M E M O R A N D U M

To: Interested Parties
From: Ned McCulloch
Date: February 1, 1999
Subject: Draft Physical Restraint Language

Attached is Draft 2 (and by no means the final draft) of a physical restrain bill.

The bill has two goals:

1) to extend standards on the use of restraints to mental health patients
2) to add a reporting requirement for deaths and serious injuries to mental health patients.

It is our intent to work off of existing law where ever possible. Therefore, the bill extends to the mental health population an existing standard from OBRA '87 that has proven workable for nursing homes and significantly reduced the use of restraints.[1] The reporting requirement likewise piggybacks on existing law – in this case, by adding to existing reporting to the ongoing reporting to accrediting bodies and HHS.

The provisions are applicable to all institutional providers in Medicare and Medicaid. The reporting requirement applies only to those sentinel events that are an "unexpected occurrence involving death or serious physical or psychological injury to an individual admitted to a provider of services for treatment for a psychiatric or psychological illness that is unrelated to the natural course of the individual's illness or underlying condition." The intention of this limiting definition is to make sure that injuries to mental health patients get reported without forcing reporting of all deaths (and injuries) in institutions.

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[1]OBRA '87 reads as follows

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed--

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

I would appreciate any feed back you can give. Needless to say, no bill is perfect and this draft represents a number of compromises. It will go through additional changes before introduction. Please do not circulate it because it does not represent the final product. In particular, this is a staff draft and does not carry with it any member endorsement or member scrutiny.

Please fax comments to Ned McCulloch at 228-0341 or e-mail to "Ned_McCulloch@Lieberman.Senate.Gov". For questions, call me at 224-4042.

106TH CONGRESS
1ST SESSION

S. _____

IN THE SENATE OF THE UNITED STATES

Mr. LIEBERMAN introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To amend titles XVIII and XIX of the Social Security Act to ensure that patients enjoy the right to be free from restraint, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "_____ Act of 1999".

SEC. 2. PATIENTS' RIGHT TO FREEDOM FROM RESTRAINT AND REPORTING OF SENTINEL EVENTS UNDER MEDICARE.

(a) IN GENERAL.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395x et seq.) is amended by adding at the end the following:

"PATIENTS' FREEDOM FROM RESTRAINT AND REPORTING OF SENTINEL EVENTS

"SEC. 1897. (a) IN GENERAL.—A provider of services eligible to be paid under this title for providing services to an individual entitled to benefits under part A or enrolled under part B (including an individual provided with a Medicare+Choice plan offered by a Medicare+Choice organization under part C) shall—

"(1) protect and promote the right of each such individual to be free from restraints in accordance with the requirements of section 1819(c)(1)(A)(ii); and

"(2) submit the reports required under subsection (b).

"(b) REPORTS.—

"(1) SENTINEL EVENTS.—

"(A) AGENCY OR ENTITY WITH OVERSIGHT AUTHORITY.—

"(i) IN GENERAL.—A provider of services shall report each sentinel event to

the agency or entity described in clause (ii) that has primary oversight jurisdiction over the provider.

"(ii) AGENCY OR ENTITY DESCRIBED.—The agency or entity described in this clause is as follows:

"(I) The Secretary.

"(II) The State Attorney General.

"(III) The primary accrediting body for the provider of services.

"(iii) DEFINITIONS.—In this section:

"[*review*] (I) PROVIDER OF SERVICES.—The term 'provider of services' has the meaning given that term in section 1861(u), [except that for purposes of this section the term does not include a home health agency].

[*Note: The term means a hospital, critical access hospital, skilled nursing facility, a comprehensive outpatient rehabilitation facility, and a hospice program.*]

"(II) SENTINEL EVENT.—The term 'sentinel event' means an unexpected occurrence involving death or serious physical or psychological injury to an individual admitted to a provider of services for treatment for a psychiatric or psychological illness that is unrelated to the natural course of the individual's illness or underlying condition.

"(B) INVESTIGATION AND REPORTING OF SENTINEL EVENTS.—Upon receipt of a report made pursuant to subparagraph (A), the agency or entity shall—

"(i) conduct an investigation of the sentinel event reported;

"(ii) determine the cause of the sentinel event;

"(iii) establish a time-limited procedure to correct the problem that resulted in the sentinel event (that allows for review and approval of analyses and corrective actions proposed and made by the provider of services); and

"(iv) prepare and submit a report in accordance with subparagraph (C).

"(C) REPORTS TO THE HEALTH CARE FRAUD AND ABUSE DATABASE.—

"(i) IN GENERAL.—Upon completion of the corrective procedure established under subparagraph (B)(iii), the agency or entity shall submit a report to the database established under section 1128E in accordance with the requirements of that section.

"(ii) ADDITIONAL INFORMATION TO BE REPORTED.—In addition to the information required under section 1128E(b)(2), the report submitted under clause (i) shall include a description of the corrective action taken by the provider of services with respect to the sentinel event and any other measures necessary to prevent similar sentinel events from occurring in the future.

"(2) ADDITIONAL REPORTING REQUIREMENTS FOR SENTINEL EVENTS RESULTING IN DEATH.—In addition to the reports required under paragraph

(1), a provider of services shall report any sentinel event resulting in death to—

"(A) the Secretary;

"(B) the State protection and advocacy system established pursuant to part C of title I of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6041 et seq.) for the State in which the event occurred; and

"(C) the relevant accrediting body for the provider.

(b) CONFORMING AMENDMENTS TO THE HEALTH CARE FRAUD AND ABUSE DATABASE.—Section 1128E of the Social Security Act (42 U.S.C. 1320a–7e) is amended—

(1) in subsection (d), by adding at the end the following:

"(3) ADDITIONAL ACCESS.—The Secretary shall provide by regulation for procedures under which health care researchers and the public may access the information maintained in the database with respect to information reported pursuant to section 1897(b)(1)(C)."; and

(2) in subsection (g)(3), by adding at the end the following:

"(G) Private accrediting bodies described in section 1897(b)(1)(A)(ii)(III).".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section take effect on the date of enactment of this Act.

(2) REPORTING REQUIREMENT.—The reporting requirement under section 1897(b) of the Social Security Act, as added by subsection (a), shall apply to sentinel events occurring on and after the date of enactment of this Act.

SEC. 3. PATIENTS' RIGHT TO FREEDOM FROM RESTRAINT AND REPORTING OF SENTINEL EVENTS UNDER MEDICAID.

(a) STATE PLANS FOR MEDICAL ASSISTANCE.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (65), by striking the period and inserting "; and"; and

(2) by adding at the end the following:

"(66) provide that the State will ensure that any institutional provider (as defined in section 1905(v)) that provides services to an individual for which medical assistance is available shall—

"(A) protect and promote the right of each individual to be free from restraints in accordance with the requirements of section 1919(c)(1)(A)(ii); and

"(B) submit the reports required under subsection (b) of section 1897 (relating to sentinel events) in the same manner as a provider of services under that section is required to submit such reports.".

(b) DEFINITION OF INSTITUTIONAL PROVIDER.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following:

"[*review*] (v) The term 'institutional provider' means an entity that provides hospital services, nursing facility services, services of intermediate care facilities for the mentally retarded, hospice care, or services in an institution for mental diseases.".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section take effect on the date of enactment of this Act.

(2) REPORTING REQUIREMENT.—The reporting requirement under section 1902(a)(66)(B) of the Social Security Act (42 U.S.C. 1396a(a)(66)(B)), as added by subsection (a), shall apply to sentinel

events occurring on and after the date of enactment of this Act.

(3) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with such requirements solely on the basis of its failure to meet the additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

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A Nationwide Pattern of Death

By ERIC M. WEISS
With reporting by Dave Altimari, Dwight F. Blint and Kathleen Megan
This story ran in The Courant on October 11, 1998

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Two Connecticut Deaths, Two Questionable Investigations

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Common Terms

Roshelle Clayborne pleaded for her life.

Slammed face-down on the floor, Clayborne's arms were yanked across her chest, her wrists gripped from behind by a mental health aide.

I can't breathe, the 16-year-old gasped.

Her last words were ignored.

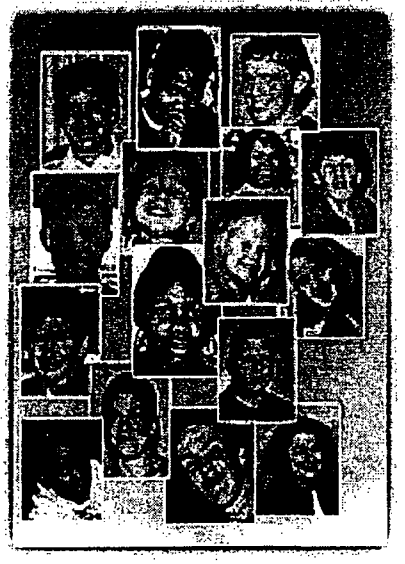
A syringe delivered 50 milligrams of Thorazine into her body and, with eight staffers watching, Clayborne became, suddenly, still. Blood trickled from the corner of her mouth as she lost control of her bodily functions.

Her limp body was rolled into a blanket and dumped in an 8-by-10-foot room used to seclude dangerous patients at the Laurel Ridge Residential Treatment Center in San Antonio, Texas.

The door clicked behind her.

No one watched her die.

For The Record: 11 Months, 23 Dead



Click on picture to see profiles.

But Roshelle Clayborne is not alone. Across the country, hundreds of patients have died after being restrained in psychiatric and mental retardation facilities, many of them in strikingly similar circumstances, a Courant investigation has found.

They died pinned down on the floor by hospital aides until the breath of life was crushed from their lungs. They died strapped to beds and chairs with thick leather belts, ignored until they strangled or their hearts gave out.

Those who died were disproportionately young. They entered our health care system as troubled children. They left in coffins.

All of them died at the hands of those who are supposed to protect, in places intended to give sanctuary.

If Roshelle Clayborne's death last summer was not an isolated incident, neither were the recent deaths of Connecticut's Andrew McClain or Robert Rollins.

A **50-state survey by The Courant,** the first of its kind ever conducted, has confirmed 142 deaths during or shortly after restraint or seclusion in the past decade. The survey focused on mental health and mental retardation facilities and group homes

nationwide.

But because many of these cases go unreported, the actual number of deaths during or after restraint is many times higher.

Between 50 and 150 such deaths occur every year across the country, according to a statistical estimate commissioned by The Courant and conducted by a research specialist at the Harvard Center for Risk Analysis.

That's one to three deaths every week, 500 to 1,500 in the past decade, the study shows.

"It's going on all around the country," said Dr. Jack Zusman, a psychiatrist and author of a book on restraint policy.

The nationwide trail of death leads from a 6-year-old boy in California to a 45-year-old mother of four in Utah, from a private treatment center in the deserts of Arizona to a public psychiatric hospital in the pastures of Wisconsin.

In some cases, patients died in ways and for reasons that defy common sense: a towel wrapped around the mouth of a 16-year-old boy; a 15-year-old girl wrestled to the ground after she wouldn't give up a family photograph.

