

Ohio Association of County Behavioral Health Authorities

Raising the Standard – Safeguarding the Health and Safety of Children in Residential Treatment Facilities White Paper

January 20, 2006

Introduction

Children in Ohio’s residential treatment facilities are restrained thousands of times every year. These restraints often result in non-reportable incidents such as:

- Bruises
- Chipped teeth
- Rug burns
- Scratches
- Bloody noses
- Black eyes
- Cuts
- Retraumatization
- Emergency Medication Intervention

Notification to the child’s parents is not required. Notification to the child’s guardian is not required. Notification to the Alcohol, Drug Addiction and Mental Health (ADAMH) Board/Alcohol, Drug Addiction Services (ADAS)/Community Mental Health (CMH) Board that pays for the child’s treatment is not required. Notification to the ADAMH/ADAS/CMH Board in the county where the facility is geographically located is not required. Notification to the Ohio Department of Mental Health (ODMH) is not required. Notification to the Ohio Department of Alcohol, Drug Addiction Services (ODADAS) is not required. Notification to Ohio Legal Rights Services (OLRS) is not required. Notification to those outside the facility where these “minor” restraint-related injuries occurred is not required. This is unacceptable.

Background

In March 2004, the *Cincinnati Enquirer* ran a series of articles focusing on children with mental illness and the abuse they suffer in state licensed residential treatment facilities. One year later, the *Columbus Dispatch* ran a series highlighting how children in facilities licensed by ODMH are being “manhandled” and “drugged into submission.”

About this same time, the Chair of the Ohio Association of County Behavioral Health Authorities (OACBHA) Kids Committee received a request to review the impact that changes to the Ohio Department of Mental Health’s certification standards on the reporting of major unusual incidents were having on Boards’ ability to properly monitor the care of children in residential treatment facilities. The Committee agreed that this issue was of significant concern.

From April through December 2005, the Committee dedicated a portion of each meeting to focus on this issue in an attempt to gain a clear understanding of how the process in which incident reports involving children in residential treatment facilities are handled in the behavioral health system. At the same time, the Committee looked to other systems to identify potential solutions. It looked to the Department of Mental Retardation/Developmental Disabilities (MR/DD) to learn how similar incidents are handled in that system and it looked to the Department of Aging to learn about how that system shares information about nursing home facilities with purchasers and users of those services.

Children in residential care are the most vulnerable population in the behavioral health system and therefore deserving of prioritization. In addition to being less likely to understand and make use of processes in place to protect their rights, children and adolescents are placed in residential care as a result of an individual or agency's decision—not their own. For these reasons, the Kids Committee focus has been and continues to be on improving behavioral healthcare for children and adolescents in Ohio.

The Kids Committee also recognized that there is a corresponding problem related to the unnecessary placement of children in residential treatment facilities that results when public children services agencies and juvenile courts make a unilateral decision to place a child without input from the local ADAMH/CMH/ADAS Board. While it was acknowledged that this is a significant problem, Committee members agreed to limit the scope of their work for the time-being to the safety of children in the behavioral health system for whom the decision has already been made to place in residential treatment.

Guiding Principles

The Kids Committee was guided by the following principles as it weighed through the information that was presented:

- The obligation to protect the health and safety of children in residential treatment is paramount and should not be overshadowed by a desire to protect the state, the Boards, or providers from liability.
- As the payer of behavioral health services provided to children placed in residential treatment facilities, it is the role and responsibility of Boards to evaluate and supervise those treatment services and the facilities that provide them.
- Boards have an obligation to the public at large to ensure that children are getting safe and effective family-centered, trauma-informed care and that every precaution is taken to ensure that children are not retraumatized while in residential care.
- Tracking patterns of seclusion and restraint is a necessary component in the overall effort to reduce the use of these interventions. [Source: President's New Freedom Commission on Mental Health]

Problem Statement

Ultimately, the Kids Committee concluded that Boards do not have access to sufficient information to satisfactorily meet their statutory requirements relative to children's residential treatment programs pursuant to Ohio Revised Code Section 340.03, 340.033, and 340.04. [See Appendix A.] In the process of coming to this conclusion, the Committee identified the following areas of concern:

1. Children's residential treatment facilities are not required to submit sufficient or timely information on the use of seclusion and restraint.
2. Current rules require children's residential treatment facilities to report incidents to the ADAMH/ADAS/CMH Board but do not define whether the provider should send reports to the Board in which the facility is geographically located or the Board that is paying the Medicaid match, if it is different.
3. The general lack of availability and ready access to critical information collected by ODMH and ODADAS regarding the health and safety of children in residential treatment facilities prevents placing authorities from making informed decisions.
4. Plans of Correction issued by ODMH and ODADAS to meet its obligation to assure the health and safety of children in residential treatment facilities only temporarily remediate an immediate health and safety concern.

