disABILITY LAW CENTER OF VIRGINIA

Protection & Advocacy for Virginians with Disabilities

Treatment Failure at CCCA: The Restraint of RS

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disAbility Law Center of Virginia

INTRODUCTION

The Commonwealth Center for Children and Adolescents (CCCA) uses coercive and excessive restraint practices that are inconsistent with acceptable trauma-informed care principles. This is despite receiving thousands of dollars in federal grants for technical assistance from the Substance Abuse and Mental Health Services Administration (SAMHSA), numerous trainings by experts in the field on trauma-informed care practices, and multiple leadership changes at CCCA. The use of restraint is a treatment failure, not a behavioral intervention, and has no therapeutic benefit. The introduction and use of the Emergency Restraint Chair as a form of restraint for children and adolescents is especially egregious. Virginia is failing one of its most vulnerable and marginalized populations: children with mental health needs and developmental disabilities.

The disAbility Law Center of Virginia (dLCV) is the federally-mandated Protection and Advocacy System for Virginians with disabilities. dLCV conducts ongoing monitoring at CCCA and investigate allegations of abuse or neglect pursuant to the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act.[i]

dLCV urges the Department of Behavioral Health and Developmental Services (DBHDS) and the Commonwealth to implement immediate corrective action to eliminate the use of the ERC at CCCA, and to implement trauma-informed principles of care.

HISTORY

The Commonwealth Center for Children and Adolescents (CCCA) is a 48-bed facility located in Staunton, Virginia. CCCA provides acute inpatient psychiatric care for children and youth, and is licensed and operated by DBHDS and accredited by the Joint Commission. CCCA is the only state-operated inpatient mental health facility for children and is mandated to accept for admission children and youth from across the state who cannot be served elsewhere.

CCCA currently subscribes to SAMHSA's strategies for a trauma-informed care approach to treating individuals with mental illness. CCCA received federal grants in 2007 and 2008 to obtain SAMHSA's technical assistance on implementing a trauma-informed system and culture. Under these grant projects, a specialized technical team began to work with leadership. SAMHSA's team engaged in plan development, identification and development of resources, and identification of trauma-informed care principles. The team conducted reviews of data and individual client files, consulted on cases, and conducted numerous site visits, center-wide training, and consulted on a leadership reorganization.

WHAT IS TRAUMA-INFORMED CARE?

Childhood trauma is a significant public health concern. Exposure to trauma can disrupt brain development and have lifelong adverse effects on a person's ability to function.[ii] SAMHSA has developed a model for treatment of and service provision to individuals with complex trauma histories termed "trauma-informed care" or "trauma-informed approach." Trauma-informed care and trauma-specific interventions are designed

to address the consequences of trauma in an individual. Trauma-informed care is a treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. This framework facilitates treatment designed with the knowledge of what trauma does biologically and emotionally within an individual. This approach looks at typically termed "negative" symptoms as adaptations to dealing with trauma in their lives.

A trauma-informed response includes six core strategies employed in treatment. These six strategies are as follows:

- safety
- empowerment through voice and choice,
- recognition of cultural, historical, and gender differences and issues,
- trustworthiness and transparency,
- collaboration and mutuality of treatment, and
- peer support and guidance.

For example, a trauma-informed approach would work to increase a child's perceived level of safety, recognizing the signs and symptoms of trauma, such as nightmares, flashbacks, and self-injury. Above all, SAMHSA's trauma-informed approach seeks to avoid re-traumatization. For this reason, trauma-informed care promotes elimination of the use of seclusion, restraints, and other coercive practices.[iii]

