

# A Tragic Result of a Failure to Act

## The Death of Angellika Arndt

November 26, 2008

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## **INTRODUCTION**

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This report chronicles Disability Rights Wisconsin's investigation into the circumstances leading to and surrounding the death of Angellika Arndt in Rice Lake Wisconsin, from complications of chest compression asphyxia while at the Rice Lake facility of the Northwest Counseling and Guidance Clinic on May 25, 2006. When she died, Angie was only seven years old.

Disability Rights Wisconsin (DRW) is the federally mandated Protection and Advocacy System for individuals with disabilities in Wisconsin. DRW is authorized under state and federal law to investigate incidents of abuse and neglect in settings that serve people with disabilities.

Independent investigations into Angie's death were conducted by the Rice Lake Police Department, Barron County Child Protective Services, the State of Wisconsin Department of Health and Family Services Bureau of Quality Assurance\*\* and the Wisconsin Department of Justice. Additionally, the Office of Medical Examiner of Hennepin County Minnesota conducted a post mortem examination. In order to examine potential factors which contributed to her death, DRW's investigation reviewed the results of these investigations and reports, along with information gathered from Angie's foster family, Rice Lake Day Treatment Center policies and records, Angie's public school records, and her mental health clinical records.

In the many months since Angie's death DRW, along with other advocates and concerned parents have engaged the Department of Health Services in discussions regarding the circumstances and policies that allowed such a death to occur. During the course of these discussions advocates have presented DHS with many of the recommendations contained in this report. Unfortunately, the DHS response has been neither sufficient nor timely, nor with enough sense of urgency or importance to adequately safeguard against this type of death happening again to another Wisconsin child. DRW believes that the policies and conditions remain sufficiently unchanged so as to allow such lethal restraint practices to continue in this state, thus making it potentially only a matter of time until there is another tragedy.

In issuing this report DRW hopes that the lessons learned from Angie's tragic death will translate into increased use of positive behavioral supports, a decrease in the use of seclusion and restraint with children and a prohibition of the use of restraints that have the potential to cause serious injury or death, as well as changes in the provision and oversight of day treatment services for children in the state of Wisconsin.

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\*\*On July 1, 2008, the Department of Health and Family Services became the Department of Health Services and the new Department of Children and Families was created. Additionally, the Bureau of Quality Assurance has become the Division of Quality Assurance. This report attempts to employ the proper title depending on each circumstance as it appears in this report, and refers to DHFS or BQA in the historical factual context only. Recommendations for prospective policies and actions are directed to the appropriate entity, DHS or DCFS, as the situation warrants.

## **INVESTIGATIONAL BACKGROUND**

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Disability Rights Wisconsin operates in accordance with state and federal laws that have been established to protect and advance the civil rights of people with disabilities in the state of Wisconsin. Under its federal mandate set forth in the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act of 1986, as amended (Title 42 United States Code section 10801 et. seq.), DRW has the authority to investigate allegations of abuse and/or neglect of adults and children with psychiatric disabilities, including the death of such individuals while receiving care and treatment in the state of Wisconsin.

Materials reviewed for the purpose of this report include:

- Hennepin County Medical Examiner Autopsy Report
- Physical Abuse Consultation by Children's Hospital and Clinics of Minnesota
- West Bend Public Schools Individual Education Plan dated 12/9/03
- Ladysmith Public Schools Individual Education Plan dated 3/28/06
- Rice Lake Day Treatment Center Clinical Record (4/24/2006 to 6/1/2006)
- Northwest Counseling and Guidance Clinic Policies and Procedures Manual
- Department of Health and Family Services Citation Reports
- Northwest Counseling and Guidance Clinic Citation responses and proposed Plans of Correction
- Expert Report of Randy Cullen, M.D. prepared for DHFS, dated July 17, 2006
- Transcript of Proceedings, Barron County Criminal Court
- DHFS intra-departmental e-mail and correspondence, investigation notes
- Chapter HFS 40, Children's Day Treatment, Wisconsin Administrative Code\*
- Chapter HFS 94, Patient's Rights, Wisconsin Administrative Code\*
- Chapter 51, Mental Health Code, Wisconsin Statutes\*

\* Selected portions of these statutes and regulations appear in an appendix at the end of this report