Many of the actions would land a parent in jail, yet staffers and facilities were rarely punished.

"I raised my child for 17 years and I never had to restrain her, so I don't know what gave them the right to do it," said Barbara Young, whose daughter Kelly died in the Brisbane Child Treatment Center in New Jersey.

The pattern revealed by The Courant has gone either unobserved or willfully ignored by regulators, by health officials, by the legal system.

The federal government -- which closely monitors the size of eggs -- does not collect data on how many patients are killed by a procedure that is used every day in psychiatric and mental retardation facilities across the country.

Neither do state regulators, academics or accreditation agencies.

"Right now we don't have those numbers," said Ken August of the California Department of Health Services, "and we don't have a way to get at them."

The regulators don't ask, and the hospitals don't tell.

As more patients with mental disabilities are moved from public institutions into smaller, mostly private facilities, the need for stronger oversight and uniform standards is greater than ever.

"Patients increasingly are not in hospitals but in contract facilities where no one has the vaguest idea of what is going on," said Dr. E. Fuller Torrey, a nationally prominent psychiatrist, author and critic of the mental health care system.

Because nobody is tracking these tragedies, many restraint-related deaths go unreported not only to the government, but sometimes to the families themselves.

"There is always some reticence on reporting problems because of the litigious nature of society," acknowledged Dr. Donald M. Nielsen, a senior vice president of the American Hospital Association. "I think the question is not one of reporting, but making sure there are systems in place to prevent these deaths."

Typically, though, hospitals dismiss restraint-related deaths as unfortunate flukes, not as a systemic issue. After all, they say, these patients are troubled, ill and sometimes violent.

The facility where Roshelle Clayborne died insists her death had nothing to do with the restraint. Officials there say it was a heart condition that killed the 16-year-old on Aug. 18, 1997.

Bexar County Medical Examiner Vincent DiMaio ruled that Clayborne died of natural causes, saying that restraint use was a separate "clinical issue."

But that, too, is typical in restraint cases. Medical examiners rarely connect the circumstances of the restraint to the physical cause of death, making these cases impossible to track through death certificates.

The explanations don't wash with Clayborne's grandmother.

"I'll picture her lying on that floor until the day I die," Charlene Miles said. "Roshelle had her share of problems, but good God, no one deserves to die like that."

With nobody tracking, nobody telling, nobody watching, the same deadly errors are allowed to occur again and again.

Of the 142 restraint-related deaths confirmed by The Courant's investigation:

Twenty-three people died after being restrained in face-down floor holds.

Another 20 died after they were tied up in leather wrist and ankle cuffs or vests, and ignored for hours.

Causes of death could be confirmed in 125 cases. Of those patients, 33 percent died of asphyxia, another 26 percent died of cardiac-related causes.

Ages could be confirmed in 114 cases. More than 26 percent of those were children -- nearly twice the proportion they constitute in mental health institutions.

Many of the victims were so mentally or physically impaired they could not fend for themselves. Others had to be restrained after they erupted violently, without warning and for little reason.

Caring for these patients is a difficult and dangerous job, even for the best-trained workers. Staffers can suddenly find themselves the target of a thrown chair, a punch, a bite from an HIV-positive patient.

Yet the great tragedy is that many of the deaths could have been prevented by setting standards that are neither costly nor difficult: better training in restraint use; constant or frequent monitoring of patients in restraints; the banning of dangerous techniques such as face-down floor holds; CPR training for all direct-care workers.

"When you look at the statistics and realize there's a pattern, you need to start finding out why," said Dr. Rod Munoz, president of the American Psychiatric Association, when told of The Courant's findings. "We have to take action."

Mental health providers, who treat more than 9 million patients a year at an annual cost of more than $30 billion, judge themselves by the humanity of their care. So the misuse of restraints -- and the contributing factors, such as poor training and staffing -- offers a disturbing window into the overall quality of the nation's mental health system.

For their part, health care officials say restraints are used less frequently and more compassionately than ever before.

"When it comes to restraints, the public has a picture of medieval things, chains and dungeons," said Dr. Kenneth Marcus, psychiatrist in chief at Connecticut Valley Hospital in Middletown. "But it really isn't. Restraints are used to physically stabilize patients, to prevent them from being assaultive or hurting themselves."

But in case after case reviewed by The Courant, court and medical documents show that restraints are still used far too often and for all the wrong reasons: for discipline, for punishment, for the convenience of staff.

"As a nation we get all up in arms reading about human rights issues on the other side of the world, but there are some basic human rights issues that need attention right here at our back door," said Jean Allen, the adoptive mother of Tristan Sovern, a North Carolina teen who died after aides wrapped a towel and bed sheet around his head.

Others have a simple explanation for the lack of attention paid to deaths in mental health facilities.

"These are the most devalued, disenfranchised people that you can imagine," said Ron Honberg, director of legal affairs for the National Alliance of the Mentally Ill. "They are so out of sight, so out of mind, so devoid of rights, really. Who cares about them anyway?"

Few seemed to care much about Roshelle Clayborne at Laurel Ridge, where she was known as a "hell raiser."

But Clayborne had made one close friendship -- with her roommate, Lisa Allen. Allen remembers showing Clayborne how to throw a football during afternoon recess on that summer afternoon in 1997.

"She just couldn't seem to get it right and she was getting more and more frustrated. But I told her it was OK, we'd try again tomorrow," said Allen, who has since rejoined her family in Indiana.

Within three hours, Clayborne was dead.

She had attacked staff members with pencils. And staffers had a routine for hell raisers.

"This is the way we do it with Roshelle," a worker later told state regulators. "Boom, boom, boom: [medications] and restraints and seclusion."

After she was restrained, Roshelle Clayborne lay in her own waste and vomit for five minutes before anyone noticed she hadn't moved. Three staffers tried in vain to find a pulse. Two went looking for a ventilation mask and oxygen bag, emergency equipment they never found.

During all this time, no one started CPR.

"It wouldn't have worked anyway," Vanessa Lewis, the licensed vocational nurse on duty, later declared to state regulators.

By the time a registered nurse arrived and began CPR, it was too late. Clayborne never revived.

In their final report on Clayborne's death, Texas state regulators cited Laurel Ridge for five serious violations and found staff failed to protect her health and safety during the restraint. They recommended Laurel Ridge be closed.

Instead, the state placed Laurel Ridge on a one-year probation in February and the center remains open for business. In a prepared statement, Laurel Ridge said it has complied with the state's concerns -- and it pointed out the difficulty in treating someone with Clayborne's background.

"Roshelle Clayborne, a ward of the state, had a very troubled and extensive psychiatric history, which is why Laurel Ridge was chosen to treat her," the statement said. "Roshelle's death was a tragic event and we empathize with the family."

With no criminal prosecution and little regulatory action, the Clayborne family is now suing in civil court. The Austin chapter of the NAACP and the private watchdog group Citizens Human Rights Commission of Texas are asking for a federal civil rights investigation into the death of Clayborne.

Medications and restraint and seclusion.

Clayborne's friend, Lisa Allen, knew the routine well, too.

For six years, Allen, now 18, lived in mental health facilities in Indiana and Texas, where her explosive personality would often boil over and land her in trouble.

By her own estimate, Allen was restrained "thousands" of times and she bears the scars to prove it: a mark on her knee from a rug burn when she was restrained on a carpet; the loss of part of a birthmark on her forehead when she was slammed against a concrete wall.

Exactly two weeks after Roshelle Clayborne's death, Lisa Allen found herself in the same position as her friend.

The same aide had pinned her arms across her chest. Thorazine was pumped into her system. She was deposited in the seclusion room.

"It felt like my lungs were being squished together," Allen said.

But Lisa Allen was one of the lucky ones.

She survived.

Additional research was contributed by Sandy Mehlhorn, Jerry LePore and John Springer

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A Different Kind Of Restraint: Understanding

A Vicious Cycle Of Stifling Anger

Lesson And Legacy In Iowa Boy's Death

Who Died And How

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Improper Technique

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Common Terms

Why They Die

Little Training, Few Standards, Poor Staffing Put Lives At Risk

By KATHLEEN MEGAN and DWIGHT F. BLINT
With reporting by Dave Altimari
This story ran in The Courant on October 12, 1998

She was a 15-year-old patient, alone in a new and frightening place, clutching a comforting picture from home.

He was a 200-pound mental health aide bent on enforcing the rules, and the rules said no pictures. She defied him; the dispute escalated.

And for that, Edith Campos died. She was crushed face down on the floor in a "therapeutic hold" applied by a man twice her size.

Shy and well-behaved as a girl growing up in Southern California, Edith had problems as a teen. She ran away, took drugs, hung with the wrong crowd. Her family hoped treatment at the Desert Hills psychiatric center in Tucson, Ariz., would help.

WESTERN STATE HOSPITAL, a 375-bed facility in Staunton, Va., is part of a federal investigation into the quality of mental health care throughout Virginia. Here, a patient in Western's forensic unit, naps in his room.

But Edith Campos died -- as did Andrew McClain and Roshelle Clayborne and countless others -- when a trivial transgression spiraled into violence. Too often, it's a reaction built right into our system that cares for people with psychiatric problems and mental retardation.

The people who make and execute the critical decisions to use physical force or strap a patient to a bed or chair are often aides, the least-trained and lowest-paid workers in the field.

They must make instantaneous decisions affecting patients' physical and psychological well-being against a backdrop of staffing cuts that result more in crowd control than in patient therapy.

"I can't understand why patients don't die more often with all the things that happen on a daily basis," said Wesley B. Crenshaw, a psychologist who has conducted one of the few national surveys on restraint use.

"You have people who are 'cowboying' it," Crenshaw said, "people who really want to get in there and show they're the boss."

Yet only three states -- California, Colorado and Kansas -- actively license aides in psychiatric facilities. Licensing of aides is nearly non-existent in the mental retardation field as well, allthough a handful of states do certify aides.

So, while individual states and facilities may set their own standards, there is no uniform, minimum training for psychiatric or mental retardation aides nationwide -- even in life-saving techniques such as CPR.

In the Edith Campos case, aide Daniel Thomas Walsh successfully fought negligent homicide charges by arguing he had followed hospital guidelines. And the guidelines didn't say he needed to watch Edith's face for signs of distress, the judge found.

"It was a tragedy that this girl died in our care," said Kirke Cooper, director of business development for Desert Hills. "But I don't feel there was any wrongdoing on the part of our staff. They are all well-trained in physical control and seclusion."

Done correctly, a restraint can protect a patient and worker from harm. Done under the right circumstances, patients say, it can be beneficial.

Yet too often, it is done badly and for the wrong reasons. Nowhere is this tragedy more apparent than in the deaths of children.

A Courant investigation has found more than 26 percent of restraint-related deaths over the past decade involved patients 17 and under. Yet children make up less than 15 percent of the population in psychiatric and mental retardation facilities, according to federal statistics.

The death rate should come as no surprise.