Problem 1: Children's residential treatment facilities are not required to submit sufficient or timely information on the use of seclusion and restraint.

ODMH

In January 2004, ODMH revised their residential Notification of Incident Reporting form. Incident Reports for seclusions or restraints are now only required if the incident involves: 1) death 2) attempted suicide, 3) an allegation of abuse or neglect, 4) serious bodily injury or when medical intervention or hospitalization is required, 5) medication error or adverse reaction, 6) involuntary termination of treatment, or 7) sexual assault. As a result of the revision to the form, the number of Incident Reports related to seclusion, physical restraint, and emergency medication intervention decreased from 6947 incidents in 2003 to 112 in 2004. At the time, the Department justified the need for the change by claiming that fewer reports would increase its ability to manage them more efficiently. As it stands, the process may be more efficient, but it is not considered to be more effective.

Providers certified by ODMH are required to submit Performance Improvement Surveys every six months. As part of the Performance Improvement Survey, providers are required to include seclusion and restraint (including emergency medication intervention) data for the six-month timeframe. These data are submitted in aggregate form. As of January 2006, these aggregate data have not been shared with any ADAMH/CMH Board.

Since the change was made to the Notification of Incident Reporting form, Boards are no longer able to identify current trends and patterns in the use of seclusion and restraint by providers in their Board area or by providers that are receiving Medicaid match from that Board. More important, Boards can no longer intervene on behalf of a particular child if reports demonstrate

that the child is being subjected to multiple restraints. Receiving this information six months after the fact from aggregated log reports compiled by ODMH prevents Boards from fulfilling their responsibility to protect client rights and personal safety.

ODMH staff has stated in discussions with the Kids Committee that even if Boards were informed of all restraints and seclusions, Boards would be prevented from intervening because the reporting forms do not contain identifying information. ODMH maintains that HIPAA prevents such information from being included on the form. However, OACBHA and OLRs disagree with ODMH's interpretation of the law and contend that so long as a statute or a rule states that such identifying information may be disclosed to the Board, it would satisfy the requirements of HIPAA under its "required by law," and most likely, its "health oversight agency" exceptions (*Ohio Legal Rights Service v. Buckeye Ranch, Inc.*, 2005).

ODADAS

ODADAS rule 3793:2-1-04 currently requires providers to report on major unusual incidents (MUIs) which are defined as "death or serious injury of a client, allegations of physical, sexual or verbal abuse of a client, and staff neglect." There is no rule that requires children's residential facilities certified by ODADAS to report the use of restraint or seclusion to any entity, including the Department itself or the appropriate Boards.

ODADAS staff reported to the Kids Committee that over a recent ten-month period, they received 132 MUI reports. Of the 132 reports, 70 did not meet ODADAS' MUI criteria. The rule does not mandate a uniform reporting form, nor does the rule specify what kind of information should be reported. Therefore, these data coming to the Department are reviewed case-by-case to determine if they qualify as an MUI. It is our understanding that there is no mechanism in place to collect and analyze data in the aggregate and over time.

Seeking Solutions

At the same time that ODMH was taking steps that limited access to safety information and ODADAS was maintaining its status quo, the Department of MR/DD toughened their reporting requirements, causing its figures to spike from 12 reported restraints in 2001 to 542 in 2004. Since 2000, MR/DD has made the reduction of restraint and seclusion a priority by adding several staff members to its investigative unit, creating an online registry of caregivers that have abused people with disabilities, and developing a web-based reporting system for incidents. Providers report MUI information electronically to the local MR/DD Board and the local Board is responsible for taking immediate action. HIPAA has not proven to be an obstacle for the MR/DD system. Boards have access to all MUI information within their jurisdictions.

Problem 2: Current rules require children's residential treatment facilities to report incidents to the ADAMH/ADAS/CMH Board but do not define whether the provider should send reports to the Board in which the facility is geographically located or the Board that is paying the Medicaid match, if it is different.

