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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 10-030-9006

University of Illinois Medical Center

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at University of Illinois Medical Center. It was alleged that a recipient was restrained in violation of the Mental Health Code. If substantiated, this allegation would be a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

University of Illinois Medical Center is part of the largest health sciences center in the country, housing the largest medical school and one of only four comprehensive health science centers in the United States per the medical center website profile. The University of Illinois hospital is a 507-bed facility with more than 40 primary and specialty outpatient clinics. The Department of Psychiatry offers a full range of general psychiatric services as well as five specialty programs, and the inpatient program serves up to 37 patients. The Comprehensive Assessment and Response Training System (CARTS), developed to treat youth with histories of abuse or neglect and serious emotional disturbances, contains the Comprehensive Assessment and Treatment Unit (CATU), a short-term 10-bed adolescent inpatient unit for Department of Children and Family Services (DCFS) referrals.

To review these complaints, the HRA conducted a site visit and interviewed the Director of the Behavioral Health and Welfare Program, the Medical Director, the Nurse Manager, and the Director of Patient Care Services. Hospital policies were reviewed, and the recipient's clinical records were reviewed with written consent.

FINDINGS

The complaint centers on the 29-hour application of physical restraint (from 11:00 a.m. 9/23/09 until 5 p.m. 9/24/09) of a 16 year old youth at the University of Illinois Medical Center CATU program. The Psychiatric Discharge Summary describes the recipient's course of treatment:

[*Recipient] initially presented to CATU in an irritable and labile state, exhibiting unpredictable risk for rapid escalations towards rageful and violent behaviors. In fact, he was in prolonged restraint the night of admission and during his first two weeks, he required multiple episodes of physical and chemical restraining. It had been reported in his 72 hour staffing that placement had sensed a shift in his level of engagement in treatment over the past several months. They had tried to incentivize him and sought creative and novel approaches to keep him motivated in exhibiting prosocial interactions. Placement had reported his obsessional concern with strength building and his desire to create a new self image as a brutally strong young man who could no longer be victimized. Significant history had been his stay in detention last spring for assaulting a teacher and during this stay, family contact was more frequent. Indeed, during /his first weeks on CATU, [recipient] reported that he had enjoyed being in jail, wanted to go back as he liked the 'fighting' and the 'card playing.' He also wanted a 'lateral move', /interpreting [his placement's] compliance with the transfer to CATU as a sign of their rejection and abandonment. He also wanted 'visits from his family', and later in the first week, wanted to be off precautions in order to get back his clothes. [Recipient] was familiar with the routines of CATU and most staff were familiar with [recipient] from previous admissions. Nonetheless, staff shared similar sentiment with placement, sensing a shift in [recipient's] level of engagement, motivation for treatment and lack of insight and remorse for his recent behaviors. [Recipient] tended to act in an entitled manner, feeling above the rules and interacting in intrusive and impulsive ways to quickly gratify his needs. He denied any clinical concerns with his 'anger' and lack of self-control, voicing he felt justified in exhibiting hostility and threats to authority and he routinely externalized blame to others. He tended to unpredictably escalate in contextual situations that challenged his autonomy, required him to cognitively shift, or caused narcissistic injury. He unpredictably defied staff directives and caused much disruption to the unit through his intimidating stances.*

As stated above, during his initial stay, [recipient's] inability to de-escalate without intervention prompted the frequency of restraints. On 9/22/09, he became very agitated and explosive, and got his 'anger out' by destroying his bedroom and breaking a piece of wood from a desk in an effort to use it as a weapon. He had premeditated this destruction and displaced his desire to 'kill' a male staff whom he had physically assaulted the afternoon before. At that time, the male staff had noticed him to be too dysregulated to return to a group following a time out in his room. [Recipient] pushed past the staff who attempted to stop his progress, resulting in [recipient's] falling and accidently bruising his cheek on the floor. [Recipient] reacted by punching this staff in the jaw and had been subsequently restrained. Clinical assessment on 9/22/09 found [recipient] to be paranoid and rageful. He lacked remorse and insight and could not contract for safety and on the following day was offered a succinct 'safety plan' that provided 1 to 1supervision and required [recipient] be out of programming and isolated from his peers. He refused to contract, became agitated and was again placed in restraints. These restraints were sanctioned by Dr…to be prolonged as a clinical intervention to quell the dangerous cycle of [recipient's] outbursts and to emphatically communicate to [recipient] that the unit was in charge and would not tolerate his insistence on 'controlling' the milieu. Psychopharmacological interventions were also implemented at this time.

....By early October, [recipient] began to respond very well to the changes in medications and was gradually reintroduced to the milieu and full programming. In addition, specific

psychotherapeutic interventions were brainstormed, discussed, and put into place. These interventions included the MVP program whereby [recipient] could earn up to 14 'bucks' on day shift and up to 12 'bucks' during the evening shift. He then had up to three days to use these bucks to purchase certain rewards, like extra free time, etc. The employment of this intervention was a key contributing factor in [recipient's] improved behavior throughout the remainder of his hospitalization….

For the restraint event that began on 9/23/09, the record contains a New Medical Order (electronic) for restraint for each two-hour period beginning at 11:00 a.m. on 9/23/09 and ending at 5:00 p.m. on 9/24/09. Each order contains the following statement:

> *Order: restraints- Behavioral Management*
> *Rationale Prevent harm to self/others, Apply Leather limb x 4, Maximum time for ages 9-17 years is 2 hours, Start …, End…, Assess Evaluation Q15 Min, Assessment Q15 Min, & Remain in Constant Observation.*
> *1) A face to face MD evaluation within 1 hour & reason for restraint will be documented in clinical note.*
> *2) Involve/instruct Patient/Family as to the Purpose and safe Management of Patient While Restrained.*