"You can't believe how many times a kid gets slammed into restraints because an argument will ensue after calling a staff member a name," said Wanda Mohr, director of psychiatric mental health nursing at the University of Pennsylvania.

She and other analysts say children disproportionately bear the brunt of the misuse and overuse of restraints. A 1995 New York study, for instance, found children almost twice as likely as adults to be restrained.

"It's socially acceptable to spank and punish children," said Mohr, reflecting the responses of other experts who say our culture tolerates a physical response to unruly children.

Yet children are both a vulnerable and challenging population.

Firm diagnoses often cannot be made until late adolescence or early adulthood, so providers are less sure how to treat children. And many troubled children enter the mental health system with histories of physical or sexual abuse -- so even the threat of physical force can be traumatizing.

For their part, many patients say improper or frequent use of restraints hurts their recovery and defeats the very reason they were admitted. In interviews with more than a dozen children and adults, The Courant's investigation found these patients were left confused, angry and afraid.

They rarely felt better.

Researchers are finding the same. In a 1994 New York study, 94 percent of patients restrained or placed in seclusion had at least one complaint about the process. Half complained of unnecessary force, 40 percent cited psychological abuse.

In a study published this year, Mohr interviewed children after their hospital stays and found many were further traumatized when they were restrained or secluded -- or even watching others undergo the procedure. Usually, she found, children saw such treatment as punishment.

The leader of the nation's psychiatric association acknowledged the problem.

"It must be especially frightening for a child," said Dr. Rod Munoz, president of the American Psychiatric Association. "It's a struggle of wills where the most powerful win."

And troubled children are the ones who lose.

Elaina Huckin, 17, of Granby, Conn., is still so disturbed by a restraint five years ago that she can barely speak about it. She was put in a "body bag," a sort of neck-to-toe straitjacket.

"They tie you in it. They pull it tighter and tighter. I couldn't move to breathe," Huckin said. "I was screaming and pleading, 'Somebody, please, somebody take me out.'

"It made you so much more suicidal," she said.

As mental health aides take this step that can do such physical and psychological harm, they are poorly monitored much of the time.

ELAINA HUCKIN, 17, still has nightmares about being restrained in a body bag – a sort of neck-to-toe straitjacket – five years ago. Huckin was last hospitalized in February 1996. She posed for this photo with her mother, Karen Huckin, at their home in Granby.

Although most institutions require a supervisor to oversee a physical restraint, The Courant found such rules are often ignored.

When 11-year-old Andrew McClain was restrained last March at Elmcrest psychiatric hospital in Portland, Conn., the duty nurse sat nearby eating breakfast. She ignored the initial cries of distress from Andrew, whose chest was crushed during the restraint.

The decision to strap a patient to a bed or chair, or cuff their hands, must be cleared by a doctor, according to many hospital and state policies. If a doctor is not available, efforts must be made to contact one as soon as possible.

But in more than a dozen cases reviewed by The Courant, patients were tied to their bed or chair for several hours at a time without regular review by a physician.

Mental health advocates say doctors must keep a closer eye on how long their patients are restrained.

"The ultimate responsibility falls to the doctors, who are supposedly the kings in these places," said Curtis L. Decker, executive director of an organization representing patient advocates nationwide. "They're in control and ought to exercise their authority."

Yet in certain facilities, physicians give staffers virtual carte blanche by issuing an order to restrain as needed.

"It's a go-ahead to slap restraints on a person without evaluating why the patient was acting up in the first place," said Dr. Moira Dolan, a medical consultant in Texas, where standing restraint orders are allowed in certain facilities. "There's no guidance on when to restrain someone."

Despite such responsibility, minimum hiring standards are few and pay is typically low for aides. A survey by The Courant last spring, for example, found aides were paid as little as $10 per hour in Connecticut.

When federal investigators began looking into the quality of care at Western State Hospital in Staunton, Va., last summer they found the $15,000 starting pay was less than what an employee could make at the nearby department store.

"When you can make $10 an hour working at the new Target," asked union representative Allen Layman, "what incentive is there to come here?"

Especially when the work can be demanding and dangerous.

For every 100 mental health aides, 26 injuries were reported in a three-state survey done in 1996. The injury rate was higher than what was found among workers in the lumber, construction and mining industries.

"Depending on the situation, it's scary, it's violent," said David Lucier, a veteran mental health worker at Natchaug Hospital in Mansfield, Conn. "Oftentimes, patients are kicking and punching and spitting and verbally abusive."

Over a 19-year career, Lucier said, he has developed communication skills that allow him to rarely touch patients. The skills described by Lucier are gained by training and by understanding the patients.

At some hospitals, though, staff are moved about like pawns in a chess game, leaving them little chance to know their patients.

To fill less-desirable shifts such as weekends, institutions use less-trained, part-time workers. When faced with wide fluctuations in the numbers of patients, they resort to shuffling workers from one unit to another.

A staff shortage landed aide Spero Parasco on Andrew McClain's unit March 22.

Parasco, who usually worked with adults, had never met Andrew before that morning at breakfast and had not read the child's medical chart. Indeed, Andrew's ward that Sunday was staffed largely with part-time workers.

So when Andrew defied Parasco's instructions to move to another table at breakfast, the dispute escalated into a "power struggle." Had workers known more about Andrew, had Parasco been better-versed in ways to calm him, the boy would not have died, a state investigation concluded.

Better staffing also reduces the risk of a restraint, like the face-down floor hold in which Andrew died.

The American Psychiatric Association recommends at least five people -- one for each limb, plus someone to watch -- be involved in any physical restraint.

That would have been nearly impossible in Andrew's case. A total of five staffers were on duty in the unit that Sunday morning, overseeing 26 children. As it was, just two aides were involved in Andrew's restraint.

"A takedown requires four staff members and, with staff cuts being made at many institutions, they end up with only two people doing the work of four people," said Tom Gallagher of the Indiana Protection & Advocacy Services office. "That's when problems occur."

At least six of 23 recent deaths reviewed in depth by The Courant occurred during a restraint executed by only one or two people. Another six patients died in seclusion or mechanical restraints after being left, unmonitored, for several minutes or more.

"Hospitals have cut their staffing to a bare minimum," said Dr. David Fassler, a psychiatrist, author and chairman of the Council

on Children, Adolescents and Their Families. The same fiscal pressures, he said, have led institutions to reduce training as well.

All this at a time when patients particularly need skilled help. As managed care limits access to hospitals, most analysts say patients are entering the system in more troubled conditions than ever before.

In the wards, staffers feel the pressure.

Pausing during a recent double shift at Western State Hospital in Virginia, a 375-bed facility for adults, nurse Judy Cook talked about the need to devote time to patients.

"Every time we've had a downsizing of staff we've had an increase in restraints and seclusions," said Cook, who has seen 23 years of trends at Western. "When you have more staff you can intercede better and you don't have to just place someone in restraints to calm them down."

But reducing the use of restraints requires a financial and philosophical commitment -- a commitment to use force only as a last resort, and only by well-trained staff who care about the patient.

Across the nation, the commitment is too often absent.

Last summer, a staff shortage at Western State forced nurses to call on security guards to help perform restraints. One guard, who didn't want his name used, showed little interest in the patients he might forcibly restrain.

Or much interest in doing it correctly.

"I didn't get hired," he said, "for all this bull-crap interacting with people or tackling psychotic patients."

Courant Staff Writer Eric M. Weiss contributed to this story.

Patients suffer in a system without oversight

By ERIC M. WEISS and DAVE ALTIMARI
This story ran in The Courant on October 13, 1998


Gloria Huntley

Had Gloria Huntley been able to move, had she not been bound to her bed with leather straps for days on end, perhaps she would have tried to draw the attention of the inspectors who were conducting a three-day tour of Central State Hospital.

Had she been able to move, had she not been pinned down by the wrists and ankles, she might have held up a sign, as she had done before when a visitor came through Ward 7. Her handwritten plea was simple: "Pray for me. I'm dying."

But the inspection team from the nation's leading accreditation agency never noticed Gloria Huntley before leaving the Petersburg, Va., psychiatric hospital.

The three inspectors from the Joint Commission on the Accreditation of Healthcare Organizations issued Central State a glowing report card -- 92 out of 100 points. They also bestowed the commission's highest ranking for patients' rights and care when they concluded their review on June 28, 1996.

The next day, Gloria Huntley died. She was 31.

Her heart, fatally weakened by the constant use of restraints, had inflamed to 1 1/2 times its normal size. In her last two months, she'd been restrained 558 hours -- the equivalent of 23 full days.

Nine months later, the Joint Commission gave Central State an even better score in a follow-up review -- even though Huntley's treatment would ultimately be labeled "inhumane" by the state of Virginia and condemned by the U.S. Justice Department.

"How could JCAHO give Central State the highest rating in human rights when they were killing people?" asked Val Marsh, director of the Virginia Alliance for the Mentally Ill.

The way the country's health care system works, how could it not?

The Courant's nationwide investigation of restraint-related deaths underscores just how faulty -- how rife with conflicts of interest, how self-protective, how ultimately ineffective -- the system of industry oversight and government regulation really is.

The health care industry is left to police itself, but often doesn't.

Time and again, The Courant found, when it comes to the quality and safety of patient care, the interests of the industry far outweigh the public interest.

"One reason you have overuse and misuse of restraints is because oversight is practically nonexistent," said Dr. E. Fuller Torrey, a nationally prominent psychiatrist and author of several books critical of the nation's mental health system. "And the health

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industry doesn't want oversight."

The chain of agencies, boards and advocates that is supposed to provide oversight -- the kind of oversight that might have prevented Huntley's death and hundreds like it -- often breaks down in multiple places.

But the heavy reliance on the Joint Commission -- an industry group that acts as the nation's de facto regulator -- lies at the core of the problem.

The federal government relies on the private nonprofit agency's seal of approval for a psychiatric hospital's acceptance into Medicare and Medicaid programs. And 43 states, including Connecticut, accept it as meeting most or all of its licensing requirements.

But the Joint Commission doesn't answer to Congress or the public. It answers to the health care industry.

The Joint Commission was founded in 1951 by hospital and medical organizations, whose members still dominate the commission's board of directors. The commission is funded by the same hospitals it inspects.

How tough are its inspections?

Of the more than 5,000 general and psychiatric hospitals that the Joint Commission inspected between 1995 and 1997, none lost its accreditation as a result of the agency's regular inspections.

None.

When extraordinary circumstances arise -- a questionable death, for instance -- the Joint Commission may conduct additional inspections. Even then, less than 1 percent of facilities overall lost accreditation.

Central State was not among them.

Joint Commission officials are the first to say they are not regulators. Participation is voluntary, and 83 percent of hospitals inspected were found to have shortcomings that needed to be addressed.

"Joint Commission accreditation is intended to say to the patient: This is a place that does things well and is constantly working to improve things," said Dr. Paul M. Schyve, a psychiatrist and senior vice president of the Joint Commission.

If the industry is not adequately watching itself, neither is the government. The nation's top mental health official says he has little latitude when it comes to tougher regulation and oversight.