## EXECUTIVE SUMMARY

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On May 26<sup>th</sup>, 2006, seven-year-old Angellika Arndt died at Children's Hospital in Minneapolis from complications associated with chest compression asphyxiation, never regaining consciousness from the day before when staff at the Rice Lake Day Treatment Center (RLDTC) had put her in a control hold, face down on the floor for hours until she turned blue. Several staff members had held Angie's arms and legs while an adult male staff person lay across her back, forcing her head down and immobilizing her 67-pound body until she lay still, no longer breathing. Angie was finally released when they thought she had fallen asleep. Staff were unaware that Angie had stopped breathing until they rolled her limp body over to discover she had begun to turn blue. This was by no means her first prone restraint episode over the short 23 days that Angie attended Rice Lake Day Treatment Center, one of the twelve children and adolescent day treatment facilities run by Northwest Counseling and Guidance Clinic (NWCGC). There were at least nine restraint sessions recorded by RLDTC treatment staff, most of which lasted between 90 minutes and two hours.

When Angie arrived for her first day at RLDTC on April 24, 2006, she already had been through a lot in her short life. By the age of three she had been removed from the home of her biological parents after suffering physical and sexual abuse. For the next several years Angie was shuffled through the state's foster care system until at the age of five she landed at a New Vision Treatment Foster Home run by Donna and Dan Pavlik. By then she had been diagnosed with a host of psychological problems for which she took medications and received mental health treatment and special education services. However, by the spring of 2006, Angie had shown some progress both at home and at school. Despite the fact that she had handled transitioning into kindergarten in the fall of 2005, Angie was sent to RLDTC to help her prepare for first grade and monitor a new medication that had been added to help with episodes of agitation.

According to the Medicaid prior authorization form submitted by RLDTC to the Department of Health and Family Services, Angie was supposed to receive mental health services for five hours a day in addition to two hours of specialized educational services. However, Angie began attending RLDTC before they had received any of her pertinent records, before initial evaluations had been completed and before an initial treatment plan had been written. In fact, Angie's initial treatment plan remained unsigned by some of the treatment team until May 24, two days before her death, and the first meeting of Angie's full team was not scheduled to be held until June 6, 2006, too late for Angie. Despite Angie's long list of diagnoses and medications, RLDTC never raised any concerns about her placement in a Level I program, the least intensive of three levels of children's day treatment programs licensed by DHFS. Furthermore, no medication plan was ever formulated, and no follow up was discussed to properly monitor Angie's new medication.

Less than two hours into her first day at RLDTTC, staff placed Angie in a special isolated “cool down” room for hitting her chin with her hand. When she continued to fidget she was placed in prone restraint for 85 minutes. Over the course of the next few weeks, until her death, Angie spent at least 20 hours in cool downs and 14 hours in prone restraint. Typically, Angie’s behavior, such as wiggling in her chair or falling asleep, would elicit a “cool down” in the special cool down room. Some of these sessions lasted a few minutes and others continued on for hours. Often they would escalate into a prone restraint, where Angie was placed face down on the floor with staff holding her immobile for as long as an hour and a half. This practice was contrary to the provisions of the Emergency De-escalation and Control Informed Consent form signed by Angie’s foster mother, where it clearly quoted the NWCGC policy that such control holds were never used as discipline and only as a last resort for safety or security.

Although she had often received a voice mail notification of a cool down or restraint episode, Angie’s foster mother felt that she had been misled as to the nature and frequency of the seclusion and restraint that Angie was subjected to. She had told RLDTTC staff about Angie’s background and problems and was upset that none of this had impacted how Angie was treated and the expectations that were placed on her. According to staff rules, timed cool downs did not begin until Angie was sitting still and straight in her chair with her feet on the floor and her hands folded in her lap. She had to stay in this position for the entire 15 minute period or else another 15 minutes would be tacked on. Expectations of total body control are not realistic for almost any seven-year-old child, much less one with ADHD and oppositional defiant disorder among her multiple disabilities.