The first entry into the Progress Notes on 9/23/09 (5:47 a.m.) states that the recipient had slept through the night without incident. An addendum, added by the RN, states at 6:15 a.m., "Client awake knocking on door requesting to use bathroom. Followed unit protocol to bathroom then returned to wash hands. Writer inquired as to why client had destroyed unit property. Client stated he was angry at unit staff and decided to hit objects in room rather than hit staff. Stated he was relieved of anger towards male staff at present and requested LOFT [Loss of Free Time] assignment. Encouraged client to list ways he can calm self prior to physical action. Discussed future goals outside of unit…." The next entry is made at 2:20 p.m. the same day: "(Intervention): Assessed mood, affect and behavior. Met with patient and patient given an expectation protocol in an effort to return to the milieu programming. Pt. given Benadryl 75 mg stat IM and placed in FLR's. (Evaluation): Affect angry. Pt. oppositional and aggressive. As the MD, manager and additional staff attempted to process the expectations, Pt. became extremely agitated and hyper verbal. Pt. could not hear anything that staff was communicating to him. Pt. then slammed the door and staff heard a loud bang. Staff called for additional assistance as pt. was verbally threatening to destroy the room again as he did on yesterday. Pt. given water and the urinal as needed along with lunch. Patient's restraints extended due to patient being unable to contract for safety. While in restraints several staff attempted to process behaviors that led to restraints and pt. was still unable to contract for safety. Pt. currently singing a song and stated, 'I'm bad to the bone'. Pt. remains in FLR's due to being an imminent threat to staff and patients. MD assessed pt. and extended the restraints. Pt. was given 6 guidelines and pt. continued to emphatically state that he would not complete the treatment assignments and neither would he comply with the expectations for a safety plan and the criteria to be released from restraints."

The recipient's Expectations/Program protocol states the following:

"In order for you to be considered safe to re-enter into the milieu program, you must meet the following expectations:

1. No physical aggression.
2. No verbal threats.
3. You must follow staff directions without challenging staff or engaging in a power struggle.
4. You must knock on your door before coming out of your room.
5. You will be expected to process your feelings about your recent aggression on CATU in an open and honest manner.
6. You will be provided school work and alternate activities today (writing songs) and that will be completed in your room. This week-end you will be given treatment assignments and will be expected to process them with your one to one staff."

A Psych Inpatient Progress Note entered on 9/23/09 at 2:44 p.m. states, "[Recipient] was presented with the team's set of expectations for his behavior that would help in ensuring that the milieu remains safe given his frequent outbursts and destruction of room yesterday am. [Recipient] was told that there would be zero tolerance for any aggression- no physical aggression, no verbal threats, no challenges to staff directives, need to knock on door prior to coming out of room, processing his behaviors. He was told that he would remain out of programming today and given assignments to complete in his room. He was given a printed copy which he eventually threw on the floor, stating in a loud and agitated manner that he 'cannot stay in his room.' And refused to concede to directives, trying to negotiate. He was told to think about this proposal for five minutes and as team exited room, he slammed door and started banging on door, wailing in a rageful manner. Pt. thus placed in FLR for safety due to his agitated state and refusal to comply with team guidelines for safety on CATU and thus considered a threat to others."

Hospital representatives (recipient's treatment team) were asked what specific behaviors precipitated the restraint event that was ordered beginning at 11:00 a.m. on 9/23/09 since there were many restraint episodes which followed. The recipient's psychiatrist provided the following written response:

"The initiating behavior was his agitated emotional and physical state, his verbal threats to harm staff and destroy property and his rejection of a proposed safety contract. These behaviors occurred in the wake of a meeting in his room with RN staff and MD. In this meeting, staff patiently tried to process his frequent and unpredictably violent outbursts on CATU, explaining the rationale for his individualized treatment plan, proposed to keep him and the milieu safe. This plan required him to be isolated from peers but supervised by a 1 to 1 staff throughout the day. On 9/23 a.m., he continued to lack remorse for his assaultive and destructive behaviors and still felt that he should dictate his own treatment on CATU. The administrative team made sure he understood the plan, despite his rejection (he threw it on the floor) and left his room, asking him to think about our proposal for five minutes. Shortly thereafter, he slammed his door and was enraged. "Imminent threat" was perceived by 1) his verbal threats to harm staff, destroy property, his exhibition of physical agitation, (slamming door, kicking door and walls) and 2) by his inability to contract for safety and allow our milieu

to maintain him isolated from peers. His failures to show remorse, to acknowledge his need for containment in order to minimize risk of recurrent violent outbursts meant there was no therapeutic alliance. Without this alliance, he was an "imminent threat" (clinically determined by his unpredictable and extremely high risk) to react with violence when frustrated or stimulated by the standard (not individualized) expectations of the daily routines on CATU."

Hospital staff also reported that threats to harm staff were actual statements from the recipient that he wanted to kill specific staff members- these were not vague, verbal threats of harm.

A Psych Inpatient Progress Note entered at 2:49 p.m. provides an evaluation of the recipient's restraint episode: "Received up and alert; continues to be anxious and restless upon approach. Affect/mood continues to be extremely labile and unpredictable. Patient has very poor insight into illness and wants to dictate/control environment; when unable to do so patient becomes challenging, verbally aggressive, and threatening. Patient presented new behavioral expectations, by team, including director and unit manager, informing him that he would be out of programming until meeting the expectations. Patient unable to accept protocol and became threatening; slamming door, kicking doors/walls, and verbally threatening to staff. Patient assessed to be out of control, unsafe, and a (sic) imminent danger to others; placed in full leather restraints with assistance of psychiatric staff and UIC security. Patient given emergency medication (Benadryl 50 IM) with moderate results; patient continued to be agitated, hostile, yelling and unable to process following initial restraint period, refusal to comply with established treatment protocol and hostile, threatening tone, including stating, 'who gives a fuck', order given to renew restraints for an additional two hour interval with appropriate assessments. Patient continues to demonstrate very poor insight and states that he can't abide by expectations/behavioral protocol, subsequently attempting to manipulate staff and dictate his own protocol. Compliant with medication protocol. Good appetite at meals. No acute distress noted."

At 3:00 p.m. on 9/23/09 the progress notes indicate that the recipient was assessed for release of restraints. "He has not been processing with assigned staff and reports that he did not harm anyone and should not be in restraints. Feedback given him regarding his unpredictably violent behavior and how he must earn trust with staff by complying with the safety plan and processing his recent behaviors. He still says that he 'cannot stay in his room.' When told he has been staying in his room today and is currently able of handling it, he laughs, smiles, and says, 'That's because I am in restraints but I should be out by now.' Further inquiry reveals that he remains angry at being deprived of unit/group activities and will 'not stay in my room and do nothing.' He offers minimal insight to his threatening and hostile interactions, still feels that staff assaulted him Monday and feels justified in destroying his room in order to release his anger. He denies feeling that the intensity of his anger is a clinical and safety concern…. His lack of insight and failure to take responsibility reveal his continued refusal to comply with safety proposal and thus, given his unpredictability, restraints renewed."