"Most rules governing health care have been left to the states," said Dr. Bernard S. Arons, director of the U.S. Center for Mental Health Services.

When it comes to mental retardation facilities, in fact, inspection is left largely to the states.

But their record is not much better.

The General Accounting Office, the investigative arm of Congress, has found that state regulators are loath to punish state-run facilities.

In a study of state mental retardation centers, the GAO found "instances in which state surveyors were pressured by officials in their own and in other state agencies to overlook problems or downplay the seriousness of deficient care in large state institutions."

When state regulators do show up, their inspections are scheduled with such predictability that facilities can beef up staff, improve services and even apply fresh coats of paint. Often, only the new paint remains after the inspectors leave.

"These visits provide only a snapshot," said William J. Scanlon, director of health care studies for the GAO. "And it may be a doctored snapshot."

It is only when the system utterly collapses, as in the Gloria Huntley case, that the federal government intervenes to set rules for patient care.

Justice Department abuse investigators, who have authority to intercede when civil rights violations are suspected in publicly run facilities, often find these same facilities were recently given clean bills of health by licensing agencies or the Joint Commission.

"The use of restraints is clearly a very big problem and a very significant issue in nearly all of the institutions we investigate," said Robinsue Froehboese, the top abuse investigator at the Justice Department.

But with a staff of 22 attorneys, Froehboese's office can undertake only a handful of major investigations each year.

"Nineteenth-century England had a better oversight system than we have now," said Torrey, describing an English system that used full-time government inspectors to check every psychiatric facility without prior notice.

At Central State, the warning signs should have been apparent. But Joint Commission inspectors review just a sampling of patient records -- a sampling that may not include problem cases like Gloria Huntley's.

Anyone who did look at Huntley's records would have known her health was failing -- and that heavy use of restraints was a primary reason.

Two years before Huntley's death, a doctor warned officials at Central State that she would die if they didn't change her restraint plan.

"Staff members should watch their conscience, and those in charge must always remember that following physical struggle and emotional strain, the patient may die in restraints," stated the ominously titled "duty to warn" letter.

Even if the Joint Commission inspectors had missed Huntley in particular, there were other cases at Central State that should have raised red flags. One patient was restrained for 1,727 hours over an eight-month period, yet another for 720 hours over a four-month period, according to a U.S. Justice Department report.

So, in many respects, the investigation into Huntley's death is most remarkable in that it happened at all. When she died on June 29, 1996, the police were never called.

It took a hospital employee's anonymous call to a citizens watchdog group, days after Huntley's death, to tip off the outside world that she died while being restrained -- and not in her sleep as hospital officials told family members.

The Courant's investigation found at least six cases in which facilities, wary of lawsuits and negative publicity, tried to cover up or obscure the circumstances of a restraint-related death.

"It's sort of a secretive thing," said Dr. Rod Munoz, president of the American Psychiatric Association. "Every hospital tries to protect itself."

"The incentive is to settle with the family, fix it internally and move

on," said Dr. Thomas Garthwaite, deputy undersecretary of health for the U.S. Department of Veterans Affairs.

Many states, including Connecticut, have laws that shield discussions among doctors that explore what went wrong. The laws are designed to promote candid discussions, but the solutions often don't leave the closed hospital conference room.

Garthwaite and other experts said hospitals need to share problems and solutions to prevent deadly errors from being repeated. Just a year ago, the VA began a comprehensive system to track all deaths and mistakes.

But a plan by the Joint Commission to do the same all across the nation has been stymied so far by the powerful American Hospital Association.

The AHA notified the Joint Commission in January that the proposal had created a "firestorm" among its members, who worried that they would have to turn over "self-incriminating" documents.

"We've tried to make the program workable, so people would not be afraid to report on a voluntary basis," said Dr. Donald M. Nielsen, a senior vice president of the American Hospital Association. He said the two groups agreed last month on some ground rules regarding the issue.

With the industry failing to monitor itself, with government regulators unwilling to challenge the industry, uncovering abuse is left to "protection and advocacy" agencies established by Congress in each state.

Despite $22 million in federal funding this year and broad authority to root out and litigate cases of abuse, even some advocates turn a blind eye to investigating deaths.

Desperate for help, Gloria Huntley turned to one of these organizations in her last months of life.

Not only was her complaint not investigated, but three weeks after her death Huntley was sent a letter saying the advocacy agency was dropping her case because it hadn't heard from her in 90 days.

The letter ends: "It was a pleasure working with you to resolve your complaint. I wish you the best of luck in your future endeavors."

Advocates say they have too little funding for their broad charge, and are fought every step of the way by hospitals and doctor groups. Scarce money and staffing are used just to secure basic information.

"It's a David and Goliath battle," said Curtis L. Decker, executive director of the group representing advocacy organizations nationwide. "And Goliath is winning."

Hospitals see no need for drastic change, let alone more government intervention.

"Given the speed of government, it is often better to allow the private market to work issues out," said Nielsen of the AHA. "Joint Commission standards have been revised recently and are continually being improved."

Huntley's family might take issue with that assessment. They have filed a civil rights lawsuit in federal court seeking $2 million, and a wrongful death lawsuit in state court seeking $450,000.

"We knew from the get-go things weren't right when they told us she died in her sleep," said Paige Griggs, Huntley's sister-in-law.

"We thought she was being taken care of."

Courant Staff Writers Kathleen Megan and Dwight F. Blint contributed to this story.

'People Die And Nothing Is Done'

By DAVE ALTIMARI
With reporting by Dwight F. Blint and John Springer
This story ran in The Courant on October 14, 1998

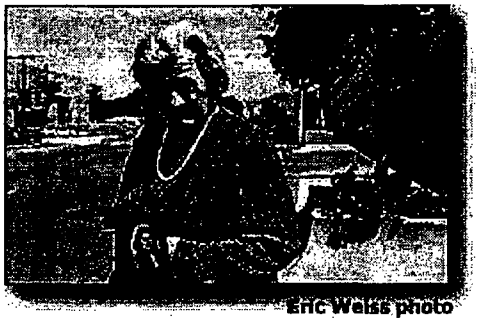
Sheriff Geno D'Angelo remembers the first time staffers at the Broome Developmental Center in Binghamton, N.Y., called his office for help last year.

A deer had been killed by a car in front of the center the evening of Nov. 24. The staff wanted it removed.

But no one from the state mental health facility had called D'Angelo four months earlier when William Roberts fell to his side, vomited and died after being restrained in a timeout room.

"I wonder how many of these deaths occur at that facility or others in this state that [police] never know about," said D'Angelo, who first learned about the death from a Courant reporter.

The Courant's investigation has found the nation's legal system falters time and again when it comes to restraint-related deaths. Just as the medical establishment fails to provide the kind of internal oversight that might prevent patients from dying, the legal system offers little hope for justice after they are dead.


Eric Weiss photo

ALVINA GAUTHIER and her family fought for a thorough investigation of the death of her daughter Sandra Gordon at the Rosewood Terrace Care Center in Salt Lake City in January. After an autopsy, the 45-year-old woman's death -- originally deemed an accident -- was ruled a homicide. The state of Utah eventually closed the facility. **Please See Story.**

Law enforcement officials, lawyers and mental health advocates say it isn't always easy, or appropriate, to place blame on the ill-trained mental health aides who typically execute restraints.

But without thorough investigation, the system too often fails to determine whether a death is a tragic accident or an act of criminal negligence. And whatever the circumstances, they say, patients' families are entitled to answers.

Yet the normal investigative process falls apart at each step, The Courant found.

Hospital workers cover up or obscure the circumstances of a death. Autopsies are not automatically performed. Police are not routinely summoned. Investigators often defer to the explanations offered by the institutions involved.

"It's easier to just say it was an accident and forget about it," said Michael Baden, a former New York state medical examiner who now serves on a state board that investigates deaths in institutions.

Thus, few are ever punished. Prosecutors rarely pursue arrests in

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restraint deaths and, when they do, they typically accept plea bargains to minor charges.

"The way the system runs, people die and then nothing is done about it," said Raul Campos, whose 15-year-old daughter, Edith, died while restrained in a dispute over a photograph.

Hers was a rare case in which criminal charges were filed. But an Arizona judge found restraint deaths are such a "rarity" that it would have been unreasonable to expect the aide to notice Edith's distress. He tossed the case out.

Families of dead patients, angry with the lack of accountability in the criminal justice system, then turn to civil court where they face one last obstacle to justice: jurors who must place a monetary worth on people at the bottom rung of society.

"The law is not disability-friendly. If you're disabled or mentally retarded, you don't have any value," said Pennsylvania attorney Ron Costen, who represents families in abuse cases.

A former prosecutor, Costen is familiar with the flaws of criminal investigations into restraint deaths.

Among the common problems he cited: Scenes are not preserved because staff immediately clean up the room where the restraint occurred. Staffers develop a story emphasizing the patient's existing physical problems. And workers say they were just protecting themselves or others from harm, making it hard to prove criminal intent.

Others have found staffers reluctant to blow the whistle on colleagues.

"Despite the legal and ethical obligations to report and protect patients from abuse, a strong code of silence among direct care staff still exists," California investigators found last year after an investigation into restraint abuses at Napa State Hospital. Two people have died in restraint-related incidents at Napa State in the past six years.

The California report found a system rotting from within. It cited a survey in which two-thirds of psychiatric aides statewide believe there to be a "code of silence." Workers, the report said, consider themselves victims of a bad and abusive system.

In Pennsylvania, Costen intends to propose legislation to put the system, corporations and administrators, on trial -- and not simply the low-paid aides who work for them.

"We have to make it possible to attack the corporate structure and hold them accountable for criminal actions," Costen said. His proposal would carry no prison sentence, instead fining corporations or, in the worst cases, putting them out of business.

But punishment can only follow investigation. Police and prosecutors typically rely on medical examiners to trigger a criminal case by issuing a homicide ruling. The trigger is infrequently pulled.

In 23 recent deaths examined in depth by The Courant, only three were ruled homicides. In the other cases, including the Binghamton death, medical examiners ruled the deaths to be accidental or attributed them to the patient's existing medical problems.

Baden, of New York, said these rulings fail to take into account the full context in which the patient died.

"Positional asphyxiation has this very nice ring to it," said Baden, referring to a common cause of death in restraint cases. "Like maybe somebody did it to themselves instead of their chests being compressed."

Most medical examiners say they struggle with restraint cases, but

ultimately cannot issue a homicide ruling if staffers are working within the scope of their jobs.

"It's difficult to say whether a hold put on a person has any role in their death unless it's clear-cut they were doing the hold wrong," said Vincent DiMaio, the Texas medical examiner who ruled that Roshelle Clayborne died of natural causes after being restrained in a San Antonio, Texas, facility.

Such clarity is nearly impossible. Across the country, The Courant has found, there are no clear, uniform standards on restraint use, and no minimum training standards for staffers.

So prosecution is rare, too.

"If a medical examiner rules a death accidental or by natural causes, it does make getting a criminal indictment more unlikely than not," said John Loughrey, a prosecutor in Monmouth County, N.J.