The DHFS Program Certification Unit, responsible for surveying and citing RLDTTC for any violations of regulations, was aware that concerns had been raised both within the Unit and through outside complaints about the seclusion and restraint practices in NWCGC facilities. In fact, one surveyor acknowledged that physical holds and time outs were “routine and frequent” in the Western part of the state where the NWCGC facilities were located. However, a NWCGC administrator had complained to the Certification Unit Supervisor and gotten a different surveyor for their facilities, one they hoped would be more lenient and cooperative in future surveys. When NWCGC Operations Manager laid out their (clearly illegal) policy for the use of restraints just five months before Angie arrived at their RLDTTC facility, they were erroneously told by the surveyor for the Department that the protections of Wisconsin’s patient’s rights law did not apply to the children in day facilities such as theirs. Neither NWCGC nor the surveyor seemed to be aware of the existing legal requirement that the use of any amount of seclusion or restraint, except in an emergency, must be approved by the Department on a case-by-case basis. Furthermore, and critically important to note, there was no documentation that DHFS ever responded to inform NWCGC of the legal inadequacy of this restraint policy.

After Angie’s death there were a number of investigations conducted by law enforcement and the Department’s Division of Quality Assurance. Additionally, an



incident report was written by RLDTTC staff. From these reports we can glean the sad and horrifying picture of Angie's final hours. Angie arrived at RLDTTC around lunch time, and a short time later found herself in a "cool down" precipitated by staff's determination that she had not followed directions for talking and was gurgling her milk with her straw. When Angie couldn't sit still in the chair for her time out, staff took her to the special cool down room. This was the special seclusion room that had no window or furniture besides the single "cool down" chair. The hard floor was covered with a thin carpet glued down to the concrete below. Staff reminded Angie that her cool down time didn't begin until she sat still and in the proper position. Instead of obeying, Angie curled up in the chair, began to cry and soon appeared to fall asleep. After about five minutes Angie awoke and began to swing her legs back and forth in the chair. Staff warned her that if she didn't stop, they would have to place her in a control hold for safety. Undeterred, Angie continued to swing her legs and cry. Eventually, staff reported that Angie made an aggressive move as she sat in the cool down chair, so they took her down with a prone restraint. More staff were called to assist with the restraint. One staff person placed his body across Angie's small back and held her head face down on the floor. Three others held her arms and legs immobile. Angie was restrained in this position for over an hour until they felt she was calming down. In the RLDTTC report written after her death, staff reported that Angie stayed on the floor making cooing noises after they freed her. Staff left her there for about five minutes, thinking she had fallen asleep. Only then, when Angie failed to respond to questions, did staff roll her over and discover that her lips were turning blue. 911 was called and Angie was rushed to the Pediatric Intensive Care Unit of Children's Hospital and Clinics in Minneapolis, Minnesota, on life supports. She was pronounced dead the following day.

Immediately after Angie's death RLDTTC suspended its operations on a temporary basis. DHFS conducted an investigation of Angie's death through the Department's Bureau of Quality Assurance and a program review by one of the Department's child psychiatric consultants. On June 15, DHFS issued its original statement of deficiency and required a Plan of Correction from NWCGC, the parent company of RLDTTC. On July 17, the expert consultant issued his report. After several attempts at a plan of correction were rejected by the Department, on August 15, 2006, it suspended funding for RLDTTC. Finally, on November 10, 2006, NWCGC wrote to DHFS informing the state that it would not reopen the Rice Lake facility. However, the remaining eleven NWCGC locations continue to receive state and federal funding.

On September 11, 2006, the Bureau of Quality Assurance for DHFS issued an official memo titled "Interim Guidance on Use of Seclusion and Restraints in Certified Day Treatment Programs for Children." In it, the Department outlined the current law governing children's day treatment facilities, and indicated its intent to issue additional policy clarification and information on training and technical assistance at a later date. Since that time, some training has occurred, but DHFS has not taken timely steps to properly review the use of day treatment in Wisconsin. It also has not reviewed or revised the children's day treatment rules or issued guidance to day treatment providers about the authorization or use of seclusion or restraint.

Criminal negligence charges were brought against one of the RLDTC staff who had restrained Angie and against NWCGC. Both the staff member and Northwest Counseling and Guidance Clinics pleaded no contest to the charges, and the Barron County Circuit Court Judge in the case imposed the maximum fine of \$100,000 against Northwest Counseling and Guidance Clinics for one felony count of negligent abuse of a resident. The staff person was sentenced to 60 days in jail and one year probation for the misdemeanor negligence charge. During sentencing the judge remarked that “there were a lot of other people who made decisions that led up to her death.”