At 4:43 p.m. another entry is made in the progress notes. It states, "Nursing administrators, Dr… and Dr… have been discussing ongoing concerns about maintaining safety on the unit given [recipient's] unpredictable violence, his destruction of property on 9/22, his

assaults to staff and his ongoing threats to harm others and property. He has proven himself to be an unpredictable and severe risk for aggression and was presented this a.m. with a safety plan and proposal for alternative programming until he is assessed as safe to return to the milieu and participate with peer and group activities…. He was placed in restraints at 11 a.m. and his repeated failures to contract for safety have resulted in renewals of FLR. His risk for violent outbursts is high as he has been frequently restrained and in need of prn's since admission. Dr… has discussed in detail his sanctioning of prolonged restraints given the extreme danger [recipient] poses at this time… Current plan is to maintain FLR unless staff perceive [recipient] as genuinely engaging in a contract for safety. He will be reassessed for alternative programming tomorrow, primarily confined to his room until deemed safe and in more control of his impulses and anger."

At 5:18 p.m. an addendum is added to the notes which states, "…patient examined but spoke with Dr… as discussed, FLR to be renewed q 2h [every two hours] by ROD [resident on duty] who was informed of plan. RN instructed to be rotating arms, legs as free for circulation and to allow him to lie on side tonight for sleep unless he is combative and unsafe."

At 5:21 p.m. the record shows that the recipient was again assessed by the psychiatrist and it was determined that he was not safe to be released from restraints. A physical exam was completed by the physician at this time. The next entry in the progress notes is made at 8:23 p.m. and it states, "Patient is currently under prolong (sic) 4xlimb leather and chest restraint for violent behavior and inability to contract for safety. He continues to be unable to contract for safety during reassessment at 7:00 p.m…." The record then shows an addendum added at 9:52 p.m, 11:34 p.m., 1:09 a.m., 3:00 a.m., 5:27 a.m. and 7:36 a.m., all of which continue the restraint order stating that the recipient was unable to contract for safety, except for the 1:00 a.m. entry which adds that the recipient was "sleeping soundly while in restraint." After these entries there is a progress note addendum made at 10:22 p.m. and it states, "Received patient in full leather restraints at 1500. Patient was agitated, thrashing from FLR and demanding to be let out of FLR. Patient was unable to contract for safety at that time stating that he didn't do anything to be in restraints. FLR was renewed at 1500 to prevent harming self and/or others. Patient continues to refuse to process aggressive behavior that led to restraint and only focus is coming off restraints. While patient was in FLR, he would yell and would provoke his peers by laughing at his peers that were going into crisis. Patient remained agitated and not contracting for safety. FLR was extended at 1700. Patient was spoon fed for dinner but remained hostile while staff was feeding him. Patient still unable to contract for safety and refuse (sic) to process with staff. Patient stated, 'You were not even there. It's only a room that I tore up. I didn't hurt anyone. Why do I have to be in restraints. I didn't do anything wrong.' FLR was again extended at 1900. Patient still thrashing from FLR, continued to demand to be let out stating, 'My armpit is burning. My finger is getting numb.' Patient's extremities were examined and checked per protocol and no issues noted. Patient was reassured of his safety while in FLR. FLR order was renewed at 2100."

The first progress note entry on 9/24/09 is made at 5:27 a.m. The (Problem) section states, "Aggression" and the (Intervention) section states, "Pt. maintained on 1:1 due to FLR. Pt. was encouraged to process thoughts and feelings pertaining restraint and aggressive behavior. Pt. was seen by ROD throughout the shift with restraint renewal. Writer sat by door per FLR protocol." The (Evaluation) sections states, "VSS afebrile [vital signs stable, no elevated

temperature]. Pt. circulation to extremity was within normal limits. No respiratory distress noted. Pt. continued to be agitated. Pt. refused to process and contract for safety." The (Plan) section states, "Continue with process and contract for safety."

The next progress note entry is made at 9:00 a.m. and states, "Patient has remained in restraints overnight for intervention sanctioned by Dr… (Director) due to his unwillingness to comply with a written safety protocol and out of program proposal to contain him away from peers until he is assessed to be safe in the milieu. [Recipient] was physically assessed at 9:00 a.m. at which time he was comfortable and denied concerns. His feet and hands were warm, his vital signs stable and chest restraint with sufficient slack as not to compress any brachial nerves. He denies any tingling/numbness in hands or extremities and is able to speak freely with no respiratory distress noted. He was subsequently seen by nursing administrators and medical Director with charge RN [10:00 a.m. to approve continuation beyond 24 hours] to further discuss his willingness to comply with alternative programming in his room today. He states he will control aggression but refuses to do HW [homework] in room with crayon nursing administration requesting he further process. FLR to be maintained at this time, with reassessment by 11:00 a.m."

At 12:00 p.m. the recipient was again assessed (late entry due to meeting). "[Recipient] was reassessed at 12 p.m. after verbal order to renew restraints. He had apparently met with DCFS and shortly afterward again became agitated, attempting to pull out his restraints and loosening his mattress from baseboard of bed. Staff called to administer prn due to his attempts to spit at and bite staff and escalating behavior with refusal to comply with directives. Patient seen at 12 p.m. at which time he looked sedated and stated that he was tired from failure to sleep last night and wanted to go nap. He denied any discomfort. VSS, extremities warm. He was told that team was meeting shortly and that he needed to agree to safety plan. To reassess at 1 p.m."

At 1:00 p.m. a progress note entry indicates the recipient was again reassessed. It states, "[Recipient] was reassessed prior to attending's departure for administrative meeting. He remains tired but spoke in cooperative fashion about his desire to work his special program when he is out of restraints in order to earn incentives, supported by his desire to reengage in treatment but told that his transition to alternative program would be deferred until change of shift at which time restraints would be discontinued. Staff instructed to start to free one side of extremities so he could roll over to nap again, he states he is physically comfortable. He has warm feet and hands, good pulses, clear breaths, and stable BP and HR. He can move head freely and talk unencumbered. Plan to remove restraints at 3 p.m. if he sustains calm demeanor and voices agreement to comply with staff directives regarding safety."