In June, Loughrey presented to a grand jury his case against two staffers at the Brisbane Child Treatment Center. Staffers said 17-year-old Kelly Young's hair was hiding her face during a restraint -- so they didn't notice that her lips were turning blue.

But the grand jury refused to issue indictments after hearing the death had been ruled accidental.

Faced with unfamiliar cases that are difficult to prove, most prosecutors simply shy away.

"There's enormous variability from state to state and even county to county on what the district attorney feels is a prosecutable offense," said Robinsue Froehboese, the U.S. Justice Department's top abuse investigator.

"Unfortunately," she said, "the jurisdictions that don't prosecute these cases far outweigh those who do."

Take the case of Melissa Neyman of Tacoma, Wash.

Gerald A. Horne, a Pierce County prosecutor, would not pursue charges in Neyman's death -- even though the state attorney general's office urged criminal prosecution against the owner and a worker at the Judith Young Adult Family Home.

Tied to her bed in a makeshift restraint on the night of July 23, 1997, Neyman managed to climb out a window before becoming entangled in the straps. The 19-year-old autistic woman had been dead six hours before workers finally noticed her -- hanging from the window about 3 or 4 feet from the ground.

"We don't charge persons who had goodwill and were doing the best job they could," Horne said.

"They didn't have any intent to hurt anybody."

But the staffer did put Neyman in a restraint without a physician's permission – a direct violation of Washington state law. The same staffer was not authorized to care for clients, did not check on Neyman for several hours, and lied to investigators about the circumstances of the death, the attorney general's office found.

When prosecutors do press charges or get indictments from grand juries, they rarely follow through and go to trial. More often they settle for a plea bargain that calls for no jail time.

Kimberlye Montgomery was originally charged with involuntary manslaughter and gross negligence, a felony with a maximum 15-year sentence, in the restraint death of 9-year-old Earl Smith in Detroit in November 1995.

Montgomery, a child-care worker at the Methodist Children's Home

Society, sat on Smith and ignored his pleas for air because it was "typical of the ruses used by children to get themselves released from restraints," she said in a court deposition.

Montgomery eventually pleaded guilty to a misdemeanor and received an 18-month suspended sentence and 100 hours of community service.

Nancy Diehl, the Wayne County prosecutor who handled the Smith case, said she had little choice because many of the witnesses were other troubled children.

"We gave her a great plea because we felt we might have some problems convincing a jury of the original charge," Diehl said. "It certainly isn't easy because your witnesses are other young kids who have various problems. That's why they are in the home."

After navigating the criminal justice system and ending up empty-handed, the Smith family ended where many aggrieved families do -- in civil court. Detroit attorney Julie Gibson, who represented the Smiths, said her clients eventually realized it was best to settle the case.

In fact, few lawsuits involving restraint victims ever make it before a jury because they are settled quietly and out of court. In the mere handful of jury verdicts over the past two decades, awards typically fell under a half-million dollars, according to legal experts and a national tracking service.

When a case does go to trial, families face a final, common hurdle. Take the case of Roshelle Clayborne.

"What's the life of a poor, black, mentally ill girl who has been institutionalized for several years going to mean to a jury?" said Martin Cirkiel, the Texas attorney who represents Clayborne's family.

"I think the answer," Cirkiel said, "is not much."

Courant Staff Writers Colin Poitras, Kathleen Megan and Eric M. Weiss contributed to this story.

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From 'Enforcer' To Counselor

By ERIC M. WEISS
This story ran in The Courant on October 15, 1998

Will Overton used to be called "The Enforcer."

With 280 pounds of solid Tennessee muscle wrapped around a 6-foot-3 frame, the aide at the Harold W. Jordan Center was called in to help "shuffle" patients -- slamming them to the ground face-down if they acted up or disobeyed. And the 30 mentally retarded and mentally ill patients -- people accused of murder, rape and other crimes -- often disobeyed.

MIKE PIGNONE, an aide at the Harold W. Jordan Center, talks with a patient on the grounds of the Nashville facility. Recent changes at the center are the result of Tennessee's efforts to minimize the need to physically restrain patients. "If we could do it here, it can be done anywhere," said a Jordan Center administrator.

"I used to be a bad boy," said Robert Hall, a short, wiry patient with the energy of a wound rubber band. "I was shuffled about every day."

Not anymore. Behind the Nashville center's locked gates and razor wire a radical turnaround has occurred in the last year. Shuffling is now forbidden, staff has been increased and given intensive training.

Tennessee's example shows that, with strong leadership, the physical restraint of patients can be minimized -- indeed, nearly eliminated -- safely and without exorbitant cost.

"If we could do it here," said Frances Washburn, deputy superintendent of Clover Bottom Development Center, which includes the Jordan unit, "it can be done anywhere."

But the routine and frequently dangerous use of restraints persists elsewhere, even though the solutions are often simple and straightforward: better training, stronger oversight, uniform standards and the collection and sharing of information.

Federal officials and health groups say they are working on it.

The U.S. Center for Mental Health Services has begun a five-state pilot program to collect restraint and seclusion data. The U.S. Department of Veterans Affairs is tracking deaths more closely.

The Joint Commission, the nation's leading hospital accreditation organization, has strengthened its guidelines on restraint and seclusion. And the American Medical Association has begun studying the use of restraints on children.

"Those steps sound pretty inadequate to me," said Dr. Joseph Woolston, medical director for children's psychiatric services at Yale-New Haven Hospital. "This sort of half-hearted patchwork approach will probably do more harm than good by giving an

illusion that something is happening when it is not."

So for now, it is left to individual hospitals to find their own way. Those committed to the task illustrate what can be done.

Riverview Hospital for Children and Youth, a state-run psychiatric hospital in Middletown, Conn., uses an intensive training program that emphasizes non-physical intervention when a patient loses control.

"These situations are often chaotic and unpredictable, and without proper training, staffers are just winging it," says Linda Steiger, executive director of Wisconsin-based Crisis Prevention Institute.

CPI, a leading private training company, provides instruction to Riverview workers. The cost is minimal: $895 per person for a four-day program to teach a small number of designated staffers, who then instruct their peers.

Tighter procedures also emphasize that every restraint is a major step -- literally, a matter of life and death.

At Riverview, a staffer is required to constantly monitor anyone in mechanical restraints. That ensures a patient's vital signs remain strong, and provides an incentive to end the intervention as soon as the patient regains control.

At Tennessee's Jordan Center, patient treatment plans that include the use of restraint are, for the most part, rejected. And every use of emergency restraint is investigated and must be defended.

"When forced to go through the self-analysis and justifications, they solve it at a lower level the next time and without restraints," said Thomas J. Sullivan, who heads Tennessee's Division of Mental Retardation Services. "Of course, this requires staff to give up total control."

Emergency restraints are so infrequent now that Sullivan gets an e-mail message every time they are used. He's gotten an average of just two to three e-mails per month since January.

Accountability means staffers share more information and learn from the mistakes of others. Techniques found to be dangerous, such as face-down floor holds and mouth coverings, have been outlawed in certain places as a result.

But tough lessons learned by individual hospitals typically aren't shared with facilities on the other side of town or 10 states away. Each hospital is left to reinvent procedures or learn the hard way -- through the death of a patient.

It doesn't have to be that way.

New York state has reduced restraint use and the number of related deaths by requiring the reporting of usage rates and by investigating all deaths.

After New York required all mental health facilities to say how often they use restraints -- and published the numbers -- the top three users revamped their policies and brought their numbers down.

When it came to deaths, the state used to allow each hospital to decide which ones were questionable enough to report. It was notified of 150 cases over three years. Once mandatory reporting of every death was instituted 20 years ago, the number of deaths requiring further investigation rose to 400 a year.

"When people have a choice in classifying deaths -- with one choice resulting in tremendous scrutiny, the other resulting in none, what do you think they're going to do?" said Clarence Sundram, the former chairman of the independent New York agency that tracks and investigates deaths.

Accountability has produced results. Restraint-related deaths in the past five years have been cut nearly in half as compared with the preceding five years, New York state records show.

Nationwide accountability could accomplish the same.

"There needs to be some kind of state-by-state evaluation to gather comparative statistics and give an annual report to Congress," said Dr. E. Fuller Torrey, a prominent psychiatrist and author.

"Until you embarrass the individual states," Torrey said, "nothing will be done."

The federal government has shown a willingness to intercede on this very issue -- in response to charges that the elderly were being abused.

When the U.S. Food and Drug Administration estimated in 1992 that more than 100 people annually were killed through the use of mechanical restraints in nursing homes, the agency tightened rules on their use.

"We also thought these cases were flukes," said the FDA's Carol Herman, "until we started digging."

The FDA now considers lap and wheelchair belts, fabric body holders and restraint vests to be prescription devices. Manufacturers are subject to FDA inspections to ensure quality control.

Such steps, advocates say, have both reduced and improved the use of restraints. In the mental health field, strong and independent government oversight can weed out bad practices and bad facilities as well, they say.

"We can't do it alone," said Curtis L. Decker of the National Association of Protection and Advocacy Systems. "The only way to truly protect patients is through a large, comprehensive monitoring program."

That means a system where government regulators, not the industry, are charged with oversight, he said. An internal patient grievance system would be bolstered by a well-funded network of independent advocates trained in death investigations.

More than money, though, many analysts say a culture in which restraints are used too soon, too frequently and for the wrong reasons must be changed.

"The single biggest prevention method is the avoidance of restraints to begin with," Sundram said. "It is often the training and opinions of staff that dictate restraints, rather than patient behavior."

In Tennessee, "the changes were top-down, bottom-up and a hard sell everywhere," Sullivan said. Before taking the top Tennessee job, Sullivan spent 27 years as an official in Connecticut's Department of Mental Retardation.

Reducing restraint use was just one of many changes forced on Tennessee by two lawsuits filed by the U.S. Department of Justice and by patient advocates. "It was a system that was disintegrating," said Ruthie Beckwith of People First of Tennessee, a patient advocacy organization that sued the state.

The state responded with new leadership, more money and staff and an intensive training regimen emphasizing calming words instead of brute force.

The total cost for the Jordan Center: $12,665 for training in restraint use and alternative methods; $255,372 annually in additional staffing to address not only restraint issues but massive deficiencies in overall patient care.

The changes in technique weren't easy on staff. About a half-dozen aides quit. Others groused. But most stayed and changed.

"It was a rough couple of months," said Robert Zavala, an aide at Jordan. "At first, they just told us we couldn't put our hands on them. Everyone was like, 'Oh, so all I can do now is run away?' "

Bernard Simons, the Clover Bottom superintendent who oversaw the transition, remembers a defining moment. He received a frantic call from staffers at Jordan saying a patient was smashing furniture and asking whether they could restrain him.

"I said, 'Let him break it,' " Simons said. "So you're going to risk hurting yourself or the patient for a $100 coffee table? The state will buy a new one."

The changes are both profound and surprising to staff and patients who remember the old ways.