How could this have happened? Angie was sent to RLDTC in order to receive more specialized, intensive mental health services than were available in her local school. These services were the direct responsibility of NWCGC staff, which in turn was under the oversight of what is now the Department of Health Services. Unfortunately, the care provided to Angie by RLDTC fell far short of the criteria established by the Department for these programs. Angie had documented emotional and behavioral needs that were beyond the services provided in a Level I Day Treatment facility, but there was no proper assessment to determine if Angie was appropriate for RLDTC. The pressure to take higher-need children than RLDTC was equipped to deal with in light of staff experience led to a hurried assessment process.

Without a proper assessment, there were no underpinnings for the development of an individualized treatment plan that addressed Angie’s needs. Little attention was paid to her transition into the program and why she was there. In fact, her initial treatment plan was not even drafted until Angie had been there for weeks. When it was finally drafted, it was negative and punitive, not therapeutic in approach, and did not reflect principles of good practice in the field. Medical oversight was not incorporated into the plan and there was no attempt to record information required for the responsible administration of medication by RLDTC. Her foster family was not involved in any sort of collaborative relationship with the day treatment program, nor was her treatment coordinated with Angie’s other service providers.

There were a number of indications that should have alerted the Department to problems with the day treatment programs run by NWCGC. As part of the certification and renewal process, DHFS Surveyors would have reviewed NWCGC policies and practices regarding isolation, seclusion and restraint, assessment and treatment planning. Some of these policies had already been found to be deficient in 1998 and were again the source of new citations by the Department issued as a result of the investigation of Angie’s death. As part of their time on-site at RLDTC, surveyors would also have had an opportunity to view RLDTC’s cool down room. These observations, along with the knowledge that restraint and seclusion was “routinely” used by NWCGC facilities, should have triggered more in-depth analysis of whether the use of such an isolation room was in compliance with Wisconsin law.

Finally, Angie’s treatment team had never met by the time Angie died. The fact that a multi-disciplinary team meeting to review Angie’s progress at RLDTC was never

convened meant that there never was a proper review of whether her initial treatment plan was appropriate, given the disturbingly high number of control holds placed on Angie in such a short amount of time.

While DHS has taken a number of steps to start the process of reducing the use of restraints and seclusion in children's programs, real change has not happened yet. There have been some excellent, well-attended trainings, but the committee charged with creating an overall plan for training and technical assistance has not yet finished its work. A memo on prohibited restraint practices which included the type of restraint that killed Angie, requested by advocates a year ago, has not been issued. The issue of the varying definitions of seclusion and restraint has not been fully addressed. Nothing has been done to review or revise the children's day treatment regulations.

## **DRW RECOMMENDATIONS**

Based on its investigation and findings, DRW is offering recommendations to both the Department of Health Services and the Department of Children and Families. Although DRW believes that all these recommendations should be enacted as expeditiously as possible, those that need the most urgent action have been highlighted with a call for immediate action. An overview of these recommendations, which appear at the end of this report, include:

### Day Treatment

- ▶ DHS should immediately issue guidance to day treatment providers about:
  - the distinctions made in the DHS regulations between the various programmatic treatment levels so that programs are not serving children whose needs cannot be met in the program.
  - the use of restraints and seclusion, clarifying that they should not be used as part of a treatment program and may only be used to prevent imminent physical harm in accordance with state law.
  - the importance of a thorough assessment before the child is admitted to ensure the program and the development of a treatment plan that is based on the assessment.
- ▶ DHS should begin a review of day treatment programs and the treatment needs of their participants to determine if these programs are the least restrictive and most effective treatment approach for the children being served.
- ▶ Funding and training should be provided to develop other components of the system of care for children with emotional and behavioral treatment needs.

- ▶ Prior authorization requirements should be revised to include a review of the level of the program to be utilized for each child.
- ▶ Continued training and technical assistance on trauma informed care, positive behavior supports and crisis prevention should be made available to day treatment programs.
- ▶ Data should be collected on the use of restraints and seclusion in these programs so that training and technical assistance can be focused on programs with high rates of use and enforcement actions should be taken when necessary.
- ▶ DHS should develop a set of guidelines and a review committee for case by case requests to use seclusion and/or restraints in children's day treatment programs.
- ▶ DHS should convene a work group composed of parents, experts, regulators, providers and advocates to review and suggest revisions to the current administrative rules for day treatment.
- ▶ DHS should review the current funding level for children's day treatment programs to determine if it is sufficient to provide quality programming for children needing this service.
- ▶ DHS should undertake a thorough review of policies and practices of all remaining NWCGC facilities to ensure adequate adherence to all existing day treatment regulations and state restraint and seclusion laws.

