

Michael B. Foster  
12 Old Marlborough Road  
East Hampton, Connecticut 06424

I am concerned that only one small part of the story is being explored in the recent articles about the “scream rooms” at Farm Hill School in Middletown. There are valid questions being raised about the need for, and the use of seclusion rooms in public schools. Parents are justifiably concerned about the students being placed in “time out” and about the disruption to the general school population when these students struggle and call out. To broaden the perspective, I would like to share a few experiences from my thirty-six years as a mental health professional.

My first job in the field was in a psychiatric hospital in the 1970s. We worked with adults and teens with adolescents making up approximately half of our population. We certainly had kids with severe psychiatric disturbances who were obvious dangers to themselves or others. Extreme behaviors frequently resulted in patients being restrained, first by trained staff and then by “body bags”, “camisoles” or medication if needed. Many teens at that time, however, were referred for behaviors that primarily alarmed their parents and threatened their futures. We admitted adolescents for drinking, smoking pot, running away from home, being “out of control” and failing in school. The average length of stay at that time was sixty days, with ninety and one hundred twenty day stays being common. All patients received a variety of treatment modalities. Family therapy was mandatory and the agreement of family members to participate was a condition of admission. Multi-family therapy sessions were held once a week for all patients on a unit and, again, family members were expected to attend. In addition, all patients received individual sessions with a psychiatrist, group therapy, and the services of art therapists, dance and movement therapists and occupational therapists. This hospital was nationally recognized as a leader in the field and its programs were models that other hospitals sought to emulate. Treatment was funded by insurance including state-funded programs for those in need.

My next experience was in another private psychiatric inpatient setting, this one for children from approximately six to thirteen. I had not worked with younger children before and was surprised at the severity of the symptoms and the behaviors that they exhibited. The length of stay and the treatments offered these children were similar to those of my previous employer. Family therapy was considered a crucial component of treatment and was compulsory. Again, it was common for patients to be physically and chemically restrained when their behavior threatened their own safety or that of others.

In the early 1980s I moved to a private clinical day treatment program. Some students suffered from severe emotional disturbances and often came from inpatient settings when discharged. More frequently, students were referred for behaviors that upset their parents and that interfered with their success in school: the types of behaviors that would have led to hospitalization a decade earlier. As a clinician, my caseload was ten students. I saw my students individually, in peer groups and with their families for required family therapy. Students typically stayed with us from one to three school years. The program was paid for by local school systems with clinical costs shared by private and public insurance. School systems also provided transportation.

Toward the end of that decade I jumped to the public school system and remained there for the rest of my career. I was initially assigned to the elementary level and worked in several different schools during the early years. In the end I went back to working with adolescents at the high school. As the years went by, I was surprised and dismayed to see more and more extreme behaviors in the general education setting. Many were the same that I had encountered first in the hospital and later in clinical day treatment. A variety of forces came together to create this trend. With the increase in medical costs, insurance companies began to restrict hospital admissions and shorten the length of stay that they would fund. Expenses to school systems for placing students in clinical day programs skyrocketed. School systems also experienced rapidly rising costs related to identifying and supporting students within the system under expanded special education legislation. Increasingly, educational mandates at the national and state levels required students to be educated with their peers in the least restrictive setting.

When thinking about the “scream rooms” (and I hate the use of this sensational term) we need to consider what we as a society are now asking of our schools. We are seeing more children coming to school with weak academic and social skills. Many parents are disengaged, some simply because they are single and have to work too hard to be available. Students with emotional and behavioral problems that would have resulted in their hospitalization followed by continued intensive outpatient treatment are now sitting in our classrooms. In comparison with the treatment offered in the former settings, these children are receiving very little support. Many are receiving services outside of school as well, but as many or more are not. Some behaviors continue to threaten the student’s own safety and that of those around them. Other students become emotionally overwhelmed and need a temporary setting away from stimulation. Behavior outbursts can be very disruptive of the educational process in the classroom. Students with these needs may need to be restrained at times, as they have always been.

There is much to be said for educating students with emotional and behavioral dysfunction in their home schools, with their peers. Many are not able to be in this setting, however, without showing the pain that they feel and exhibiting the symptoms of their disorder. Despite the possible benefits, I believe that these students are being shortchanged. When evaluating the current situation in all public schools in Connecticut, we need to consider the following:

- Children and adolescents used to receive intensive inpatient treatment for behaviors as “mild” as occasional substance abuse, truancy and rebellion against adult authority. Today’s inpatient must exhibit extreme behavior immediately threatening their own or someone else’s safety to garner admission.
- When admitted to the hospital, today’s child will generally stay from ten to twenty-one days as opposed to the months of treatment previously provided. In place of mandatory parent involvement and multi-discipline support modalities, inpatient staffs are expected to diagnosis, treat immediate symptoms and begin medication management. More often than not, there is no transition planning before discharge.
- Rarely are hospital admissions followed by referral to clinical day programs. One reason is the current emphasis on providing mental health treatment in the community. Also, unless a student is involved with the courts or child protective services, the decision to place students in

these programs is left to the schools. With the enormous and increasing expense of treatment and transportation, school systems are extremely reluctant to recommend these services for any but the most severely disturbed.

- Support services provided in the community are limited and not well coordinated. Individual therapy and medication management are generally available, although it may not be easy for students and their families to access them. Outpatient group therapy is rarer and is limited by funding constraints. Family therapy is not generally seen as a primary treatment modality and when provided, is often informational in nature and viewed as an adjunct of individual therapy. Outpatient providers rarely coordinate their services with school staff despite the many hours that children spend in the school setting and the impact that their behavior has on their school experience and education. In over twenty years in public schools, I had very few therapists contact me for input on a child's school behavior or to share treatment goals and intervention strategies.
- Although they try, school systems provide limited support for students despite the fact that behavior problems in the public schools are increasing in frequency and severity. Support is limited by financial constraints as systems struggle to control costs while at the same time improving educational outcomes as demanded by state and federal authorities. The focus of the support that is provided is usually narrowly defined as improving school outcomes.
- For a time, intensive self-contained programs were developed by school systems like Middletown's as alternatives to outplacement in hospitals and clinical day treatment. These programs not only saved the cost of therapy and transportation but provided support in the students' community with the possibility of inclusion with typical peers. Such programs have been dismantled in recent years as regulations at the state and federal level ended the segregation of these students. Another factor in the demise of these services involved the emphasis on testing as a measure of school achievement. Schools housing these students are required to report test scores as if students were members of the school despite the fact that the program is a district-wide resource. Schools were labeled as failing primarily because these needy students underperformed their peers on standardized tests. When such students are returned to their home schools it is much more difficult to provide the level of support that they received in small, self-contained classes. When the requirement is that they be educated in the mainstream whenever possible, the symptoms of their afflictions will be experienced by all.

I believe that the continuing trend is to expect our schools to provide many more services and for school staff to play many more roles than they have ever done before. At the same time, there is great public pressure to contain costs. I do not believe that schools can replace families and community organizations as agents for socializing students and providing the moral guidance that they need. I do not believe that adequate mental health treatment can be provided in the general education setting for students with severe emotional and behavioral disorders. I do believe that we need to look at the struggles at Farm Hill in a broader context and see them as a manifestation of a much larger social issue.

Sincerely,

Mike Foster