"Before, we weren't earning their respect, it was just fear," said Overton, the burly aide who still wears a belt that says "Boss."

"Now, I'm more of a counselor or big brother than an enforcer," Overton said. Like a Cold War relic, he now uses skills other than just his brawn, such as his woodworking knowledge, which he passes on to patients in a new class he teaches.

"I used to get shuffled a whole lot of times when I would go off and hit someone," said David Holland, 24, who has been at the Jordan Center for 2 1/2 years. "Now, they give us a lot more time to chill out, calm down. It's getting better each day."

How The Courant Conducted Its Investigation

The death of 11-year-old Andrew McClain in a Connecticut psychiatric hospital in March prompted a team of Hartford Courant reporters and researchers to investigate the use of restraints and seclusion.

The investigation began in May and concluded five months later. The team ultimately pored through thousands of pages of policy reports and academic studies, traveled to 10 states, surveyed federal databases and electronic news archives, and spoke to hundreds of regulators, industry officials, analysts, workers and patients.

As its first step, the reporting team conducted a 50-state survey to document deaths that occurred during or shortly after restraint or seclusion. The team concentrated on the period from 1988 to the present.

The reporters contacted officials in health care and licensing agencies, child fatality review boards and patient advocates in each state. In most states, many more calls were made to public officials and others.

As part of its investigation, the team compiled a database of 142 patient deaths in psychiatric hospitals, psychiatric wards of general hospitals, group homes and residential facilities for troubled youths, and mental retardation centers and group homes.

Deaths that were confirmed and fact-checked by Courant researchers were compiled in a database now available on our Internet site at www.courant.com.

Throughout the reporting, though, it became clear that many deaths go unreported.

For example, only New York state requires the reporting and investigation of every death in a private or state facility to an independent state agency. New York found that 64 people died during or shortly after restraint or seclusion in targeted institutions from 1988 through 1997.

In contrast, only 12 confirmed cases could be uncovered in California in the same period -- because the state simply does not collect the data.

"I hope [your story] doesn't reflect that these are the only deaths in California," said Colette Hughes, the state's top abuse investigator for a patient advocacy group. "There is no doubt that this is the tip of a huge iceberg."

To better determine the national death rate, The Courant hired statistician Roberta J. Glass. Glass is a research specialist for the Harvard Center for Risk Analysis at the Harvard School of Public Health. She has 14 years' experience in the field of statistical projections.

In her projection, Glass used data from the state of New York, the U.S. Department of Health and Human Services and earlier academic studies on restraint use, among other sources.

If facilities throughout the rest of the country used restraints as often as those in New York state, Glass found, there would be 50 deaths annually nationwide.

But Glass noted the rest of the country was not necessarily like New York state. New York monitors restraint use more closely, and facilities in New York use restraints at a lower rate than national surveys have found elsewhere in the country.

Thus, Glass projected the annual number of deaths could range as high as 150.

"Admittedly, the estimates are only rough approximations," Glass said. "The data needed for precise estimation are not collected in a systematic way nationwide.

"But it is clear that greater attention should be paid to this issue, especially in light of the fact that it affects a particularly vulnerable patient population."

Project reporters: Eric M. Weiss, Dave Altimari, Dwight F. Blint and Kathleen Megan.

Additional reporting: John Springer, Colin Poitras and Hilary Waldman.

Project researchers: Jerry LePore and Sandy Mehlhorn.

DEADLY RESTRAINT

A Hartford Courant Investigative Report

Data Key:
N/A -- Information not available
P -- Physical restraint hold | M -- Mechanical restraint | S -- Seclusion
H -- Hospital | R -- Residential facility

The database below is organized by state, and then chronologically within each state.

Name	Age	Sex	State	Date	Method	Institution	Type	Notes on death	Cause of death
Campos, Edith	15	F	AZ	2/2/98	P	Desert Hills Center	R	Restrained after not giving staff a family photo.	Asphyxiation
Ward, Charles	45	M	CA	2/14/92	M	Brotman Memorial Hospital	H	Medicated and restrained for 11 hours.	No autopsy; a doctor signed the death certificate stating Ward died of heart failure
Jadeed, Zouhair	22	M	CA	3/15/92	M	Napa State Hospital	H	Strapped face down on a mattress after eight hours of restraint.	Napa County sheriff's coroner listed cause of death as "undetermined"
Kiefer, Marc	38	M	CA	2/3/93	M	East Bay Hospital	H	Restrained to bed with straps, belts and cuffs for 18 hours.	Psychiatric drug overdose, according to lawsuit
T., Laurajean	47	F	CA	7/13/94	M	John George Psychiatric Pavilion	H	Face down on bed and placed in five-point restraints.	Asphyxiation from positioning in restraints
Webb, Barry	36	M	CA	11/19/94	M	Valley Medical Center	H	Placed in restraints for more than seven hours.	Cardiac arrest
unidentified	33	M	CA	4/1/95	M	Napa State Hospital	H	Died after being restrained overnight in a chair with waistbelt.	Cerebral and cerebellar hypoxia
Jackson, Robert	42	M	CA	4/5/96	M	East Bay Hospital	H	Strapped to bed and given anti-psychotic drug cocktail.	Overdose of clomipramine
Diaz, Joseph Richard	40	M	CA	4/30/96	P	Fairview Developmental Center	R	Restrained face down on bed.	Undetermined
Kanda, Jimmy	6	M	CA	9/20/97	M	Crow's Nest Family Care Home	R	Strangled in restraint; 911 operator had to talk staff through CPR.	Asphyxiation
unidentified	20	M	CA	N/A	M	N/A	H	Restrained face down to a hospital bed; found dead later.	N/A
unidentified	17	M	CA	N/A	M	N/A	N/A	N/A	N/A
unidentified	N/A	M	CA	N/A	N/A	CPC Fremont Hospital	H	Died while face down in restraints.	N/A
Collier, Casey	17	M	CO	12/21/93	P	Cleo Wallace Center	R	6-foot-5-inch boy restrained.	Asphyxiation
Small,						North Suburban		Hung partially out of bed with vest restraint	Strangulation by

Marcia	78	F	CO	5/8/98	M	Medical Center	H	around her neck.	ligature
Jacob, Richard	40	M	CT	3/25/90	P	Timothy Terrace CLA	R	Face down, arms in front of chest; aide on top.	Cardiac arrhythmia
Zentai, Katalin	43	F	CT	12/26/96	M	Connecticut Valley Hospital	H	Placed in a restraint chair for 30 of last 36 hours; died of blood clots.	Bilateral pulmonary emboli
McClain, Andrew	11	M	CT	3/22/98	P	Elmcrest Hospital	H	Face-down restraint with arms crossed over chest.	Asphyxiation
Crumpler, Mardee	31	F	DE	9/6/93	M	Stockley Center	H	Rolled in gym mat and suffocated.	Asphyxiation
Thomas, Emory	42	M	FL	1996	M	Manatee Glens	H	Tied to bed with five-point restraints.	Heart attack
unidentified	N/A	F	FL	12/4/95	P	Gulf Coast Center	H	One of four employees straddled her.	Anoxic encephalopathy due to mechanical asphyxia due to restraint; ruled a homicide
Rawls, Robert Lee	29	M	FL	1/11/97	P	South Florida State Hospital	H	Placed in a choke hold while struggling with aides.	Asphyxiation leading to brain damage
Payne, Gerry A.	35	M	GA	4/17/98	P	Central State Hospital	H	Attacked employee, then restrained by staff members.	Sudden, unexpected death associated with psychotic episode; contributing factor: cardiomegaly
Campbell, Chris	13	M	IA	11/2/97	P	Iowa Juvenile Home	R	Restrained four times in last 24 hours.	Undetermined
Sleeth, Ed	66	M	IA	2/3/98	M	Woodward State Hospital	H	Supposed to be restrained to wheelchair.	Blunt trauma to head
Clark, Robin Lee	39	M	IA	6/4/98	M,P	Woodward State Hospital	H	Clark tied up, physically restrained after swallowing part of toothbrush	Complications from swallowing a toothbrush
unidentified	N/A	M	ID	early '90s	N/A	Idaho State Hospital South	H	Patient went into convulsions; restrained.	No autopsy performed
Wallace, Wauketta	12	M	IL	7/11/89	P	Maryville Academy	R	Restrained on back or stomach.	Postural asphyxia and stress due to restraint
Cook, Larry	50	M	IL	1/2/97	M	Roseland Community Hospital	H	Tried to burn restraints off with lighter. Cook and another patient died.	Smoke inhalation, burns.
Gray, Roxanna	17	F	IN	7/6/89	P	Family and Children's Center	R	Restrained face down on a pillow.	Suffocation
Dahlke, David	39	M	KS	1/10/89	P	Winfield State Hospital	H	Restrained face down on mat.	Records closed to public
Mapes, Thomas	17	M	KS	7/8/94	M,P	Youth Center at Topeka	R	Handcuffed and brought face down to floor.	Asphyxiation
Bogrett, Jeffrey	9	M	MA	12/1/95	M	New England Center for Autism	R	New Hampshire boy died in restraints at a Massachusetts group home.	Sudden death during restraint
Rollins, Robert	12	M	MA	4/21/97	P	Devereaux School	R	Restrained face down with arms crossed over chest.	Positional asphyxiation during restraint
								Suffered a heart	Heart disease;

Galligan, James	59	M	MA	12/1/97	P	Pembroke Hospital	H	attack while being restrained by staff.	diabetes and bipolar disorder contributed
Soares, Mark	16	M	MA	4/29/98	P	Wayside Union Academy	R	Aides thought teen was faking unconsciousness	Cardiac arrest
Isaacson, Kent	37	M	ME	8/6/88	M	Augusta Mental Health Institute	H	Restrained to bed for long periods of time before his death.	N/A
Smith, Earl	9	M	MI	1/11/95	P	Children's Village	R	Restrained face down by staffer who thought his distress was a ruse.	Asphyxiation due to chest compression
Halfacre, Benjamin	37	M	MI	5/6/97	P	Hummer Lake Group Home	R	Held him down from behind and took him to floor.	Respiratory and cardiac arrest
Thomas, Bobby Sue	17	F	MN	8/16/96	P	Northwood Children's Home	R	Face down restraint.	Acute cardiac arrhythmia
Pettit, Sherilee	35	F	MN	5/18/97	P	Cambridge Regional Human Services Center	R	Face down restraint for 4.5 minutes.	Positional asphyxia secondary to restraint hold
Andrews, Buddy Earl	39	M	MO	4/24/95	P	Fulton State Hospital	H	Broke neck while being taken down.	Broken neck
Schumacher, Richard	44	M	MO	11/17/95	P	St. Louis State Hospital	H	Refused to be discharged, taken down by security.	Sudden death, marked agitation and physical restraint
Harris, Robin	25	F	NC	4/7/90	M	Dorothea Dix Hospital	H	Incident in which young female patient died after restraint.	Heart condition (natural causes)
Sovern, Tristan	16	M	NC	3/4/98	P	Charter Greensboro	H	Face down on floor, towel in mouth.	Asphyxiation
Young, Kelly	17	F	NJ	1/5/98	P	Brisbane Child Treatment Center	R	Placed in basket hold and taken to floor.	Asphyxiation
unidentified	50s	F	NV	1995	S	Unidentified private hospital	H	In locked seclusion; set fire to room; died of fumes.	Smoke inhalation
F.H.	30	M	NV	9/25/95	P	Nevada Mental Health Institute	H	Six aides restrained him face down, one on buttocks.	Heart disease, congenital defect of the heart
W.D.	N/A	F	NV	8/15/96	M	University Medical Center	H	Cardiorespiratory arrest in four-point restraint.	Thermal brain injury due to hypoxia due to cardiorespiratory arrest
Ramon Luz (pseudonym)	33	M	NY	1988	M	Rockland Psychiatric Center	H	Violent behavior led to camisole restraint for four hours.	Acute respiratory arrest due to drug intoxication due to multiple drug synergism
9012192	N/A	M	NY	1990	S	Creedmoor Psychiatric Center	R	Suffered severe burns in fire he started in seclusion room	Undetermined
9207042	60	F	NY	1992	N/A	Brunswick Hall	R	Became unresponsive while nursing staff placed her in bed. No deficiencies cited.	Sudden cardiac event
9711011	72	F	NY	1997	M	Cabrini Medical Center	H	Wrist restraints ordered to enhance hydration, nutrition; safety measure.	Cardio-pulmonary arrest
								Death's	