THE EMERGENCY RESTRAINT CHAIR

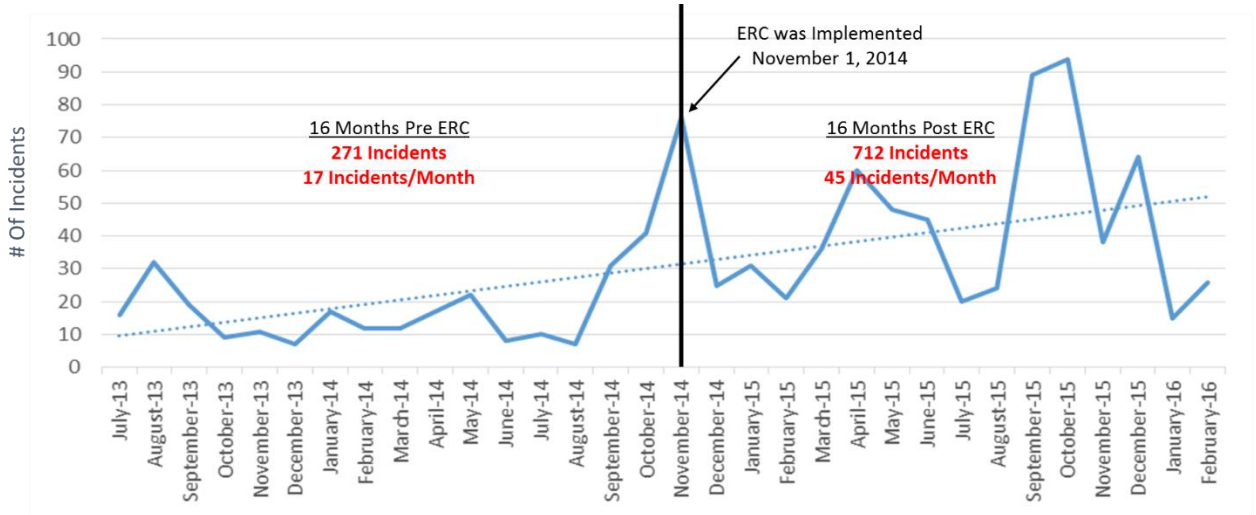
CCCA's leadership is responsible for creating a culture that supports a patient's right to be free from seclusion and restraint and to receive care in a safe environment.[iv] Research demonstrates that the use of restraint as a behavioral management technique is not only inherently dangerous, but also triggers the symptoms that it is supposed to treat. SAMHSA's trauma-informed care principles oppose the use of seclusion and restraint, teaching service providers and their organizations about the triggers and vulnerabilities of trauma survivors and effective interventions.[v] The use of seclusion and restraint has no therapeutic value, and therefore should not be utilized as treatment. Additionally, individuals with complex trauma histories consistently fail to develop the neurobiological capacity and structures necessary to process and modulate emotions in response to stress, resulting in re-traumatization if seclusion and restraint are utilized.

The Emergency Restraint Chair (ERC) is a particular form of restraint originally designed for managing violent adults in jails and prisons. The ERC is an inclined chair that straps the individual down by their shoulders, waist, wrists, and ankles. It has wheels that allow CCCA staff to move the individual in and out of the seclusion room and shower if necessary while continuing the restraint.

The use of the ERC has been introduced at Western State Hospital, a state-operated adult mental health institution. However, no other facility responsible for treating children or youth has implemented this form of restraint in Virginia. There is no child or youth sized ERC, which is designed for usage with adults only. In addition to the aforementioned risks inherent with utilizing restraints with children, the specific use of the ERC is more egregious when considering both sizing and other potential medical issues, such as asthma and obesity. Various human rights organizations have condemned the use of the ERC in correctional facilities. These organizations include Amnesty International, the American Civil Liberties Union (ACLU), and the United Nations Committee Against Torture. The ERC is described as "Spanish Inquisition technology with sort of a late 20th century advertising spin."[vi]

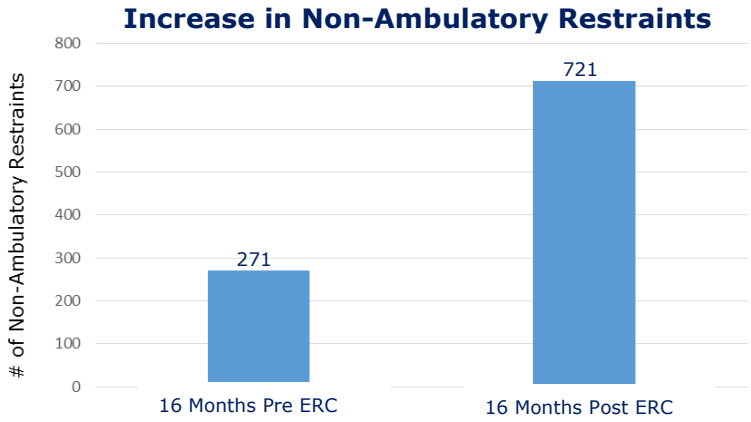
In November of 2014, the ERC was introduced at CCCA as an additional form of non-ambulatory restraint for behavioral management. dLCV adamantly opposed its implementation and sought review by the Local Human Rights Committee (LHRC), an oversight body of CCCA. dLCV advocated for the ban of the ERC, noting that it was a form of restraint not designed for treatment of children, individuals with mental illness, or developmental disabilities. dLCV further noted that the use of the ERC is inconsistent with CCCA's mission of trauma-informed care and could jeopardize the rights and safety of the children CCCA serves. SAMHSA also cited their opposition. The LHRC failed to take action.

