May 18, 2021

Representatives and Senators,

First and foremost, thank you for taking the next few minutes to read this information. I have prepared this document for you, in the hopes that it will best inform you as you prepare to vote on LD 1373, regarding restraint and seclusion in Maine schools. I have participated in hearings and discussions about this topic, with large amounts of frustration. I have stepped back to realize that those of you receiving the recently presented information only "know what you know" and "don't know what you don't know." Although I feel confident in some of my acquired professional expertise, there is much to this world that I admit to not knowing, and there are many bills on the floor that I would be ill prepared to vote for. In good conscience and in following my ethical codes (APA, BCBA Codes of Ethics and Practice), I must put what I know to paper in the hopes that you are "best informed" as you make your decision in the upcoming vote for LD1373. For the intent and purpose of this document, I will put emotion aside, and present to you factual information.

First and foremost, I am a trained behavioral clinician- as a doctoral level Board Certified Behavior Analyst (BCBA), I have spent the last twenty four years working as a clinician and administrator in specially designed schools/treatment centers for children with the most significant of behavioral need- severe forms of autism, the most significant levels of intellectual disability and a range of chromosomal disorders that have led to significant developmental disabilities in "children" ages birth to twenty two years of age.

I realized this week that many of you may be unaware of what a BCBA is. A nationally recognized Board Certified Behavior Analyst is a Master's or Doctoral level clinician who has received intensive coursework in, and extensive supervised clinical internship in human behavior, with a concentrated focus on the analysis and effective treatment of disordered, interfering or "inappropriate" behavior- what the layman may refer to as "bad" behavior. In addition to two years of supervised clinical internship, following three years of graduate coursework, a BCBA is only certified to practice after completing a national Board exam. To simplify, BCBA's spend three to six years learning how to change the behavior of people…this means changing "bad" behavior- aggression, self-injury, disrobing (taking ones clothes off in public places), spitting, intentional regurgitation or directed vomiting, fecal play, mouthing of items, property destruction, eloping, use of profanity, use of weapons, etc. In addition to changing "bad" behavior, BCBA's specialize in teaching "good behavior"- socially acceptable and positive behaviors such as communication skills, appropriate social skills, independent living skills, academic skills, etc. Essentially, we work very hard to teach people (in this instance, children) to do "what they should do" and to "stop doing what they shouldn't do." My specialty, and the specialty of many BCBA's who have recently testified against LD 1373, is in working with the children of Maine who have the highest level of behavioral challenge (those "bad" behaviors"). Often these behaviors are a direct result of learning and developmental delays that are attributed to a severe autism diagnosis, profound intellectual disability, chromosomal disorders and multiple mental health diagnosis.

To date, there are two hundred and nineteen nationally certified BCBA's in the State of Maine. Ninety five percent of us work with children, within schools and within the homes of children. We are working in pre-schools for children with special needs, in public schools, in private special purpose schools (like the Margaret Murphy Centers for Children), in hospital settings and for agencies that provide in-home therapeutic supports. Our primary clinical focus is to reduce and replace "bad" unwanted behavior and to teach appropriate "good" behavior and skills. Every BCBA in the State spends the majority of their workday doing two things- analyzing children's behavior and training staff to appropriately respond to and teach the children they support. We utilize the science of Applied Behavior Analysis (ABA) the science of changing human behavior- to make hundreds of complex decisions regarding the children in our clinical care. To date, our science, ABA, has demonstrated REMARKABLE outcomes for children with the most severe forms of all behavior imaginable. What we do is evidence based (with fifty years of literature and numerous peer-reviewed journals published monthly- Journal of Applied Behavior Analysis, Journal of Verbal Behavior, Behavior Analysis, etc.) and adheres to the principles of scientific rigor.

We are recognized as clinical practitioners nationally, and within the State of Maine (Maine Care Provider of Medically Necessary Services). DHHS/Maine Care has determined that we are critical, required practitioners to treatment teams for children receiving Specialized Section 28 Services- responsible for the development of comprehensive Crisis and Safety plans necessary to treat behavioral challenges of our students. Maine Care has determined that a BCBA must be a member of the treatment team for all students receiving Specialized Services to treat the needs of their disability, including autism and intellectual disabilities. These services are delivered in schools- and thus, impacted greatly by the proposed bill, LD 1373. All treatment plans that are developed for individual children MUST be rooted in current, evidence-based best practice- as dictated by recent publications within our field. We are not allowed "to guess" when developing treatment plans. Everything we do must be data-driven and rooted in our science.