ODMH

OAC Rule 5122-26-13 requires providers to forward incident reports "to both the department and mental health board within twenty-four hours of their discovery..." The rule does not clarify whether the provider is to notify the Board in which the facility is geographically located or the Board that is paying the Medicaid match. Considerable confusion exists among providers and within ODMH regarding which Board they must notify when an incident occurs. [See

Appendix B.] In some instances, the Board in which the facility is located is notified, and in other instances it is the Board that is paying for the cost of care that is notified.

A strong case can be made that both Boards should receive notification. It is essential that the “geographical” Board be informed so that it is able to respond to concerns within the community when an incident occurs. Additionally, it is essential that the purchaser of the service be informed so that it can adequately monitor the safety of the children for whom public funds are being used.

Directing providers to send Incident Reports to the “geographical” Board as well as to the “paying” Board would require a minor change in the OAC. When the issue was raised during a Kids Committee meeting, staff from ODMH stated that while the suggestion seems reasonable, it is likely to be met with some resistance by providers. Following the meeting, the Department took steps to gauge the willingness of provider organizations to support a rule change and learned quickly that they would not support such a change. To date, the request has not gone any further.

ODADAS

The ODADAS rule requires MUI reports to be submitted to the applicable ADAMH/ADAS Boards but it does not define “applicable.” As in the mental health system, there is significant variation in which Board gets the information. In some instances, it is the Board in which the facility is located which receives the notification, and in others it is the Board that is paying the Medicaid match.

Representatives from the Ohio Federation of Families for Children’s Mental Health and the Ohio Citizen Advocates for Chemical Dependency Prevention and Treatment pointed out during the Committee’s fact-finding that neither ODMH nor ODADAS regularly notify a parent, guardian or legal custodian when a reportable incident has occurred. [See Appendix C.] This too seems a critical omission in the process of safeguarding the well-being of children.

Problem 3: The general lack of availability and ready access to critical information collected by ODMH and ODADAS regarding the health and safety of children in residential treatment facilities prevents placing authorities from making informed decisions.

In recent years, legislation has been passed to hold providers more accountable financially; however, the issue of accountability for safety has not been made a priority by either the General Assembly or the state departments that regulate these facilities. Ohio’s most vulnerable children are being served in these facilities, and yet no one system has a good handle on what is happening inside, and no one is holding providers accountable. In an effort to get a better understanding of the system of oversight of children’s residential treatment facilities, the Kids Committee asked OLSR to develop a matrix showing current practice. One glance at this matrix and it is easy to see how any one system could “pass the buck” when a situation involving safety occurs. [See Appendix D.]

“...thousands of kids are caught in a system so confusing that even officials in the state Department of Mental Health and Department of Job and Family Services struggle to explain how it works. State officials don’t even track

how many investigations of abuse and neglect are done or their outcomes. At times the two departments argue over which agency should inspect which center. With state oversight spotty and confounding, much of the burden for funding and operating the mental health care system falls to 88 different counties. As many as five agencies in one county might share responsibility for a child – who may be in treatment several counties away or even out of state.”

Cincinnati Enquirer
March 22, 2004

Seeking Solutions

To learn more about how other systems that are responsible for the oversight of facilities serving vulnerable populations within residential care handle the issue of safety, the Kids Committee turned to the Department of Aging. Beverly Laubert, the State of Ohio Long-Term Care Ombudsman, attended the September 2005 Kids Committee meeting. She shared that one way the Department of Aging helps insure accountability of licensed facilities is through the creation of a long-term care consumer guide website. The website provides a user-friendly listing of all nursing homes in Ohio and includes several pieces of information that would be important to prospective clients and those paying for their care. Information on the website includes: results from family and resident satisfaction scores; Department of Health inspection report results; fee schedules; staff-to-client ratios; special services provided; and accreditation information.

Interestingly, it was the nursing home providers' idea to create the website, and providers are each billed \$400 annually to help maintain it. Despite the fact that nursing homes are regulated by multiple agencies, the Department of Aging has found a way to make important information available in one central location, thus making it easier for the client and the purchaser of the service (if different from the client) to make informed decisions regarding care.

Problem 4: Plans of Correction issued by ODMH and ODADAS to meet its obligation to assure the health and safety of children in residential treatment facilities only temporarily remediate an immediate health and safety concern.