8801252	N/A	F	NY	1/16/88	N/A	Elmhurst Hospital Medical Center	H	circumstances did not suggest any deficiencies in care	Convulsive disorder
8802016	39	M	NY	2/7/88	P	Hudson River Psychiatric Center	H	Patient physically restrained while face down; became unresponsive.	Probable asphyxia
8803972	N/A	N/A	NY	3/15/88	N/A	Bellevue Hospital Medical Center	H	No deficiencies in care found	Chronic ethanolism and narcotism, cirrhosis of the liver
8806172	26	F	NY	6/17/88	M	South Beach Psychiatric Center	H	Died after release from 4-point restraint	Cardiac arrhythmia following administration of antipsychotic medications
8808030	76	M	NY	8/7/88	M	County Hospital of Western Suffolk	H	On Aug. 6, patient was found on floor, with restraint attached.	Shock, dehydration and urosepsis.
8808099	N/A	F	NY	8/24/88	N/A	Kings Park Psychiatric Center	H	Physician failed to stabilize; hospital privileges revoked	Chronic bronchitis due to bronchial asthma
8810187	48	F	NY	10/23/88	M	Franklin General Hospital	H	4-point mechanical restraint; not checked as required.	Acute pulmonary thromboembolism; deep leg vein thrombosis
8901095	28	N/A	NY	1/18/89	M	Mid-Hudson Psychiatric Center	H	Death after camisole restraint; no deficiencies cited.	Acute cardiac failure, hypertensive arteriosclerotic cardiovascular disease
8902015	N/A	M	NY	2/1/89	N/A	Metropolitan Hospital Medical Center	H	No deficiencies in care cited	Probably cocaine intoxication
8903013	39	M	NY	3/4/89	P	Hudson River Psychiatric Center	H	During restraint, peers reportedly struck and sat on patient's abdomen.	Acute asphyxia secondary to aspiration of gastric contents
8907036	N/A	N/A	NY	7/11/89	P	Association for the Help of Retarded Children	R	Police did overlaying restraint; ruled homicide; no facility citations	Asphyxia due to chest compression, due to overlaying during restraint by police officers
8908106	22	F	NY	8/24/89	M	Mid-Hudson Psychiatric Center	H	During first four days was in almost constant restraints.	Suicide; asphyxia due to strangulation with sheeting material wrapped around neck
8908100	36	M	NY	8/25/89	P	Eliot House	R	Police restrained patient after he became agitated, displaying paranoia.	Cardiac arrest secondary to release of catecholamines and toxic levels of medication
8910009	74	M	NY	10/4/89	M	Erie County Medical Center	H	Patient was placed in a jacket-vest and given Haldol.	Chronic obstructive pulmonary disease, congestive heart failure
8911010	31	M	NY	11/5/89	M	Capital District Psychiatric Center	H	After Ativan and Prolixin injections, patient became unresponsive	Severe coronary artery sclerosis; ischemic damage to colon, stomach, kidney, brain, liver
						Stony Lodge		Patient collapsed during restraint attempt; no deficiencies	Exhaustive

9001042	41	M	NY	1/9/90	P	Hospital	H	cited.	psychosis
9002105	N/A	N/A	NY	2/17/90	N/A	The Bridge Inc.	R	No deficiencies cited in record	No autopsy performed
9005103	N/A	M	NY	5/17/90	M	Queens Hospital Center	H	Patient was placed in restraints twice in three days prior to death	Therapeutic complications arising from the use of certain medications
unidentified	N/A	N/A	NY	5/24/90	N/A	Builders for Family and Youth	R	No deficiencies cited in record	N/A
9007150	37	F	NY	7/27/90	S	Mohawk Valley Psychiatric Center	H	Locked in seclusion for 4 hours; released; no vital signs 2.5 hours later.	Undetermined
9008107	16	M	NY	8/19/90	P	Nassau County Medical Center	H	Patient unmanageable, restrained by staff. No deficiencies cited	Congenital heart defect
9010014	N/A	M	NY	10/2/90	P	Manhattan Psychiatric Center	H	Some staffers didn't have refresher training on restraint use since 1987	Fatal injuries sustained while being restrained
9103068	N/A	M	NY	3/8/91	M	Kings County Hospital Center	H	Became unresponsive while being transported. No deficiencies cited.	Acute and chronic substance abuse
9103075	28	M	NY	3/15/91	S	Mid-Hudson Psychiatric Center	H	While in seclusion, patient put sock in airway. No deficiencies cited.	Suicide by impaction of sock into throat and asphyxiation
9103128	39	M	NY	3/26/91	M	Elmhurst City Hospital	H	Emergency communication problems cited.	N/A
9107093	N/A	F	NY	7/4/91	N/A	St. Barnabas Hospital	H	Admitted the previous day. No deficiencies cited.	Death due to dilated hytrophic cardiomyopathy
9107081	28	M	NY	7/22/91	P	Creedmoor Psychiatric Center	R	Restraint followed by seizure-like movement; no deficiencies cited.	Hyperthermia (body temperature at 108 degrees)
9107132	N/A	N/A	NY	7/22/91	N/A	Harlem Valley Psychiatric Center	H	No deficiencies in care cited	N/A
9108127	73	M	NY	8/31/91	M	Erie County Medical Center	H	No autopsy; other findings of fault in care.	Myocardial infarction
9110071	11	M	NY	10/21/91	M	Our Lady of Victory Infant Home	R	Patient left unattended in Tumble Form seat on waterbed.	Cardio-respiratory arrest
9111165	N/A	N/A	NY	11/4/91	N/A	Metropolitan Hospital Center	H	Dept. of Health cited deficiencies in care	N/A
9201152	N/A	M	NY	1/29/92	M	Harlem Hospital Center	H	Cited for state law violations; restrained several hours without MD orders	Cause not cited
9203080	N/A	M	NY	3/21/92	N/A	Columbia Presbyterian Medical Center	H	No deficiencies in care cited	N/A
9207001	62	M	NY	7/4/92	N/A	Binghamton Psychiatric Center	H	No deficiencies in care cited.	Natural causes cited; no further investigation
9207031	84	F	NY	7/11/92	M	St. John's Episcopal South Side	H	Found dead in bed; no deficiencies cited.	Arteriosclerotic heart disease

9208036	N/A	F	NY	8/8/92	M	**Elmhurst City Hospital Center**	H	Patient was agitated, requiring wrist and ankle restraints. No deficiencies cited.	No autopsy performed
9200000	28	M	NY	10/5/92	P	**Letchworth Village Developmental Center**	R	Restrained on mat by staff; physician ordered 2.5 mg. of Valium.	Seizure disorder
9210100	29	M	NY	10/22/92	M	**Bronx Psychiatric Center**	H	Secured to bed by a sheet across his chest; ruled homicide	Asphyxia leading to anoxic encephalopathy
9211112	31	F	NY	11/23/92	S	**Creedmoor Psychiatric Center**	H	Center cited for "serious" oversight and record-keeping problems	Intoxication, due to combined effect of six drugs
9304162	N/A	M	NY	4/28/93	M	**Kings County Hospital Center**	H	Transferred there in March because of immune system conditions. No deficiencies cited.	Death attributed to AIDS
9305066	72	F	NY	5/17/93	M	**Niagara Falls Memorial Medical Center**	H	Found slumped in geri-chair with posey restraint pressing against neck.	Cardiopulmonary arrest due to hypoxic cerebral encephalopathy
9308010	77	F	NY	8/4/93	N/A	**Manhattan Psychiatric Center**	H	No deficiencies in care; record-keeping deficiencies cited.	Chronic obstructive pulmonary disease
9308054	74	M	NY	8/16/93	M	**Elmira Psychiatric Center**	H	Moved from geriatric to acute admission unit. No deficiencies cited.	Sepsis
9310044	N/A	M	NY	10/14/93	P	**Letchworth Village Developmental Center**	R	Put in day room for observation following final restraint.	Spontaneous rupture of arteriovenous malformation
9312023	34	M	NY	12/1/93	S	**Capital District Psychiatric Center**	H	Patient found slumped over in quiet room. No deficiencies cited	Acute cardiac failure, cardiomyopathy, severe hypertension; in seclusion
9402035	N/A	M	NY	2/2/94	M	**St. Luke's/Roosevelt Hospital Center**	H	Restrained for approximately 38 hours prior to death	Cardiac arrhythmia secondary to cardiac myopathy following release from prolonged restraint
9402013	38	M	NY	2/4/94	M	**Kings Park Psychiatric Center**	H	Found lethargic and verbally unresponsive in geri-chair.	Complications of agitated psychosis (bipolar disorder) w/ rhabdomyolysis and acute pneumonia
9402144	N/A	F	NY	2/27/94	M	**Coney Island Hospital**	H	Patient became assaultive, requiring Ativan and wrist and ankle restraints	Pulmonary hypertension due to chronic bronchial asthma
9403047	37	M	NY	3/14/94	P	**Wilton Developmental Center**	R	Patient vomited during takedown restraint; no deficiencies cited.	Hyperemia of tracheo-bronchial airways; pulmonary congestion
9404117	84	F	NY	4/25/94	M	**Mid-Island Hospital**	H	Death's circumstances did not suggest any deficiencies in care.	Congestive heart failure