BCBA's must adhere to stringent Codes of Professional and Ethical Conduct and may not practice outside of their competency areas. In addition to strict requirements for ongoing professional development, BCBA's must seek additional training, supervision and clinical consultation. Within our Center, and in many specialized treatment centers in Maine, our Master's level clinicians are supervised by Licensed Psychologists who are dually certified as Behavior Analysts. This ensures our students have teams led by the most credentialed experts in the State. In addition, we seek consultation from experts across the country, ensuring our practices in Maine are second to none.

I have included the full position statement on Restraint and Seclusion, published by The Association for Behavior Analysis International (ABAI). To preserve your time, I have highlighted the relevant, most pertinent information for you. This position statement was written by internationally regarded behavior analysts who continue to drive our field further into advanced, humane and effective practice. I would also like to point out to you that MMCC has long standing, on-going consultation opportunities with two of the authors of this document. In order to ensure that our students receive the best possible treatment and care, we have actively

sought many hours of training and consultation from Dr. Greg Hanley and Dr. Luis Hagopian. A brief review of their published works will certainly serve to convince you of their expertise.

"The Association for Behavior Analysis International and its members strongly oppose the inappropriate or unnecessary use of seclusion, restraint, or other intrusive interventions. Although many persons with severe behavior problems can be effectively treated without the use of any restrictive interventions, restraint may be necessary on some rare occasions with meticulous clinical oversight and controls. In addition, a carefully planned and monitored use of time-out from reinforcement can be acceptable under restricted circumstances. Seclusion is sometimes necessary or needed, but behavior analysts would support only the most highly monitored and ethical practices associated with such use, to be detailed below.

This Position Statement on Restraint and Seclusion summarizes critical guiding principles. With a strong adherence to professional judgment and best practice, it also describes the conditions under which seclusion and restraint may be necessary and outlines proper strategy to implement these procedures appropriately and safely. This statement is consistent with ABAI's 1989 Position Statement on the Right to Effective Behavioral Treatment, which asserts numerous rights, including access to the most effective treatments available, while emphasizing extensive procedural safeguards.

GUIDING PRINCIPLES

The Welfare of the Individual Served is the Highest Priority

Clinical decisions should be made based on the professional judgment of a duly formed treatment team that demonstrates knowledge of the broad research base and best practice. Included in this process are the individuals being served and their legal guardians. The team should be informed by the research literature, and should determine that any procedure used is in that person's best interests. These interests must take precedence over the broader agendas of institutions or organizations that would prohibit certain procedures regardless of the individual's needs. A core value of ABAI with regard to behavioral treatment is that welfare of the individual being served is the absolute highest priority.

Individuals (and Parents or Guardians) Have a Right to Choose

ABAI supports the U.S. Supreme Court ruling that individuals have a right to treatment in certain contexts, and that many state and federal regulations and laws create such rights. Organizations and institutions should not limit the professional judgment or rights of those who are legally responsible for an individual to choose interventions that are necessary, safe, and effective. A regulation that prohibits treatment that includes the necessary use of restraint violates individuals' rights to effective treatment. The irresponsible use of certain procedures by unqualified or incompetent people should not result in policies that limit the rights of those duly qualified and responsible for an individual through the process of making informed choices.

The Principle of Least Restrictiveness

ABAI supports the position that treatment selection should be guided by the principle of the least restrictiveness. The least restrictive treatment is defined as that treatment that affords the most favorable risk-to-benefit ratio, with specific consideration of probability of treatment success, anticipated duration of treatment, distress caused by procedures, and distress caused by the behavior itself. One may conclude from this premise that a nonintrusive intervention that permits dangerous behavior to continue while limiting participation in learning activities and community life, or results in a more restrictive placement, may be considered more restrictive than a more intensive intervention that is effective and enhances quality of life.

APPLICATION

General Definitions

Restraint involves physically holding or securing the individual, either (a) for a brief period of time to interrupt and intervene with severe problem behavior or (b) for an extended period of time using mechanical devices to prevent otherwise uncontrollable problem behavior (e.g., self-injurious behavior) that has the potential to produce serious injury. When used in the context of a behavior intervention plan, restraint in some cases serves both a protective and a therapeutic function. These procedures can reduce risks of injury and can facilitate learning opportunities that support appropriate behavior.