In contrast to the approach taken by the Department of Aging, critical health and safety information in the behavioral health system, it is either not available or very difficult to track down. For example, ADAMH/ADAS/CMH Boards are not regularly notified when Plans of Correction are issued by ODMH or ODADAS. When ODMH requires a facility to develop a Plan of Correction (which can take months to develop and implement) the local Mental Health Boards are not informed. Furthermore, there are known cases where safety concerns have been identified and a Plan of Correction required, yet nothing is done to remove the children currently under the facility's care or to prevent additional children from being admitted until the issues are resolved and child safety can be ensured. This is largely due to ineffective and inconsistent rules governing the licensing of children's residential facilities by various state departments.

Nor do ODMH's Plans of Correction address the global problem of not having timely access to critical health and safety oversight information. After ODMH approves a Plan of Correction, it

relies on its regular 2-year review cycle and aggregate data collection to monitor the facility. Furthermore, its Plans of Correction do not address the local mental health board's lack of access to pertinent information to meet its own health and safety oversight responsibilities. The Kids Committee is not aware of ODMH ever having revoked the license of a children's residential treatment facility.

Perhaps more important, parents or guardians have no way of knowing what the safety record is of a facility when deciding on the most appropriate placement for their ill child. Making this information readily available would result in better placement decisions and ultimately improved quality of care for children.

Seeking Solutions

In his presentation to the Kids Committee, Michael (Mick) Ihlenfeld, Deputy Director, Legal/MUI Division, ODMRDD, stressed the importance of looking at causes of an incident to identify long-term solutions rather than just focusing on the incident itself. The Kids Committee could not agree more; however, until and unless Boards have access to information regarding the incident or access to Plans of Correction, they cannot begin to focus on the causes and potential for reform.

Conclusion

Fear of liability and the potential for losing beds if providers go out of business when beds are so sorely needed have been cited as reasons for not wanting to make needed reforms to ensure the safety of children in residential treatment facilities. The Kids Committee recognizes and applauds ODMH for its establishment of Learning Communities, in which providers voluntarily participate in a program designed to help reduce their reliance on seclusion and restraint. However, this initiative is no substitute for the safety oversight and information sharing processes that are employed by the Department of MR/DD and Aging.

“People with mental illness or mental retardation in residential settings are among the most vulnerable members of our society. Protecting them from abuse and injury is a responsibility of the federal government, the states, the treatment facilities, and the Protection and Advocacy system. However, the safeguards currently in place are not comprehensive and fail to fully ensure the rights and safety of these individuals.”

Improper Restraint or Seclusion Use Places People at Risk
Report to Congressional Requesters
United States General Accounting Office, 1999

Kids Committee Recommendations

The intent of this White Paper is to express concerns with and expose the inadequacies of the current health and safety oversight process for monitoring the safety and well-being of children in Ohio's residential treatment facilities. Following are recommendations to address the problems identified herein:

- Require that all incidents of seclusion, restraint and emergency medication intervention are Reportable Incidents.
- Require all children’s residential treatment facilities licensed and/or certified by ODMH or ODADAS to submit timely electronic reports on all instances of restraint, seclusion and the use of emergency drugs to ODMH and ODADAS.
- Require all children’s residential treatment facilities licensed and/or certified by ODMH or ODADAS to send copies of all reportable incidents and MUIs both to the “geographical” Board as well as to the “paying” Board.
- Require all children’s residential treatment facilities licensed and/or certified by ODMH or ODADAS to send copies of all reportable incidents and MUIs to the individual or agency that placed the child.
- Establish a standard in the OACBHA Culture of Quality Initiative that speaks to how Boards should respond to the receipt of reportable incidents to: (1) determine if intervention is necessary on behalf of an individual client, (2) identify trends and patterns among providers, and (3) review the contributing factors of incidents with a view toward identifying long term solutions.
- Work with ODMH and ODADAS to develop the infrastructure needed to list all licensed/certified children’s residential treatment programs on their respective websites and to list information regarding each program including the number of beds, ages of children served, treatment specialty, number of substantiated cases of abuse/neglect, number of reportable incidents, corrective action plan status and other valuable public information.
- Identify a single state agency responsible for ensuring the health and safety of all children in out-of-home care. Establish a workgroup charged with developing a plan to transfer authority to the single state agency. Members of the workgroup shall include representatives of the Ohio Department of Job and Family Services, ODMH, ODADAS, local ADAMH/ADAS/CMH Boards, Public Children Services Agencies, Residential Treatment Providers, OLRs, and family representatives.
- If needed, seek legislative help to further these goals.

“We tinker around the edges, but nobody is biting the bullet and fixing this problem.”

Cheri L Walter, CEO; OACBHA
Cincinnati Enquirer;
March 22, 2004