### Restraint and Seclusion

- ▶ DHS and DCF should immediately adopt a comprehensive plan for the reduction and/or elimination of seclusion and restraints in programs that serve children with mental health needs.
- ▶ DHS and DCF should immediately issue a memo on prohibited practices in the application of emergency restraints with children and adolescents.
- ▶ DHS should issue a memo defining seclusion and restraint and when they may be used in children's programs and should explore the promulgation of rules or other guidance to provide more consistent requirements that are consistent with best practice guidelines.
- ▶ DHS and DCF should support changes to the state law on isolation and restraint that clarify that it may only be used to prevent imminent serious physical harm to self or others and that it may not be used as part of a treatment program. Any

restraint that blocks the patient's airway or restricts circulation, does not protect the head, causes chest compression, involves a choke hold, or uses pain to obtain compliance or control should be prohibited.

- ▶ DHS and DCF should require that all incidents of the use of restraints or seclusion in community mental health programs for children be reported to appropriate licensing staff within 72 hours. Then DHS and DCF should undertake a review of patterns of use to identify for further investigation any use over certain benchmarks, and annually report to the public on the use of seclusion and restraints in community mental health programs for children.
- ▶ DHS and DCF should require that parents and guardians receive notification of the use of seclusion and restraints on their child on the same day that the use occurred. Notification should include information about the measures used, the length of time, the behavior that preceded the use, de-escalation techniques used, identification of personnel involved, and the impact on the child. Parents and guardians should also be included in any de-briefing involving the episode.
- ▶ DHS and DCF should require that all staff in children's mental health treatment programs receive training in positive behavior supports and interventions and crisis prevention and de-escalation techniques. A plan to provide training should immediately be finalized and DHS and DCF should fund this training.
- ▶ DHS and DCF should require all children's mental health treatment programs to become trauma informed and trauma assessments should be incorporated into assessments and treatment planning. Training and other steps should be taken to ensure that children are not retraumatized by use of seclusion or restraints or other aspects of the treatment program.

Angie died as a result of an inappropriate use of restraint and seclusion in a state licensed children's day treatment program. The perceived need for physical restraint, more often than not, reflects the failure of the planned treatment. In fact, RLDTTC's treatment plan was based on faulty assumptions about how to change behavior. Instead of effective treatment Angie was subjected to "cool downs" and "control holds".

The Wisconsin Department of Health and Family Services had opportunities before Angie's death to review and intervene in the programming provided by RLDTTC. Deficiencies that Department staff had already cited at other day treatment programs operated by NWCGC, complaints received about their isolation and restraints practices, and on-site surveys should have given the Department sufficient warnings about problems in the NWCGC facilities

After Angie's death DHFS did cite the facility for numerous violations, leading to the facility's closure. However, the Department has been slow to take action to decrease the

use of seclusion and restraints in children's programs and goals dealing with care planning, training, quality assurance, and monitoring have not been met. In November 2007 a number of mental health advocacy groups wrote the DHFS Secretary requesting an official DHFS memo to providers that would identify prohibited practices in the use of restraint with children, so that additional deaths such as Angie's would not occur. That memo has not been issued.

DHFS has not taken steps to review the use of day treatment in Wisconsin to determine if it is the most appropriate least restrictive treatment for children in the programs. It also has not reviewed or revised the children's day treatment rules or issued guidance to day treatment providers about assessments, treatment plans, use of seclusion or restraint, or program levels and inappropriate admissions. It has not established any guidelines or an entity to review requests to use seclusion or restraints on a case by case basis in day treatment programs, even though this is required by administrative code.

There can be no higher priority in the state than our children. This means providing high quality treatment for children with mental health needs in a safe, nurturing environment. However, Wisconsin is not meeting this goal. It is critical that both the Department of Health and the Department of Children and Families take immediate steps to significantly reduce the use of seclusion and restraints with vulnerable children. We cannot afford more failures to act!

