Testimony of Danielle Loring, LCSW
In Strong Support of LD 181,
“Resolve, Directing the Department of Health and Human Services to Implement Secure Children’s Psychiatric Residential Treatment Facility Services”
March 21, 2023

Senator Baldacci, Representative Meyer and members of the Joint Standing Committee on Health and Human Services, my name is Danielle Loring and I serve as the Director of Intensive Services with the Maine Behavioral Healthcare Emergency Department Crisis Program. Over the past 20 years, I have been employed and trained in a variety of clinical healthcare settings across New York City, Rhode Island and Maine, including: community-based behavioral healthcare service lines, inpatient hospitals and emergency departments, and, very importantly, secure behavioral healthcare settings such as those that are the subject of this legislation. Since graduating from Columbia University with a Master’s Degree in Social Work, Advanced Clinical Practice, I have spent my career striving to improve care and clinical outcomes for youth facing behavioral health challenges.

Over the better part of the past 12 years, I have had the privilege of providing patient care and leading a crisis program dedicated to intervention with our most vulnerable youth experiencing crises within seven emergency rooms across the State of Maine. In this role, I see firsthand the significant gaps that exist in Maine’s behavioral health system. These gaps result in youth being forced to spend prolonged periods of time in the most highly restrictive setting – our hospital emergency departments.

Youth with very high needs are exhausting emergency room resources, being displaced from their homes, care teams, schooling and all forms of social interaction. Their families, residential programs, schools and providers often divert these patients to the emergency department to address their needs in a “safer” physical environment than is available within the community. In an effort to protect these youth from harming
themselves or others, they are too frequently contained in the most highly restrictive and counter-therapeutic option we have available within our behavioral health system – emergency departments.

What results from these emergency department interventions are youth in containment for days to weeks to months at a time, confined to a hospital bed in a windowless room, with no sunlight, education, fresh air, healthy diversity of meals, nor access to care, family, peers or physical exertion – all of which are necessary for any child’s development and emotional stability.

The lack of treatment resources available within an emergency care triage facility that is intended to stabilize and transfer patients to more appropriate locations for specialized care, results in children being exposed to interventions they would likely not require in an appropriate care setting. The absence of qualified, certified trained clinical staff in child development and pediatric care in an emergency department poses a significant risk to this most fragile population of children and adolescents struggling with behavioral health issues. Additionally, prolonged containment often results in inadvertent exposure to highly acute medical and psychiatric emergencies inadvertently placing them at risk of traumatization or re-traumatization.

Who are these children? They are the 12-year-old child who has spent five of the last nine months living in hospital emergency departments. During their most recently prolonged stay, which was two months and spanned Christmas, they were exposed to the death of another 4-year-old medical patient, a highly traumatizing event for a young person already severely traumatized in their life.

Another example involves three adolescent patients all of whom awaited placement for over one-week in the same ED – and all of which are high utilizers of emergency room services over the course of 2022-2023 due to significant safety concerns in the home and repeated denials from in-state residential facilities. These young people were
exposed to a traumatic event where the door to one of their rooms was kicked in by an adult psychiatric patient experiencing an acute psychotic episode.

Yet another 13-year-old patient presenting to a rural emergency room six times over the course of three months, then was hospitalized on an inpatient unit only to return immediately back to the ED where they remained for over one month. This patient caused significant damage to ED property and injuries to nurses, which escalated throughout their stay due to adverse response to being contained in an inappropriate level of care. The profound implications of these experiences on our complex youth is truly under-represented and underestimated as evidenced by our system’s limited response to intervene with safe placement options.

So what is the answer? While our youth need access to a full continuum of services at all levels, one gaping hole in our current system is secure residential treatment.

Through my clinical experience in Rhode Island, I have had the honor of engaging in care with children in a secure residential setting. This was in fact some of the most rewarding, most meaningful work I have ever been a part of. The youth being served in these settings are happy, engaged, active members of society and invested in their learning and treatment. They develop positive attachments with staff, some of which they might have never developed otherwise, spend a significant portion of their treatment and programming outdoors under the sunlight. They learn to thrive in peer relationships, overcome challenges, develop effective coping skills and to connect in a family-style setting eating meals together as a team. The consistency of staff, clinical competency of clinicians, structure of the milieu, routines, clear expectations, access to developmentally appropriate activities, trauma-informed care, comprehensive education, supportive clinical intervention and proactive de-escalation through CPI (Crisis Prevention Institute) certified providers, resulted in a placement of engaged, uplifted children focused on overcoming barriers and improving their wellness.

Although this setting was secure, the locked nature of the facility was not a noticeable feature nor a focal point to the children it served. Family visits were encouraged in
homey rooms equipped with comfortable couches and games, and children were provided the parameters in which to connect, improve upon these relationships and to succeed. Young people were able to move seamlessly between the secure setting and their homes as part of their treatment plans. Parents were most often willing to facilitate discharge planning discussions with the care team knowing this resource would be accessible again if indicated after the child returned home. Children demonstrated improvements in their overall symptom and safety profiles, did not require frequent restraints, although a secure safety room was available if and when they needed space to regroup and de-escalate. The amount of time spent outdoors engaging in fresh air afforded them the respect and independence they deserved and were often seeking. Many of these children went on to thrive in other environments and were greatly impacted by their stay due to the highly influential treatment teams they interfaced with on a daily basis. In fact, some of my most impactful clinical interventions occurred within the confines of this PRTF setting.

In conclusion, the emergency room is a necessary and critically important component within our system of care in treating acute medical and psychiatric emergencies. However, once those presentations have been stabilized, further containment in this location is detrimental to any patient, especially our struggling youth. Expediting transfer to a more secure location where youth are able to thrive and receive the care they are so desperately needing in a safe, secure location, will allow them the opportunity to persevere, overcome and succeed in our state. Too often, our system focuses on patient rights all while denying the fact that over-applying our perspective may inadvertently cause harm to the most vulnerable populations we are all here to support. I truly believe youth outcomes will exponentially improve with the addition of PRTF options within Maine.

I strongly encourage you to support this legislation and ensure that the Department moves quickly to develop this important treatment option.