Seclusion involves isolating an individual from others to interrupt and intervene with problem behavior that places the individual or others at risk of harm. When used in the context of a behavior intervention plan, seclusion in some cases serves both a protective and a therapeutic function. These procedures can reduce risks of injury and can facilitate learning opportunities that support appropriate behavior. ABAI is opposed to the use of seclusion when it is operationally defined as placing someone in a locked room, often combined with the use of mechanical restraint or sedation, and not part of a formal behavior intervention plan to which the individual served or his or her guardian has consented. We support the use of a planned time-out treatment or safety intervention that conforms to evidence-based research, is part of a comprehensive treatment or safety plan that meets the standards of informed consent by the individual served or his or her legal guardian, and is evaluated on an ongoing basis via the use of contemporaneously collected objective data.

Time-out from reinforcement is an evidence-based treatment intervention that involves reducing or limiting the amount of reinforcement that is available to an individual for a brief period of time. It can entail removing an individual from his or her environment, or it may entail changes to the existing environment itself. When time-out involves removing an individual from the environment, it should only be used as part of an approved behavior intervention plan. Time-out from reinforcement is not seclusion, but it may involve seclusion if it is not safe to have others in the room. In addition, some innocuous versions of time-out from reinforcement, such as having a child take a seat away from a play area, are not deemed to be intrusive. Such procedures are commonly used and are generally safe.

Use of Restraint as Part of a Behavior Intervention Plan

The use of restraint in a behavior intervention plan is done as part of an integrated effort to reduce the future probability of a specified target behavior or to reduce the episodic severity of that behavior. A behavior intervention plan that incorporates contingent restraint must (a) incorporate reinforcement-based procedures, (b) be based on a functional behavior assessment, (c) be evaluated by objective outcome data, and (d) be consistent with the scientific literature and current best practices. Procedures describing the use and monitoring of this type of procedure should be designed by a Board Certified Behavior Analyst, or a similarly trained and licensed professional who is trained and experienced in the treatment of problem behavior.

Use of Time-Out (or in Rare Cases, Seclusion) as Part of a Behavior Intervention Plan

Time-out may be used as part of an integrated behavior intervention plan designed to decrease the future probability of a prespecified target behavior or to reduce the episodic severity of that behavior. The behavior intervention plan that incorporates the use of time-out must (a) be derived from a behavioral assessment, (b) incorporate reinforcement strategies for appropriate behavior, (c) be of brief duration, (d) be evaluated by objective outcome data, and (e) be consistent with the scientific literature and current best practices.

The Necessity for the Use of Emergency Restraint and Seclusion

Emergency restraint involves physically holding or securing a person to protect that person or others from behavior that poses imminent risk of harm. These procedures should be considered only for dangerous or harmful behaviors that occur at unpredictable times, that make the behavior not amenable to less restrictive behavioral treatment interventions, and that place the individual or others at risk for injury, or that will result in significant loss of quality of life. The procedures should be considered only when less intrusive interventions have been attempted and failed or are otherwise determined to be insufficient given adequate empirical documentation to prove this point.

When applied for crisis management, restraint or seclusion should be implemented according to well-defined, predetermined criteria; include the use of deescalation techniques designed to reduce the target behavior without the need for physical intervention; be applied only at the minimum level of physical restrictiveness necessary to safely contain the crisis behavior and prevent injury; and be withdrawn according to precise and mandatory release criteria.

Emergency restraint procedures should be limited to those included within a standardized program. Medical professionals should review restraint procedures to ensure their safety.

Consideration of emergency restraint should involve weighing the relative benefits and limitations of using these procedures against the risks associated with not using them. Associated risks of failure to use appropriate restraint when necessary include increased risk of injury; excessive use of medication; expulsion from school; placement in more restrictive, less normalized settings; and increased involvement of law enforcement.

Crisis management procedures are not a replacement for behavioral treatment and should not be used routinely in the absence of an individualized behavior intervention plan. The best way to eliminate restraint use is to eliminate behavior that invites its use via systematic behavioral treatment procedures. If crisis intervention procedures are used on a repeated basis, a formal written behavior plan should be developed, reviewed by both a peer review committee and human rights committee (when available), and consented to by the individuals served and their parents or legal guardians.

Informed Consent

As members of the treatment team, the individual and parents or guardians must be allowed the opportunity to participate in the development of any behavior plan.

Interventions that involve restraint or seclusion should be used only with the full consent of those who are responsible for decision making. Such consent should meet the standards of "information," "capacity," and "voluntary." The individual and his or her guardian must be informed of the methods, risks, and effects of possible intervention procedures, which include the options to both use and not use restraint.