At 3:10 p.m. progress note entry states, "pt. was interviewed at 3:00 p.m. and was in restraints at that time. Pt. c/o 'I've been in restraints since 10:00 yesterday.' Pt. said that he agreed to the treatment/incentive plan, including the part of studying in his room…. Pt. was asked if he has behaved inappropriately and he replied 'when you put it that way, yes'. Pt. said that he apologized to [staff] and that [staff] apologized to him, because they hit each other. Pt. was congratulated for being so mature. Pt. said, 'If it's an object, I don't feel any remorse' and

cited the destruction of his room as an example of an object. Pt. seemed embarrassed by his actions, but denied feeling embarrassed when asked directly."

Hospital representatives were interviewed regarding the statement that staff had hit the recipient. They stated that this comment referred to the incident which occurred on 9/21/09 when 2 male staff had attempted to redirect the recipient in the hallway and in the process all three individuals fell to the floor (see above). When the recipient fell he hit his cheek on the floor and mistakenly believed that he was hit by staff. He later processed this event with the staff person, to whom he apologized for his rage and the subsequent destruction of his room.

At 6:42 p.m. an entry in the progress notes indicates that the recipient was released from restraints: "Received patient in full leather restraints (FLR) at 1500 [3:00 p.m.]. Patient was agitated and refusing to contract for safety at that time. Patient later calmed down and processed superficially. Patient was able to contract for safety and was released from FLR at 1645 [4:45 p.m.]. Patient was maintained on 1:1 for safety. Patient remained testy but was able to follow directions after firm limit setting."

Although the record contains three internal forms labeled Behavioral Seclusion/Restraint Form, the record contains only one Restriction of Rights Notice:

> *9/23/09 at 11:00 a.m. for restraint. The reason stated: "Pt. was given a list of expectations he needed to achieve to return to milieu. Pt. got agitated and loud and proceeded to slam his door in an aggressive manner, and threatening. UIC police called and pt. placed in FLR's and given Benadryl 75 mg IM stat."*

The Notice does not indicate the duration of the restriction. The Notice indicates that the recipient designated his preferences for emergency intervention however it states that these were not used because, "Pt too agitated." It indicates that the notice was faxed to the recipient's designee.

Hospital representatives were asked about the lack of Restriction of Rights Notices for such a prolonged restraint episode. They stated that they remembered completing these forms however they were unable to locate them for the HRA. They also noted that the DCFS worker was notified of the restraint and the record shows the DCFS worker was present on the unit during the restraint episode. Representatives reported that all staff that take part in a restraint episodes are trained in the application of restraint.

The record contains a 15-minute observation sheet for the period of 9/23/09 through 9/24/09 and 15-minute assessments and evaluations of the recipient's medical condition and that the restraints pose no undue harm to the recipient's health. The staff reported that the recipient was spoon fed and that he likely drank with straws. They also reported that his restraints were loosened for comfort in eating and sleeping and staff wiped his face, etc. for hygiene purposes and they stated he was given a urinal. The bathrooms on the unit are routinely locked and residents use the bathroom that is located near the front desk. The recipient in this investigation was restrained in his room but was not behind locked doors, and doors are not locked while residents are there.

Hospital representatives reported that restraint episodes generate a packet of papers to be completed for each episode, which are then reviewed by the unit supervisor. These packets are then reviewed by Quality Improvement for each episode and they are reviewed again monthly, which results in a quarterly report. The hospital Safety Committee also reviews all occurrences of restraint monthly.

Program Information

Hospital representatives provided information regarding the CARTS and the CATU program. The CARTS Program is a multidisciplinary program consisting of an acute psychiatric inpatient unit- the CATU, and a mobile consultation team- the Response Training System (RTS). The CARTS Program was designed to improve the quality of mental health services provided for DCFS wards with severe emotional disturbances. According to this model there would be a network of satellite CARTS programs consisting of an inpatient unit and a mobile consultation team that work with affiliated residential treatment facilities. The CARTS Program was designed to serve as the primary site of intake into this system, where recipients would be given in-depth assessment and a comprehensive treatment plan that would then be shared with the program where the adolescent resides. Additionally, the consultation team would be available to provide technical assistance and consultation to the satellite program.

The recipients treated in the CARTS Program have, by definition, experienced severe neglect; physical, emotional, and/or sexual abuse; have been removed from their family of origin; have behavioral and emotional disturbances severe enough to warrant psychiatric hospitalizations and/or incarceration; and have a history of multiple placements. Recipients in the CATU program must have a severe disorder of mood, thought, or behavior; must present an acute danger to self or others; and must be able to benefit from inpatient psychiatric hospitalization. They must have a history of severe, repetitive aggression that may be directed to toward others, property, or self.

Referrals for admission to the CATU Program are made by the DCFS Psychiatric Hospital Program, the gatekeeper of the CARTS Program.

Hospital Representatives' Statement

The Director of the CATU program offered the following clinical input into the investigation of the recipient's restraint:

"The subject of the HRA inquiry… is a 16-year old male who has been treated on the CATU inpatient unit on a number of occasions over the past few years when he required a clinical setting better equipped to manage his extraordinarily destructive outbursts.