## **CIRCUMSTANCES SURROUNDING THE DEATH**

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### **Who Was Angie and how did she get to Northwest Counseling and Guidance Clinic's Rice Lake Day Treatment Center**

Angie started her life suffering significant neglect, physical abuse and sexual abuse while in the care of her biological mother and father. By the time she was three, she had been removed from her parents' care and placed in foster care as a ward of Milwaukee County. Before she arrived at the Ladysmith, Wisconsin home of Donna and Dan Pavlick in 2005 at the age of five, Angie had bounced around the state's foster care system for several years; and continued to struggle with a number of emotional and behavioral problems brought on or exacerbated by the numerous out-of-home placements and lack of consistent parenting.

The Pavlicks, who operate a treatment foster home as part of New Vision Treatment Foster Homes, knew that Angie had come from a troubled background and that Angie had picked up a number of psychiatric diagnoses, including post-traumatic stress disorder, reactive attachment disorder, bipolar childhood disorder, attention deficit hyperactivity disorder, anxiety and oppositional/defiant disorder, for which she took five or six psychiatric medications daily, in addition to receiving mental health treatment and special education services.

By the spring of the year before kindergarten, Angie seemed to be improving. According to her foster parents and preschool teachers, Angie was learning to be part of both their family and the preschool classroom. She then attended kindergarten in the regular classroom with supports for her behaviors. She still experienced angry outbursts, but for the most part, the school and family had learned how to deal with them using a time-out system. She never needed to be restrained, and was not a threat to anyone.

In order to support a successful transition into kindergarten, Angie had spent eight weeks in the summer of 2005 at the Mikan Therapeutic Day Treatment Program. During her time in that program she was never restrained. She worked to improve her affect regulation and threat response. Angie made significant progress and left with a positive experience and improved behaviors, ready to begin kindergarten.

Despite the fact that Angie appeared to be getting along in her kindergarten class, in March of 2006, the foster care social worker decided that Angie might benefit from additional positive therapy prior to starting first grade in the Fall. Additionally, Angie's psychiatrist had recently placed her on Tenex, a new medication to help calm her behavior when she got out of control, which she was taking on an as needed or "PRN" basis. The rationale behind a day treatment placement was that they would be more able to closely monitor this new medication and document the use and its effects and report back to the psychiatrist who could then determine the effectiveness of the medication and make any necessary changes. Since Angie was not old enough for another program in nearby

Ladysmith, the social worker for New Vision Treatment Foster Homes settled on the next closest program in Rice Lake, and Angie was enrolled in the Rice Lake Day Treatment Center of Northwest Counseling and Guidance Clinic. From April 24 until her death, Angie attended RLDTC five days a week, arriving in the morning and returning in the afternoon to her foster parents' home.

The Ladysmith school staff were surprised by Angie's admission to Rice Lake Day Treatment Center since they had not been consulted prior to her admission and were of the opinion that Angie was making sufficient progress to continue on to first grade in the Fall without an increase in problems, since she had been improving during the school year and her outbursts were decreasing under their time-out program. The Pavliks decided to go along with Angie's admission to the program since it appeared, from the information supplied by Rice Lake Day Treatment Center, that the services provided were similar to what she had received in the past.

Donna Pavlik filled out a brief initial intake form. In it, she listed all the past behaviors that Angie had displayed over time, in order to provide background information which RLDTC would not get from other records. However, there is no indication in RLDTC's record that this information was ever incorporated into Angie's treatment plan. No mention was ever made in the assessment of the positive experience Angie had in the Mikan prior day treatment program, nor was any attempt made to contact that program for Angie's records or to get their insight into treatment approaches for Angie. Angie also was receiving ongoing counseling from a clinical social worker from Marshfield Clinic. There is no information in Angie's chart to show that there was any involvement of this social worker in either the assessment or treatment plan.

On March 26, 2006, RLDTC staff sent releases of information and admission documents to the guardian in Milwaukee County to sign. On March 30th the guardian faxed signed copies back to RLDTC. Along with other documents, the guardian signed the required informed consent for emergency de-escalation and control, which contained the warning that, if consent was withdrawn it would be considered a direct violation of the day treatment agreement and could result in a client's termination from the program. It also stated that the control holds employed by staff were not to be used as discipline, and police or other authorities would be called prior to, or simultaneously with, the use of a control hold.