Oversights and Monitoring

Restraint or seclusion (not including brief time-out) for both treatment and emergency situations should be made available for professional review consistent with prevailing practices.

The behavior analyst is responsible for ensuring that any plan involving restraint or seclusion conforms to the highest standards of effective and humane treatment, and the behavior analyst is responsible for continued oversight and quality assurance.

These procedures should be implemented only by staff who are fully trained in their use, receive regular in-service training, demonstrate competency using objective measures of performance, and are closely supervised by a Board Certified Behavior Analyst or a similarly trained professional. The use of restraint or seclusion should be monitored on a continuous basis using reliable and valid data collection that permits objective evaluation of its effects.

Procedures that involve restraint or seclusion should be continued only if they are demonstrated to be safe and effective; their use should be reduced and eliminated when possible. *Efficacy* with respect to treatment programs refers to a reduction in the rate of the specified target behavior or reduction in the episodic severity of that behavior. With respect to emergency treatments, *efficacy* refers only to the time and risk associated with achieving calm.

In addition to the "rules of our field" as outlined in the Position Statement, Maine developed Chapter 33 Regulations for all Schools in 2013. These rules, outlining allowable and prohibited use of Seclusion and Restraint, are among the most comprehensive and strict in the nation. Our BCBA's, and the BCBA's practicing in Maine schools, adhere to both our Board Codes and Maine Regulations.

Our opposition to LD 1373 is rooted in the guidance provided within the Position Statement of our field. While this bill may have been written with good intent, eliminating the use of all restraint or seclusion will be to the detriment of some of Maine's Children. I have watched the philosophical debate about restraint and seclusion unfold. I have also heard the stories- emotional and unfortunate, about cases where, reportedly, restraint and seclusion have been used under questionable circumstances. I would never begin to defend a case where a child was restrained or secluded if these guidelines had not been followed, and yet, I am certain that there are cases of necessity each day in this State. To ignore the treatment needs of some children, those of the highest need, to fulfill a philosophical belief, will be a travesty. We owe it to the children of Maine to recognize that there is an internationally recognized science of effectively treating and changing behavior, with clear guidelines of practice, and with specialized clinicians with expertise to apply.

LD1373 does not seek to provide further guidelines for use of seclusion or restraint, nor does it seek to provide additional oversight of Chapter 33. LD1373 does not move Chapter 33 into statute, nor does it propose sanctions to those who refuse to follow Chapter 33, which has been a reported concern by supporters. LD 1373 does not outline professionals who must be responsible for the creation of plans that utilize restraint or seclusion, nor does it outline training requirements of those who may be in the necessary position to utilize restraint or seclusion. LD 1373 simply seeks to abolish ALL restraint and seclusion in schools, *including specialized schools* that are DUALLY certified as day treatment programs, licensed to provide medically necessary treatment services. This cannot be acceptable for those who will vote on behalf of the neediest of children in the State of Maine. Although it might feel uncomfortable to imagine, there are children who NEED this level of intensive treatment opportunity in order to move through a critical crisis period in their lives. A vote in favor of LD 1373 will be a vote against children's federal and state protected right to access medically necessary, evidence-based and scientifically supported treatment.

Within our Centers, on this day, we serve 240 children with disabilities. Within our student population, 80% of children are making meaningful, measurable behavioral progress without the use of restraint of seclusion. However, 20% of our students did not make meaningful behavioral progress until we introduced restraint or seclusion (16% restraint, 4% seclusion). These measures were introduced after careful behavioral analysis, use of less restrictive measures and data evaluation. In aligning with the position statement, restraint and seclusion have been carefully selected, as a last resort, with informed consent, with ongoing clinical oversight, and with data that continues to support the intervention due to effective behavioral change. We have many single case studies, across our former and current students, that demonstrate the importance of carefully selected and implemented behavior plans- based on their progress and their success- and the fact that they no longer require the use of restraint or seclusion. This

should speak volumes to the necessity for our ability to continue to consider and utilize restraint or seclusion when clinically indicated, based on the science of applied behavior analysis.

I am humbled by and grateful for the opportunity to present this information to you, and I thank you for taking the time to critically evaluate this very pressing, important issue. With all sincerity, the trajectory of children's lives are tied to this bill, and I urge you to give this your full attention. They deserve it.

Sincerely,

Michelle Hathaway, Psy.D., Board Certified Behavior Analyst

Senior Director,

The Margaret Murphy Centers for Children