By his clinical history, this youth often displays severe aggression, behavioral instability and paranoia when he experiences stress or conflict in residential settings; most worrisome, these episodes tend to culminate in extraordinarily violent outburst:

- *It should be especially noted that [recipient's] numerous admissions to CATU have typically occurred following uncontrollable and violent outbursts toward both staff and peers- generally requiring emergency medications and physical restraints- when he was at [placement].*
- *Following one such violent episode at [placement] in which [recipient] slammed a door on the hand of a staff member, severing part of the man's finger- no fewer than nine police officers were required to subdue him.*
- *Of particular interest, [his placement facility] officials have routinely had to call for police assistance during such incidents involving [the recipient] when their …units and …staff have proven to be inadequate to the task of managing such youths.*
- *Most recently, [recipient] is reported to have been out of control during a court hearing, where he attempted to trash the courtroom; as a result of this explosive outburst [the recipient] was sent to juvenile detention by the judge.*
- *Despite the fact that the data indicates [recipient] has typically done significantly better during his CATU hospitalization than at either [of his placements]- including less frequent need for the use of emergency medications and physical restraints- one unusually violent outburst during a recent CATU admission in September 2009 required him to remain in restraints for a approximately 29- hour period before he was able to calm himself and safely return to the milieu.*

From a clinical perspective, however, it is important to note a change in the trajectory of [recipient's] course of treatment on CATU:

- *Including the prolonged restraint episode, [recipient] required 9 restraints in 14 hospital days (0.64 restraints/hospital day) and 14 emergency medications in 14 hospital days (1 emergency medication administration /hospital day).*
- *Following the prolonged restraint, [recipient] had 3 restraints in 48 hospital days (or 0.063 restraints/hospital days) a ten-fold decline in restraint usage- and 8 emergency medication administrations during that period (or 0.17 emergency medication administration/hospital day).*

Moreover, this improvement continued into [recipient's] subsequent hospitalization (1/13/10- 2/8/10); during that 26-day hospital stay, [recipient] had only one restraint and required one emergency medication administration (0.038 incidents/hospital day)."

STATUTORY RIGHTS

The Mental Health Code mandates that upon commencement of services every recipient 12 years of age and older shall be informed orally and in writing of their right to designate a person or agency to receive notice when their rights are restricted, or to direct that no one be notified (ILCS 5/2-200). Also, upon commencement of services the facility must inform the recipient of the conditions under which the law permits the use of forced emergency medication, seclusion, and restraint, and what form of intervention the recipient would prefer if these situations should arise. These preferences are to be noted in the medical record to be referenced should they become necessary (5/2-200 d). Additionally, the Code states that whenever any rights of the recipient are restricted, notice must be promptly given to the recipient, a designee,

the facility director or a designated agency, and it must be recorded in the recipient's record (ILCS 405 5/2-201).

Restraint is a therapeutic tool that the Mental Health Code carefully regulates. Although its use is to prevent harm, the Code outlines specific measures to ensure that it is safely and professionally applied:

"Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff.

(a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this Section….

(c) The person who orders restraint shall inform the facility director or his designee in writing of the use of restraint within 24 hours.

(d) The facility director shall review all restraint orders daily and shall inquire into the reasons for the orders for restraint by any person who routinely orders them.

(e) Restraint may be employed during all or part of one 24 hour period, the period commencing with the initial application of the restraint. However, once restraint has been employed during one 24 hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director.

(f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others…. (405 ILCS 5/2-108).

The Mental Health Code defines seclusion as " the sequestration by placement of a recipient alone in a room which he has no means of leaving. The restriction of a recipient to a given area or room as part of a behavior modification program which has been authorized pursuant to his individual services plan shall not constitute seclusion, provided that such restriction does not exceed any continuous period in excess of two hours nor any periods which

total more than four hours in any twenty-four hour period and that the duration, nature and purposes of each such restriction are promptly documented in the recipient's record.

HOSPITAL POLICY

The UIC Medical Center provided policy regarding the use of restraints, which comports with the Mental Health Code guidelines. The policy states the objective of restraint use:

"Promote a restraint- free environment for all patients. Restraints or seclusion are only imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. The individual's physical and emotional needs are considered when the patient is in restraint or seclusion."

Further policy describes restraint or seclusion use:

1. Restraint or seclusion is only used to support medical healing or protect the patient, staff, or others from harm when restraint alternatives have been determined to be ineffective.
2. Use of restraint or seclusion for the management of violent or self-destructive behavior is an emergency intervention; nonphysical interventions are the first choice.
3. Medications are used as part of an individualized treatment plan for the patient's condition and assessed needs; medications are not used as chemical restraints.
4. The type of restraint or seclusion used is the least restrictive intervention that will be effective to protect the patient, staff or others from harm.
5. The decision to restrain or seclude is made in the context of an ongoing process of assessment, intervention and evaluation.
6. Restraint and seclusion may be used for the safety and protection of the patient or other persons on the unit and to provide necessary aid in administering safe and essential care to the patient.
7. Restraint or seclusion is discontinued at the earliest possible time.
8. All use of hard restraints (leather), locked or non-locked, require additional interventions and assessments consistent with those for management of violent or self-destructive behavior as outlined in this policy and procedure…."

The hospital policy outlines the procedure for documentation of restraint and seclusion and indicates that "Nursing staff complete the State of Illinois Department of Human Resource 'Notice Regarding Restriction of Rights of an Individual' form and advice [sic] the patient it is their right to have any person of their choosing notified of their restraints and/or seclusion. This includes the Guardianship and Advocacy Commission or the agency designated pursuant to the Protection and Advocacy for Developmentally Disabled Person's Act…. On the adolescent psychiatric unit, a copy of the restriction of rights form is also faxed to the Department of Children and Family Services Guardian's office."

CONCLUSION

At issue in this case is whether the restraint episode that was initiated at 11:00 a.m. on 9/23/09 and continued until 5:00 p.m. on 9/24/09 was initiated and extended according to the guidelines set down by the Mental Health Code and University of Illinois Hospital policy. The Code states that "Restraint may be used only as a therapeutic measure to prevent the recipient from causing harm to himself or physical abuse to others" and "In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff." University of Illinois policy states, "Restraints or seclusion are only imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. The individual's physical and emotional needs are considered when the patient is in restraint or seclusion."

The record (physician's order) indicates that the restraint episode began on the 9/23 at 11:00 a.m., however the first entry in the progress notes describing the event is made at 2:20 p.m. and states that "Patient's restraints extended due to patient being unable to contract for safety." The notes indicate that the recipient was given his expectation protocol and was "verbally threatening to destroy the room again as he did yesterday." This note suggests that the recipient had already been placed in restraints and that he was refusing to comply with the safety plan that was the criteria for his release. If the recipient had been placed in restraints at 11:00 a.m. as indicated by the restraint order, there was no entry in the progress notes corresponding to the precipitating event, and no description in the physician's order of the events leading up to the need for restraint and the purposes for which it was employed as mandated by the Mental Health Code.