In response to dLCVs request for information, CCCA was unable to provide any statistical reports on its use of restraints, and denied conducting any trend analysis regarding the use of the ERC. Based on an analysis of raw data obtained from DBHDS, dLCV determined that the ERC has become a frequent form of restraint at CCCA. During the 16 months from July 2013 to October 2014, there were 271 incidents of non-ambulatory restraint. In the 16 months following introduction of the ERC, November 2014 to February 2016, there were 712 incidents of non-ambulatory restraint (see table below). Since CCCA began using the ERC, non-ambulatory restraint usage has increased 163%.



According to CCCA's own reported data, prior to the implementation of the ERC, CCCA utilized non-ambulatory restraints in approximately 14% of all restraint incidents.[vii] After the ERC was introduced, CCCA's use of non-ambulatory restraints increased to 24% of all restraint incidents.

(See table 2 to the right)



dLCV's INVESTIGATION: COERCIVE TREATMENT PATTERNS

In 2015, dLCV received a report that a fourteen-year-old male resident of CCCA was injured during physical restraint and use of the ERC. Emergency personnel determined that his arm was fractured. Upon receipt of this report and complaint, dLCV launched an investigation, as authorized by federal law, into the circumstances surrounding the treatment of children at CCCA.

RESTRAINT OF RS

RS has been the victim of significant trauma and abuse throughout his fourteen years. He was admitted to CCCA on October 23, 2015. This was his second admission to CCCA and fifth hospitalization in six months.[viii] CCCA was aware of RS's trauma as his second admission was just two days after discharge from his first admission. CCCA documentation noted that RS's symptoms are likely related to anxiety, attachment disruptions, and trauma,[ix] and that RS struggles with anger, aggression, suicidal ideation and attempts[x] and self-injury.[xi] RS's diagnoses are noted as Unspecified Disruptive Behavior Disorder, Unspecified Mood Disorder, and Attention-Deficit/Hyperactivity Disorder.[xii]

Three days after his second admission, RS became combative with staff after he was not able to speak to his mother. CCCA staff restrained RS.[xiii] A Western State Hospital staff security personnel was called into aid in the incident. This security staff reported numerous staff "had control" of RS's right arm[xiv] during the four minutes RS struggled against staff. [xv] WSH security staff further relayed to CCCA that he could tell RS "was in a great deal of pain" but that he was unable to see the position of RS's arm due to the position of the other staff. RS continued to struggle against staff's hold to his arms and legs as he was forcibly placed into the ERC.

A CCCA Registered Nurse stated that, as staff were attaching the chair straps [she] thought [RS] said "my ribs popped" and only later realized that [RS] had said "wrist" as opposed to "ribs."[xvi] When interviewed, all CCCA direct-care staff present during the restraint reported hearing RS complain of pain to his arm but felt that his statements were "part of a provoking and resisting demeanor."[xvii] When RS was restrained in the ERC, his right arm was also strapped down despite his repeated assertions that he heard his wrist "pop" and "snap." At some point RS's right wrist was let out of the restraint strap for nursing assessment, although the time is unclear in CCCA documentation. RS was not allowed out of the ERC for fifty-one minutes, despite crying and repeated statements to staff that his arm was hurt.[xviii] Eventually RS was transported, in restraints,[xix] to the Augusta Health Emergency Room for assessment. Augusta Health Emergency Room x-rays denoted that RS's arm was fractured.[xx]