The initial intake interview at RLDTC was held on April 11, 2006. The social worker from New Visions brought Angie unaccompanied by Angie's foster mom, the one person who undoubtedly knew Angie better than anyone else. The only information available to the unidentified intake worker were any observations of Angie made at that time, and possibly the initial intake form. Only a few notes recording this interview were taken. The parents' form indicates past issues with hyperactivity, poor attention span, tantrums, poor fine and gross motor skills. The foster parents express goals of: 1) tantrums resolving into quiet time-outs and 2) achieving a better response to directions. Angie's strengths are listed as: outgoing, can be very fun, liked well by most peers, happy most of the time, can be



helpful, self sufficient. “She can be a very fun, silly girl, very sweet and loving.”

### **Northwest Counseling and Guidance Clinic’s Operation of Rice Lake Day Treatment Center**

Rice Lake Day Treatment Center (RLDTC) was one of twelve day treatment programs in Wisconsin run by Northwest Counseling and Guidance Clinics (NWCGC). RLDTC, like other NWCGC programs, received the major portion of its funding through the State of Wisconsin-run federal Medicaid program. Between 2003 and the time it closed its doors after Angie’s death, RLDTC received 1.8 million dollars in Medical Assistance payments. The Rice Lake program has had as many as 22 children at one time, ranging in age from 7 to 17 years of age.

Northwest Counseling and Guidance Clinic’s clinical programming for mentally ill or behaviorally disturbed children draws children from many communities in northwest Wisconsin and, with relatively few alternatives in rural northern Wisconsin, NWCGC responded to this growing need by opening a number of new satellite programs, such as Rice Lake Day Treatment Center, over the course of several years. This expansion had often led to staffing problems due to the lack of experienced, qualified staff in rural areas.

All 12 of the Northwest Counseling and Guidance Clinic programs, including RLDTC, were certified as a Level I day treatment program, the lowest level under the Wisconsin Administrative Code HFS 40. These administrative regulations also provide for more intensive service requirements for children’s day treatments under Level II and III programs. As a Level I program, RLDTC was required to deliver services designed to assist clients whose needs were principally derived from conduct disorders or oppositional disorders. The Administrative Code describes these Level I structured services as including individual, group and family counseling, educational support or direct academic instruction and recreational therapy, provided in an extended therapeutic milieu.

In order to be certified as a Level I program NWCGC had to complete an initial application, and then be re-certified at regular three- year intervals. In addition to documentation to be supplied to the state, continued certification required on-site surveys of the program by State of Wisconsin surveyors to determine whether the program continued to meet the standards set out in the Administrative Code. These standards laid out minimum qualifications for staff, clinical supervision, training and required services. However, the regulations allow for any of these requirements to be waived for a particular program if it is determined that it would result in an unreasonable hardship for the provider or to the client. Such waivers are not supposed to diminish the effectiveness or violate the purpose of the program or adversely affect client health, safety or welfare. The Program Certification Oversight Unit of DHFS reported that NWCGC submitted eleven written requests for regulatory relief through code waivers for all its facilities. The DHFS Program Certification Unit approved four waivers, denied five and deemed two to be unnecessary. Ten of these eleven requests were for a waiver of specific staff credentials. Two of the

eleven requests were for the RLDTTC facility; one was denied and the other found by DHFS to be no longer necessary.

In the fall of 1998, during certification or recertification by DHFS, two other locations of the children's day treatment facilities run by NWCGC, in Frederic and Superior, were required to take corrective action regarding, among other things, their policies and practices around the isolation (cool down rooms) and restraint (control holds) of their clients. NWCGC was strongly encouraged to consult with the Department's Bureau of Community Mental Health to develop a restraint policy that addressed the criteria, duration, monitoring, documentation and evaluation of restraint. Additional policies for the use of cool downs and admission criteria were also to be developed.

In March of 2005, more than a year before Angie's death, a DQA surveyor responsible for oversight of the region which contained many of the NWCGC day treatment centers, including RLDTTC, expressed concern via e-mail within the Department about the lack of policies and procedures in place to review, approve or deny the use of restrictive measures such as physical restraint. The surveyor pointed out that the development of guidelines might help facilities to think critically about use of restrictive measures such as the use of physical holds and time-outs that were described as "routine and frequent" in the Western region of the state. However, after some internal dialogue within the Department, this idea went nowhere. Several years earlier there had been another proposal for a Departmental informational memo regarding the use of restraint and seclusion for persons with mental illness in community settings, which also was never created since the Department believed that neither was occurring with enough frequency to require such a memo.