Although UIC hospital staff reported quite clearly that the recipient was continued in restraints because he was an imminent threat of physical harm, this rationale is not reflected in the progress notes and physician's orders. Repeatedly in the notes the staff confirm that the recipient refuses to "contract for safety" or "comply with safety proposal" and is continued in restraints solely for this reason. The recipient is continued in restraints even while asleep (and we wonder how he can "contract for safety" while sleeping) and when he finally agrees to his behavior plan, he must wait until shift change to have his restraints removed:

- 9/23 3:00 p.m. "His lack of insight and failure to take responsibility reveal his continued refusal to comply with safety proposal and thus, given his unpredictability, restraints renewed."
- 9/23 4:43 p.m. "…his repeated failures to contract for safety have resulted in renewals of FLR…maintain FLR unless staff perceive [recipient] is genuinely engaging in a contract for safety. He will be reassessed for alternative programming tomorrow, primarily confined to his room until deemed safe and in more control of his impulses and anger."
- 9/23 8:23 p.m. "He continues to be to be unable to contract for safety during reassessment at 7:00 p.m."
- 9/23 9:52 p.m., 11:34 p.m., 9/24 at 1:09 a.m. (asleep), 3:00 a.m., 5:27 a.m., and 7:36 a.m. "Unable to contract for safety."
- 9/24 a.m. "He was subsequently seen by nursing administrators and medical director with charge RN to further discuss his willingness to comply with alternative programming in his room today. He states he will control aggression but refuses to do

HW [homework] in room with crayon nursing administration requesting he further process. FLR to be maintained at this time, with reassessment by 11:00 a.m."

- 9/24 1:00 p.m. "He remains tired but spoke in cooperative fashion about his desire to work his special program when he is out of restraints in order to earn incentives, supported by his desire to reengage in treatment but told that his transition to alternative program would be deferred until change of shift at which time restraints would be discontinued… Plan to remove restraints at 3:00 p.m. if he sustains calm demeanor and voices agreement to comply with staff directives regarding safety."

Although the HRA understands the importance of the recipient's behavioral contract, in this case the end simply does not justify the means. The progress note entry made at 3:10 p.m. indicates not the success of a treatment protocol but the resignation of a youth to a power structure he understood perhaps better than the staff: "pt. was interviewed at 3:00 p.m. and was in restraints at that time. Pt. complained 'I've been in restraints since 10:00 yesterday'. Pt. said that he agreed to the treatment/incentive plan, including the part of studying in his room…pt. was asked if he behaved inappropriately and he replied 'when you put it that way, yes'. Pt. said that he apologized to [staff] and that [staff] apologized to him, because they hit each other. Pt. was congratulated for being so mature. Pt. said, 'If it's an object, I don't feel any remorse' and cited the destruction of his room as an example of an object. Pt. seemed embarrassed by his actions, but denied feeling embarrassed when asked directly." Asking a youth if he behaved inappropriately or if he was embarrassed by his behavior after putting him in restraints for 29 hours seems humiliating, and places the restraint episode in a punitive, disciplinary light, which the Code specifically denounces. Also, even after this evaluation, completed at 3:00 p.m., the recipient remained in restraints until 5:00 p.m. according to the clinical record, violating hospital policy that restraints must be discontinued at the earliest possible time.

The youth in this investigation was restrained for 29 hours, which we hope is an exception to the usual length of time that residents are restrained on the unit. Given the unusually long period of restraint, the clinical justification becomes even more important. For this justification we turn to the physician's order for restraint, which never varied in one word from one order to another. The Code states that no restraint shall be ordered until the recipient is personally observed and examined and that the examiner is clinically satisfied that the restraint is justified to prevent physical harm. Additionally, the Code mandates that the order clinically justify the length of time that the restraints are to be continued. In this case the order never reflected the personal observation of the recipient or the clinical justification for the restraint. Additionally, there was only one Restriction of Rights form completed for the event and it did not give a duration for the restraint episode so we are left to believe that one Notice extended for 29 hours which clearly violates the intent of the law, which is to give recipients the right to notify chosen persons when their rights are being restricted.

The HRA substantiates the complaint that the recipient was restrained in violation of the Mental Health Code and hospital policy.

RECOMMENDATIONS

1. Train all staff to follow the Mental Health Code (405 ILCS 5/2-108) guidelines for restraint and ensure that all aspects of the law are followed, including the completion of a Notice of Rights Restriction whenever the rights of the recipient are restricted.

SUGGESTIONS

1. Given that the CATU program is specifically developed to treat severely emotionally disturbed youth who are repetitively prone to violence, the HRA suggests that the program developers formulate policy and procedure for restraint that is nuanced for this population, outlining the specific and unique responses to threats of violence and their accompanying rationale and documentation.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

UIC UNIVERSITY OF ILLINOIS AT CHICAGO

Michael W. Naylor, MD
Director, Behavioral Health and Welfare Program

Institute of Juvenile Research (MC 747)
Department of Psychiatry
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August 20, 2010

Jill Quinto
HRA Chairman
Illinois Guardianship and Advocacy Commission
1200 S. 1st Ave., Box 7009
Nines, IL 60141

RE: #10-030-9006

Dear Ms. Quinto,

In response to the findings of the investigation of case 10-030-9006, we would first and foremost like to acknowledge the great degree of patience and tenacity displayed the Chicago regional HRA during the course of their inquiry. We concur with the recommendation to train all staff on the Mental Health Code (MHC) guidelines which were unwittingly violated. We also appreciate the suggestions for policy reform in order to address the unique challenges involved in the therapeutic management of our severely ill youth on the CATU. To paraphrase Socrates, "the unexamined unit is not worth running." Furthermore, although not on trial for heresy, our administration had already initiated review of the exiting rationales for current milieu interventions and structure. With such receptivity to our ongoing "self examination", we welcome the opportunity to address the concerns highlighted in this report and will take or already have undertaken corrective actions to ensure that our youth continue to be treated with dignity in a safe, humane environment where they are suitably empowered by education of their rights and unencumbered access to advocacy.

We would now like to address several conclusions drawn during the investigations, noting our plans for changes as well as clarification of contextual factors that may influence judgment.