CCCA conducted an internal investigation of the incident and found no inappropriate or excessive force utilized by staff. CCCA concluded their internal investigation as unsubstantiated for staff abuse because they were not able to identify the time or instance in which RS's arm was fractured by staff. CCCA additionally stated that abuse did not occur as RS suffered a previous break to his arm five years prior. However, CCCA documented that it "is certainly conceivable" that RS's arm could have been broken during the restraint.[xxi] CCCA's investigation failed to note that the Code of Virginia cites abuse as any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to a [sic] individual with mental illness.[xxii]

Shortly after the fracture to his wrist, CCCA developed a "Special Program" for RS to establish continuity and safety as RS "faces absolute uncertainty in his life." CCCA documented that RS must "earn the privilege of being with the group." This "Special Program" detailed that RS receive programming "separate from the other kids, that the team would decide "on his privilege of joining the group." CCCA documented that RS was told he may experience seclusion or restraint while in his "Special Program." Additionally, to avoid contact with other units, RS was not allowed to utilize walks down the hallway or the gym.[xxiii] The "Special Program" created by CCCA leadership, as based upon privilege level and earning of inclusion with peers, denotes a lack of trauma-informed care and practice within CCCA.

CONCLUSION

CCCA has failed to promote a culture of trauma-informed care consistent with their self-professed "best practices". The pattern of abuse at CCCA in regard to the use of restraint constitutes a pattern of coercive treatment and lack of trauma-informed care. The introduction of the Emergency Restrain Chair for use in children is especially egregious. It is inherently dangerous and has no therapeutic benefit. The introduction of the ERC at CCCA has directly contributed to a dramatic increase of 163% in the overall number of non-ambulatory restraint incidents.

This failure is further demonstrated by the victimization and re-traumatization of RS. RS to receive adequate and appropriate treatment for their mental illnesses. This is just one story from the 712 incidents of restraint utilized at CCCA over a sixteen-month period. How many other stories are we unaware of? CCCA has failed to protect our children from harm, instead relying on abusive restraint and seclusion.

dLCV urges DBHDS to promptly take all necessary steps to ensure that children and youth at CCCA are safe, free from unlawful and abusive restraint, and receive services consistent with trauma-informed care principles.

- Immediate elimination of the use of the ERC on children and adolescents;
- Elimination of non-emergency uses of seclusion and restraint;
- Transparency with families, providers, and the public by publishing the seclusion and restraint usage; and
- Staff retraining on trauma-informed care principles.

[i] Please reference the Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801, et seq., and regulations thereto 42 C.F.R. § 51.1, et seq.
[ii] IMPACT. Ideas and Information to Promote the Health of Connecticut's Children., SAMHSA.
[iii] Substance Abuse and Mental Health Services Administration (SAMHSA).
[iv] CMS State Operations Manual – Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals.
[v] Substance Abuse and Mental Health Services Administration (SAMHSA).
[vi] Wilkinson, Cherry. Death in the Restraint Chair. 2004.
[vii] CCCA Seclusion and Restraint Data, acquired through DBHDS.
[viii] CCCA Discharge Summary, November 5, 2015.
[ix] CCCA Psychiatric Evaluation, October 23, 2015.
[x] CCCA Psychological Assessment, November 2, 2015.
[xi] CCCA Medical Evaluation, October 23, 2015.
[xii] CCCA Psychiatric Evaluation, October 23, 2015.
[xiii] CCCA Psychological Assessment, November 2, 2015.
[xiv] CCCA Internal Investigation, Investigator's Summary, November 24, 2015.
[xv] CCCA Seclusion and Restraint Flowsheet, October 26, 2015; CCCA Record of Restrictive Interventions.
[xvi] CCCA Internal Investigation, Investigator's Summary, November 24, 2015.
[xvii] CCCA Internal Investigation, Investigator's Summary, November 24, 2015.
[xviii] CCCA Seclusion and Restraint Flowsheet, October 26, 2015.
[xix] CCCA Physician's Orders, October 26, 2015.
[xx] Augusta Health Emergency Room Radiology Report, October 26, 2015.
[xxi] CCCA Internal Investigation, Investigator's Summary, November 24, 2015.
[xxii] 42 U.S.C. § 10802(1)
[xxiii] CCCA 1 Special Program, October 30, 2015.