Lauri Marchewka
The Collaborative School

Commentary related to L.D. 1373 as amended on 4/29/2021 "An Act To Keep All Maine Students Safe by Restricting the Use of Seclusion and Restraint in Schools" (HP1007) (Presented by Representative MILLETT, R. of Cape Elizabeth) (Cosponsored by Senator RAFFERTY, J. of York, Representative MCCREIGHT, J. of Harpswell, Representative MADIGAN, C. of Waterville, Representative CRAVEN, M. of Lewiston)
April 28, 2021
Honorable Committee Members,
Thank you for taking the time to consider our feedback regarding LD 1373.
We have grave concerns about the unintended consequences of eliminating the use of supine restraint as a measure of last resort when other interventions have been unsuccessful. As the Executive and Training Directors of the Collaborative School, a private special purpose day treatment program, we have over 20 years of experience serving children and adolescents with significant trauma and attachment disorders as well as Autism. Our program is based on creating a physically and emotionally safe environment for clients and family to heal. Our students come to us having struggled and failed multiple times within the public school system. We utilize a high staff/student ratio, a therapeutic milieu and embedded psychiatric, psychological, social work, OT, and speech language service to address the impact of trauma and other related DSM 5 diagnoses. Additionally, we have regular consultation from leading attachment and trauma experts to support best practices.These resources are enhanced by our commitment to providing a high level of training in prevention and de-escalation of dangerous behaviors. We have two staff members who are certified in Therapeutic Crisis Intervention (TCI) which utilizes a trauma-informed approach in all aspects of training. Annually, TCI requires12 hours training, physical practice and a written test All of our administrators are trained in TCI so that the philosophy and strategies are part of our program's culture and they participate in debriefing of difficult situations.
Despite this thoughtful and well-resourced approach to serving this extremely vulnerable population of children and adolescents, there are times in which some of the students require a higher level of support in the form of restraint to maintain safety for all. This is a last resort reserved for situations when a student is at risk of hurting himself or someone else in his proximity. The majority of restraints occur with our youngest students who do not yet have the skills to manage stress and triggers. Their pain based behavior comes out in the form of kicking, hitting, biting, or self-harm. Our data indicate that these behaviors decline over time as they develop better emotional regulation skills and coping strategies. For the older population of students, proactive training in the use of walk plans, sensory breaks, OT strategies and individualized plans provide a safe way for adolescents to manage their pain based behaviors without violence and without the need for physical restraint.
Many public schools do not have the ability to provide such intensive, wrap around training and programming. Private special purpose schools are able to provide clinical supervision, sufficient staffing, and ongoing trauma-informed care. Without this tool for unsafe situations, we are very concerned about the following:
If a younger student is dysregulated, angry, throwing things, breaking equipment and/or aggressive toward another child, the entire classroom of children would likely begin to feel unsafe.
Our only option would be to call their parents to come pick them up, recreating the exact situations that did not work in public schools and we are farther away, so the wait time would be longer.
If an older student was in a similar situation, the physical safety of others is at an even greater risk. The situation could be retraumatizing to classmates and lead to anxiety, stress and trigger their pain based behaviors.
Our options would be to call parents, crisis or the police. If we call parents, they often do not know how to manage this behavior, so now family members are also at risk. If we call the police and they ask the youth to leave the building and they do not, we have to say they are trespassing and the youth would be removed in handcuffs.

All of these options leave staff to intervene in some undetermined manner because they have already used all strategies, plans and experienced school staff and clinicians.

All schools are struggling to hire open BHP/Ed Tech positions and special education teachers. This could create a chaotic and undesirable working environment and make it even more difficult to find quality staff.
Having a student evaluated in the ER is another option in lieu of the use of restraint. This option is currently utilized by our program when indicated. Due to the significant lack of child and adolescent hospital beds (see table below), it is common for our parents to spend from 4-5 days in the ER if not longer due to the scarcity of inpatient resources. Without the use of restraint, the acuity of children and adolescents often increases and to the point that they

require more restrictive settings such as extended hospitalization or residential treatment. The lack of hospital and residential beds in the state of Maine has been widely documented (see information below).
Spring Harbor Hospital: 12 children's unit beds,14 adolescent unit beds
12 Dev. Disorders beds
St. Mary's Hospital: 10 beds
Acadia Hospital: approx. 10 children unit bed, and 10 adolescent unit beds
Northern Maine Medical Center: 7 children's unit beds
Residential Bed in Maine: Approx. 300 licensed residential beds

While eliminating the use of restraint is laudable and something that all mental health providers would undoubtedly support, in the absence of a systemic approach to meeting the needs of our children and adolescents with severe mental illness, it may increase the problem it seeks to remediate.

The follow is a list of suggestions aimed at addressing the problem of the misuse of restraint and seclusion:
Training standards should be created so that crisis and de-escalation programs must have a significant number of refresher hours built in the program as well as yearly testing proficiency and knowledge of strategies and techniques.
Trainers should be available to consult with staff members as needed to process restraints and work on additional de-escalation plans.
Exploring a certification process in which Special Purpose Private schools could demonstrate both the need for certain types of physical restraint and the training and supervision needed to successfully use restraint.

As mental health providers and administrators who work with a very specialized population, we would welcome the opportunity to be part of the working group related to this bill. Additionally, we would like to take this opportunity to invite any committee members who are able to visit and tour the Collaborative School.

Sincerely,

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