1. The first entry of conclusion reports that although there is no "entry in the progress note corresponding" to the initial 11 am order it should be noted that our computerized charts are time of written entry not necessarily "real time" of action. At the time of the order, corresponding paper documentation was completed at 11 am at which time MD examined patient and documented written rationale. MD then departed to an urgent administrative meeting (regarding this patient), returned to unit to briefly reassess patient at 1pm and sign written documents, gave a verbal order to renew but returned to unit later at which time orders and progress notes were entered in computerized chart. There are sequential notes for each order renewal that afternoon. These serial assessments were done in a timely manner.

Corrective action: all MDs will be trained to enter the "result status" to correspond to the order time and ensure that any serial assessments are done in a timely manner and entered as an individually timed note that contains all the necessary observations and justifications.

2. There are also violations raised by the electronic medical record physician order template, which is limited to standardized descriptors imbedded in the order's computerized menu.

   Corrective action: we will request expansion of the template and/or train all MDs to add specific comments on the order in compliance with mandates of the MHC.

3. The following conclusions address the concern that our "end" of maintaining recipient in restraints until there was contract for safety did not justify our "means". As stated previously, recipient was actively threatening to harm staff and we will assert our clinical justification that until recipient was able to endorse the safety requirement and expressed a desire to create a therapeutic alliance ("bought in"), he remained an "imminent threat" and the application of restraints as "therapeutic measure to prevent (harm) to himself and to others", both staff and peers, was indicated. This clinical decision was not taken lightly and as documented by the Director of the CATU, the intervention resulted in a more positive trajectory of recipient's subsequent hospital courses (an unintended but welcome outcome)

   We would like to add contextual clarity to the bullet points on pages 13-14 as follows, noting as above that many entries were delayed and not 'real time' and again, orders were template driven.

   The 9/23/09 3 pm MD note is a justification for renewal of restraints at 1 pm. As previously described in an MD response on page 4, recipient was agitated and threatening harm when initially placed in FLR at 11 am. Below, in its entirety is the day shift report by the staff assigned which notes that although compliance with the proposed safety plan is an important goal, observation of recipient's clinical state and assessment of his "reality orientation" (given recipient's grandiosity and paranoia) are critical determinants as well.

   (Problem): Ineffective Individual Coping Skills

   I: *(Intervention): Encouraged compliance with treatment protocol. Set limits as needed. 1:1 interaction to venilate feelings/thoughts. Provided reality orientation. Monitored precautions per policy.*

   E: *(Evaluation): Received up and alert; continues to be anxious and restless upon approach. Affect/mood continues be extremely labile and unpredictable. Patient has very poor insight into illness and wants to dictate/control environment; when unable to do so patient becomes challenging, verbally aggressive and threatening. Patient presented new behavioral expectations, by team, including director and unit manager, informing him that he would be out of programming until meeting the expectations. Patient unable to accept protocol and became threatening: slamming door, kicking doors/walls, and verbally threatening to staff. Patient assessed to be out of control, unsafe and a imminent danger to others; placed in full leathers*

restraints with the assistance of psychiatric staff and UIC security. Patient given emergency medication (Benadryl 50 IM) with moderate results; ***patient continued to be agitated, hostile, yelling and unable to contract for safety during appointed assessments. Due to patients' continued inability to process following initial restraint period, refusal to comply with established treatment protocol and hostile, threatening tone, including stating "who gives a fuck," order given to renew restraints for an additional two hour interval with appropriate assessments.*** *Patient continues to demonstrate very poor insight and states that he can't abide by expectations/behavioral protocol, subsequently attempting to manipulate staff and dictate his own protocol. Compliant with medication protocol. Good appetite at meals. No acute distress noted.*

P: *(Plan): Continue to monitor precautions per policy. Encourage verbalization of feelings for healthy, therapeutic responses. Provide reality orientation to help patient focus on reality based thinking. Set clear, firm and consistent limits for safety and management. Follow plan of care as prescribed.*

Additionally, the MD note, written based on interview with recipient and consultation with assigned staff is based on a clinical assessment which found recipient to still be angry, hostile, and threatening. He was examined and found to be physically comfortable. The restraints were initiated when patient became an imminent threat when triggered by the unit's firm stance that compliance with a proposed safety plan was necessary to ensure patient's safety, staff safety, and peer safety. As noted above, patient continued to exhibit agitation between 11am to 1 pm and to reject the safety plan. Thus, the initial justification for application of restraints continued.

The 9/23 4:43 pm MD note is a brief documentation discussing a planned clinical intervention, discussed throughout the day with administrators given the concern that recipient had failed to exhibit any clinically significant diminution of his angry, hostile, threatening behaviors while in restraints for over six hours, during which time staff were actively processing therapeutic goals. Patient's continued denial that his violent outbursts threaten safety of all; his desire to "do what he wants"; his inability to maintain affective regulation, intact reality orientation and impulse control are documented in progress notes. The planned intervention was using recipient's willingness to comply with a safety plan as a clinical indicator that recipient had relinquished a desire to harm staff and was able to accept imposition of external limits
(e.g., 1-to-1 staff, isolation from peer group, activities in room or designated areas where environmental stimuli could be reduced) to help control his aggressive impulses and thus reduce the risk for recurrence of violent behavior. As documented in notes, MD discussed with nursing staff that restraints could be released or reduced as clinical assessment warranted.

The 9/23/09 and 9/24/09 notes written by the covering "resident on duty" are insufficient and corrective actions, as aforementioned, will be taken to educate all staff as to the needs for improved documentation as mandated by the MHC. Nonetheless, the nursing notes do document patient as yelling, provoking, agitated, hostile and threatening. Recipient continued to refuse to engage in any reflective conversation about therapeutic goals and thus compromised the necessary clinical assessment needed to evaluate whether his ideations of harming others had abated sufficiently to minimize the risk of imminent violence if released from restraints.

