punishment was administered, reference resolution start/end dates/times in section D of the Behavior Data Standards.

- The name and position of the individual who administered the punishment. This can be documented on the resolution detail section in the *Behavior Admin Staff Name* field.
- The names and positions of any witnesses to the punishment, reference section participant details in Section C of the Behavior Data Standards.
- The time and date of the prior verbal consent.
- The name and relationship of the individual providing prior verbal consent.
- The trauma-informed behavior intervention deployed prior to administering the corporal punishment.
- The time and date of the required counseling appointment.

The verbal consent details, behavior intervention information and counseling appointment details can be documented within IC in a location determined by the district. KDE recommends documenting and uploading to the student record the contact log, comments sections or an external Word document.

Section Seven: District Policies

It is important that each community understands how a district intends to use corporal punishment. Districts are required to adopt a policy that either prohibits the use of corporal punishment or allows the use of corporal punishment.

If a district adopts a policy to allow the use of corporal punishment, the policy must:

- Define the circumstances under which corporal punishment may be deployed, which shall not exceed the minimum justification in KRS 503.110;
- Define the procedures for deploying corporal punishment;
- Define the tool or instrument to be used when administering corporal punishment and include a prohibition on the use of dangerous instruments or deadly weapons;
- Define the limits on corporal punishment and ensure that corporal punishment does not result in physical injury or serious physical injury; and
- Define the procedures for documenting and reporting corporal punishment.

Districts that choose to utilize corporal punishment are encouraged to develop and adopt policies that include a high level of detail to ensure that everyone in the community understands when and how corporal punishment will be deployed in the district. Districts should consider creating clear limitations on the frequency with which an individual student may experience a corporal punishment, the duration of each corporal punishment incident and the procedures for reporting any unforeseen circumstances that may result from the administration of corporal punishment.

Additionally, districts should consider developing corporal punishment policies in collaboration with community stakeholders, including parents and families, students, teachers, administrators and local pediatric health authorities.