9408031	32	M	NY	8/10/94	P	Letchworth Village Developmental Center	R	Restrained face down; patient stopped struggling after 12 minutes.	Asphyxiation due to aspiration of stomach contents
Griffiths, Jamar	15	M	NY	10/18/94	P	Allen Residential Center	R	Breathing was obstructed while being restrained.	Traumatic asphyxia and brain death from lack of oxygen due to heart and lung failure
9604131	37	M	NY	4/24/96	P	Taconic DDSO	R	Placed in standing hold; went into lying hold for 20 minutes.	Undetermined
9608047	N/A	M	NY	8/12/96	P	East Leon Road IRA	R	Float staff unfamiliar with case placed him in hold.	Traumatic asphyxia
9608105	N/A	M	NY	8/31/96	S	Finger Lakes DDSO	R	Placed in timeout room; no deficiencies cited.	Acute subdural hematoma
9702024	36	M	NY	2/5/97	P	Sunmount DDSO	R	Placed in lying hold; no deficiencies cited.	Ventricular arrhythmia
9704018	23	M	NY	4/3/97	M	Interfaith Medical Center	H	Died during 4-point restraint; second of day. No deficiencies cited.	Hypertensive cardiovascular disease
Hunt, Donald	39	M	NY	4/25/97	P	The Holliswood Hospital	H	Died during takedown in preparation for restraint.	Cardiac arrest
Martoral, Maximo	40	M	NY	6/24/97	P	Finger Lakes DDSO	R	Died of choking and asphyxia during restraint	Asphyxiation
Roberts, William	34	M	NY	7/13/97	P	Broome Developmental Center	R	After placed in hold, patient fell to side and vomited.	Massive aspiration of gastric contents
Phelps, Dustin E.	14	M	OH	3/1/98	M	Lancaster foster home	R	Boy was wrapped in a blanket and mattress with straps	Undetermined
Goldman, Kevin	24	M	OK	12/21/93	P	Pioneer Home	R	Collapsed after being restrained by five aides.	Cardiac arrhythmia
Jang, Jung Sook	34	F	OR	10/10/90	M	Lane County Psychiatric Hospital	H	Strapped to bed and given three types of drugs	Heart attack
Gorneau Jr., Peter Lynn	32	M	OR	10/8/93	P	Dammasch State Hospital	H	Towel over face while holding him on table	Smothered while being restrained
Prinkey, Leroy	14	M	PA	9/28/88	P	Western Center	R	Aide used a "one-man body" slide that led to face-down restraint	Cerebral anoxia caused by heart and lung failure due to forceful restraint
Tallman, Jason	12	M	PA	5/12/93	P	KidsPeace	R	Restrained face down on pillow	Suffocation
Dorsey, Sakena	18	F	PA	6/10/97	P	Foundations Behavioral Health	R	Placed face down on the floor with staffer laying across back	Suffocation
Arnold, Michael	19	M	PA	7/15/97	P	Keystone City Residence	R	Prone torso restraint after he tried to leave a day camp	Asphyxiation due to chest compression
Knisley, Betty Jean	60	F	PA	1/23/98	M	Laurelton State Mental Retardation Ctr	R	Strangled in wheelchair restraints	Asphyxia by mechanical restraint
						Hamburg State			

D.S.	N/A	M	PA	Feb. 1995	P	Mental Retardation Ctr	R	Staff took boy to floor	N/A
Harris, Diane	17	F	TX	4/11/90	P	Seguin Community Living Center	R	Basket hold technique was used	Asphyxiation
Jacques, Jorge	28	M	TX	10/11/90	P	Rio Grande State Center	H	Banging his head on floor; put a pillow under it; suffocated	Suffocation
Green, Anthony	15	M	TX	5/12/91	P	Brookhaven Youth Ranch	R	Unruly resident restrained in face-down floor hold for 15 minutes	Asphyxiation
Roberts, Eric	16	M	TX	2/22/96	M	Odyssey Harbor	R	Wrapped in a plastic and foam blanket with Velcro for one hour.	Stopped breathing due to pressure on the chest, according to autopsy
Randolph, Bobby Jo	17	M	TX	9/26/96	P	Progressive Youth Center	R	Taken to floor and restrained by two aides	Asphyxia due to compression of neck
Epps, Trake	26	M	TX	12/1/96	P	Corpus Christi State School	R	Found unconscious on floor, subdued by choking.	Cardiac disrhythmia during restraint by bar/positional asphyxia
Clayborne, Roshelle	16	F	TX	8/18/97	P	Laurel Ridge	R	Pinned face down by aides, given tranquilizer.	Cardiac arrhythmia or irregular beating of the heart
Mulkey, Christopher	26	M	TX	8/19/97	P	Corpus Christi State School	R	Mulkey placed in basket hold; later suffered a severe asthma attack.	Asthma attack
Jeffries, Demetrius	17	M	TX	8/26/97	P	Crockett State School	R	Stopped breathing while being restrained.	Strangulation
Gordon, Sandra	45	F	UT	1/6/98	M	Rosewood Terrace Care Center	R	Left unchecked in restraints for 10 hours.	Strangulation and blunt trauma
Wilson, Elwin Darrick	23	M	VA	5/27/93	M,P	Central State Hospital	H	Restrained by more than a dozen staffers and left in seclusion room.	Sudden cardiac death
Huntley, Gloria	31	F	VA	6/29/96	M	Central State Hospital	H	Restrained 300 hours in last month of life.	Acute and chronic myocarditis (inflammation of the heart)
McGraw, Shinaul	12	M	WA	6/5/94	M	New Directions, Second Chance	R	Wrapped in bedsheet with gauze over mouth and restrained to bed.	Hyperthermia
Malloy, Joseph	41	M	WA	11/9/94	P	Rainier School	R	Arms, legs held down by staff for 7 to 8 minutes.	Hypoxic encephalopathy, broncho pneumonia
Weston, Loretta	61	F	WA	12/01/95	M	Rainier School	R	Restrained to toilet and left alone; lost consciousness, died 5 days later.	N/A
Neyman, Melissa	19	F	WA	7/24/97	M	Private group home	R	Unmonitored in restraints; hung out window unnoticed for six hours.	Strangled after climbing out window with restraints
Ferrarini, Joshua	13	M	WI	1/8/89	P	St. Aemelian-Lakeside Hospital	R	Face-down restraint.	Suffocation
unidenified	49	M	WI	3/9/96	M	Winnebago Mental Health Institute	H	Patient put in "burrito" restraint (body wrap), then vomited and aspirated.	Aspiration

Polite, Fred	47	M	WI	9/14/96	M.P	**Mendota State Hospital**	H	Struggled with workers, restrained with sheet, left alone	Asphyxia, rib fractures, blunt trauma

Congress of the United States

Washington, DC 20515

December 11, 1998

David M. Walker
Comptroller General
of the United States
General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Walker:

Earlier this year, the *Hartford Courant* ran a series of articles that detailed 142 deaths connected to the use of physical restraints and seclusion in mental health facilities. Experts retained by the *Courant* to examine the data estimate that between 50 and 150 such deaths occur each year across the country.

The 142 deaths detailed by the *Courant* may be unrepresentative of care in mental health facilities, but demand attention. Mental health facilities must be able to provide privacy to their clients, but the *Courant* articles indicate that, behind the high walls of sanatoriums, privacy may be degenerating into something cruel and non-therapeutic.

We are requesting that the General Accounting Office examine the use of restraints and seclusion in mental health facilities, with regard to the following questions:

1) The extent to which data is available on the rate, duration, and range of seclusion and restraint in institutions treating persons with serious mental illness and what that data shows.

2) The extent to which data is available on the rate, duration, and range of deaths connected to the use of seclusion and restrain in institutions treating persons with serious mental illness and what that data shows.

3) The extent to which data is collected and reported to federal, state, or other governmental authorities on deaths in institutions treating persons with serious mental illness (including connections to the use of seclusion and restraint) and what that data shows.

4) Are there uniform policies and protocols for the use of restraints and seclusion in mental health facilities (comparable to the civil commitment statutes that are fairly uniform across states)?

We look forward to the results of your research.

Thank you for your assistance in this matter.

Sincerely,

Table 4.2 Expenditures on Mental Health, Alcohol, and Other Drug Abuse (MHAOD) Treatment by Payer and MHAOD Diagnosis, 1996

Type of Payer	Mental Health		Alcohol Abuse[1]		Other Drug Abuse[2]	
	$Millions	%	$Millions	%	$Millions	%
Private - Total	**31,632**	**47.4%**	**2,105**	**42.4%**	**2,580**	**33.9%**
Out-of-Pocket	11,608	17.4	392	7.9	684	9.0
Private Insurance	17,911	26.9	1,419	28.6	1,535	20.2
Other Private	2,112	3.2	294	5.9	360	4.7
Public - Total	**35,073**	**52.6**	**2,857**	**57.6**	**5,034**	**66.1**
Medicare	9,607	14.4	608	12.2	441	5.8
Medicaid[3]	12,585	18.9	832	16.8	1,021	13.4
Other Federal Government[4]	1,322	2.0	465	9.4	1,256	16.5
Other State/Local Government	11,558	17.3	952	19.2	2,316	30.4
Total MHAOD Expenditures	**66,704**	**100%**	**4,962**	**100%**	**7,614**	**100%**

Source: CSAT/CMHS Spending Estimates Project

[1] Includes patients with primary alcohol problems (based on first listed diagnosis for the general service sector and for the specialty sector on provider classification as "alcohol only").

[2] Includes patients with primary drug disorders and patients with combined drug and alcohol disorders (based on first listed diagnosis for the general service sector and for the specialty sector on provider classification as "drug only" or "alcohol and drug").

[3] Includes both state and Federal Medicaid expenditures.

[4] Includes Veterans Affairs, Department of Defense, and Federal Block Grants.

e (ii), a nursing facility must not use on a full-
rse aide in the facility on or after October 1,
the individual—

ng and competency evaluation program, or a
ram, approved by the State under subsection

le nursing or nursing-related services.

t on a temporary, per diem, leased, or on
ermanent employee any individual as a nurse
nuary 1, 1991, unless the individual meets the
(i).

ation programs for current employees

, for individuals used as a nurse aide by the
a competency evaluation program approved
1) of this section and such preparation as may
complete such a program by October 1, 1990.

permit an individual, other than in a training
am approved by the State, to serve as a nurse
for which the individual has not demonstrated
ich an individual as a nurse aide unless the
registry established under subsection (e)(2)(A)
lieves will include information concerning the

h (A), if, since an individual's most recent
petency evaluation program, there has been a
e months during none of which the individual
elated services for monetary compensation,
a new training and competency evaluation
luation program.

n

vide such regular performance review and
sures that individuals used as nurse aides are
nurse aides, including training for individuals
related services to residents with cognitive

nurse aide" means any individual providing
es to residents in a nursing facility, but does

th professional (as defined in subparagraph
or

ide such services without monetary compen-

l defined

ensed health professional" means a physician,
oner, physical, speech, or occupational thera-
apy assistant, registered professional nurse,
d or certified social worker.

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(6) Physi

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conducted under subsection (e)(7) of this section.

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ary medical

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well as the results of any pre-admission screening

(7) Required social services

In the case of a nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) Privacy

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) Accommodation of needs

The right—