The 9/24 notes, again should be understood in context. The MD had a morning assessment at 9 am. Patient was engaging with MD but when approached by nursing staff, again was agitated and threatening at which time release from restraints would have been contraindicated and thus restraints renewed with plan to reassess by 11 am. Again, the direct care staff note is below:

P: *(Problem): Aggression*

I: *(Intervention): Encouraged compliance with treatment protocol and behavioral expectations. 1:1 interaction to venilate feelings/thoughts. Provided reality orientation. Set limits as needed. Monitored precautions per policy.*

E: *(Evaluation): Received patient awake and alert; anxious upon approach. Affect/mood continues to be labile and unpredictable. Patient received in FLR's and continues to be oppositional, defiant, threatening, hostile and verbally abusive towards staff; unable/unwilling to contract for safety and/or comply with treatment protocol or behavioral expectations. Patient continues to try to manipulate staff to alter programming designed to enhance the safety of unit and making it clear that he is not going to follow guidelines. Despite numerous attempts by team of staff members to reinforce program and expectations,* ***patient continues to be oppositional, defiant and threatening; becoming very agitated and attempting to pull self out of restraints, while being verbally abusive and threatening to staff.*** *Patient received PRN medication with moderate efficacy, as* ***patient remains very labile and unpredictable.*** *Alterations made in current medication regiment, which patient was compliant with, though gamey.* ***Thought process is rigid and concrete and patient clearly wants to dictate/control environment; easily agitated when this is not the case, manifesting itself in intense anger, rage and aggression.*** *Patient continues to be a high risk for violent acting out behavior, with no insight into illness or remorse for his behavior(s)/action(s).*

P: *(Plan): Continue to monitor precautions per policy. Encourage verbalization of feelings for healthy, therapeutic responses. Set clear, firm and consistent limits for safety and management. Reinforce behavioral protocol and expectations to accentuate compliance and plan of care. Follow plan of care as prescribed.*

4. We would also like to clarify contextually the 9/24/10 progress note entry referenced in your conclusion. This note was entered by a trainee physician who had been absent from the unit the morning and early afternoon of 9/24/10 and did not appreciate the complexities of the case nor the administrative sanctioning of prolonged restraint for this youth who had history of both severe reactive and premeditated aggression. This recipient's resistance to comply with interventions proposed to keep our milieu safe by providing him with external, therapeutic containment of his impulses was fueled by the recipient's entitled sense of self, rigid and inflexible thinking, underlying paranoia and affective instability. We could not effectively treat this recipient or his peers without ensuring safety and maintaining the cohesiveness of the milieu. Of note, a 9/24/10 12:30 progress note from the male staff assigned as recipient's 1-to-1 primary for the day shift is omitted from the report. Please see the excerpt above as this note documents that the recipient continued expressing verbal threats associated with episodes of rageful anger. Nonetheless, staff was continually processing with recipient and gradually building an alliance that enabled the recipient to contract for safety and engage in treatment. We also take issue with the conclusion that the patient's endorsement of the behavioral contract represented, "the resignation of a youth to a power structure he understood perhaps better

than the staff." Instead, the patient's acquiescence shows an acknowledgement of his desire to commit to treatment and receive help by both pharmacological and non-pharmacological interventions. The verbatim inquiry of the 3:10 pm note "leads the witness'. Our trainee walked into the recipient's room while the attending was at another administrative meeting (about the case), perhaps conceptualized the restraint as "behavioral" and framed her questions accordingly. This random encounter, although documented, should not be used to characterize the manifold and intensive interactions this recipient had with various staff during the course of the episode and to conclude that the episode was initiated and maintained for "punitive" and "disciplinary" reasons is incorrect.

5. It was reported that we did not comply with the notice of restriction of rights MHC mandate. This was indeed an error. Nursing administration had initially thought that the charge nurses had filled out the forms and notified the guardian but we subsequently learned that staff had mistakenly not followed up on completing the serial notifications of restriction of rights.

   Corrective action: We have re-educated staff about the need to fax the Restriction of Rights notification to DCFS for each restraint order, whether new or a renewal of an ongoing restraint. We have made this one of our quality indicators. Our QI protocol includes checking to assure that the restriction of rights notification is send for each restraint episode. We will ensure that patients are regularly informed of their rights and that guardians are notified.

6. Finally, we wish to assure the HRA that this episode was indeed an extreme outlier and an exception to the usual management of youth on the CATU. Never in this history of the CATU has anyone been in restraints even remotely close to this long. Indeed, never in the combined history 32years as inpatient attendings in clinical and administrative roles) of the two physicians involved in managing the recipient have they felt compelled to use such an extreme intervention. This recipient, as aforementioned, came to CATU with a history of extreme violence (a dangerous combination of both predatory and affective aggression), recent therapeutic disengagement with placement staff and desire to go "back to jail". On our unit, he had recently assaulted staff and destroyed his room and had become a dangerous and disruptive presence. We nonetheless felt committed to his treatment and, given his individual psychopathology and escalating behaviors, felt compelled to offer the prolonged restraint as a necessary intervention to maintain the safety of the other patients, the staff and the recipient, not a punishment or coercion. At all times, his physical safety and welfare was monitored appropriately and at no time was he harmed.

The CATU has a long history of providing superb care to the most challenging youth in the Illinois foster care system. Youth treated on the CATU experience a 50% decrease in inpatient psychiatric hospital utilization following their first CATU hospitalization compared to an equal period of time preceding the index CATU admission. This is but one measure of success that the CATU can claim. Following the child's initial hospitalization, consultants in the Response Training System or RTS (the outreach component of the CATU) provide technical assistance and

consultation to the residential treatment facilities treating these youth. These facilities find the consultations Very Helpful or Helpful for 88% of the youth discharged from the CATU. Indeed, placements value our consultation so much that many will not admit extremely challenging youth without the RTS consultation. The consultations have had observable benefits for our patients, perhaps most importantly, increased placement stability. Based on our data we estimate that the improved functioning of youth treated on the CATU following their index hospitalization translates into a savings of $2.3 M for the state in the six months following discharge in hospitalization costs alone. This does not include the savings of the *perdiem* rates paid to residential treatment facilities to hold a child's place during their hospitalization. These savings could amount to an additional savings of $1 M over the same 6 month period.

We hope we have addressed the concerns of the Human Rights Authority as related to this recipient. We continually to strive to improve the care we provide and have used this inquiry as an opportunity to educate staff about the mandates set forth in the Mental Health Code regarding the use of restraint.

Sincerely,

Elizabeth Charney, M.D.
Director, Comprehensive Assessment and Treatment Unit

8/20/10
Date

Michael W. Naylor, M.D.
Director, Behavioral Health and Welfare Program

8/20/10
Date