The Department was aware that there were problems with seclusion and restraint at NWCGC facilities. In a series of e-mails between the Supervisor of the Program Certification Unit and a Department Licensing Specialist, the supervisor acknowledged that he had removed a surveyor from NWCGC visits after they had complained about the criticism they had received, and while the new surveyor was also not happy with the use of restraint by NWCGC, he had been given the impression that physical restraints were only used if the patient became violent or threatened self or others. In May 2005, the Department had received at least one complaint from a county regarding the use of physical restraint by NWCGC on one of its clients. This complaint was investigated by another county and resulted in recommendations to the facility for changes in procedures. It is unclear if any action was taken by the facility in response to these events and the Department did not feel it necessary to cite NWCGC, even though DHFS surveyors and their superiors noted that in recent years NWCGC had generated the most requests and notices of restraints in that DHFS region.

In August of 2005, a number of on-site issues were raised with the NWCGC clinical director by the state licensing surveyor. These included concerns about staff who do not have experience in working with children with mental illness and facilities operating without certain required staff.

In November of 2005, just five months before Angie arrived at RLDTC, the Operations Manager for NWCGC e-mailed a surveyor with the Bureau of Quality Assurance at DHFS to get clarification for the use of restraints for longer than an hour. According to the e-mail, in a previous conversation, the DHFS Licensing and Certification Specialist had inaccurately told the NWCGC Operations Manager that the patients rights protections of Chapter 51 relating to isolation and restraint only applied to inpatient facilities, and not a day treatment program such as RLDTC. Therefore, the requirements that isolation or restraint only be used in an emergency or as part of a Department-approved behavior plan, and that a written order from a physician or licensed psychologist be obtained for any restraint lasting over one hour, were deemed inapplicable to RLDTC. Additionally, the DHFS licensing staff felt that it would be more appropriate for a facility like RLDTC to notify parents or the police to come and get the client, rather than notify the physician or psychologist as actually required by law.

The specific question raised by NWCGC in the e-mail was whether they could finish the restraint, no matter how long it lasted, and then send the client out of the program with the parent or police, in order to keep the parent from appearing as the “savior” instead of making the client deal with the issue and fully process it. In response, the DHFS Licensing Specialist commented that they should only be concerned if they were restraining children for “too long,” thus increasing the possibility of injury or claims of abuse. For children requiring repeated and longer restraint sessions, the DHFS Specialist would want to have the assurance of the parent or physician that this was proper programming, again ignoring the legal requirement that use of seclusion or restraint, other than in an emergency, must be approved by the Department on a case-by-case basis.

In a final e-mail, the NWCGC Manager laid out their current policy for control holds lasting over one hour. In such cases, staff were to contact one of NWCGC’s two behavioral specialists for their 12 locations to see how they should proceed. This specialist would then ask the staff questions to get a “feel” for where the client is emotionally and whether the hold can continue or not. There is no documented response by DHFS to this e-mail.

### **What happened at Rice Lake Day Treatment Center and how Angie died**

Angie’s first day at RLDTC was April 24, 2006, before RLDTC had any of her pertinent records, before initial evaluations were completed and before the initial treatment plan was written. In the rush to admit Angie, there were no records indicating any clear decisions about how to address Angie’s needs before she started the program. In fact, the clinical records note confusion among the staff about whether to use or not use the PRN recently prescribed by Angie’s psychiatrist to help her settle when agitated. However, RLDTC admitted that they did not originally send the proper release to speak to the psychiatrist and this was not corrected, nor were other efforts made to speak to the doctor’s nurse until the week before Angie died. It also appears that no consideration was given to Angie’s history of trauma, relative young age for the program, or the fact that she had a diagnosis of ADHD. The initial treatment plan was written by RLDTC and signed by

the various members of the RLDTTC treatment team over a series of dates, beginning May 5, and ending with the signature of the staff person eventually charged with criminal negligence in Angie's death, on May 24, the day before the events leading to Angie's death. It is hard to assume, given the late date, that there had been time for any substantial discussion among the members of Angie's treatment team of this initial treatment plan.

On the initial assessment and treatment plan Angie is noted as having a difficult time engaging in any conversation or activity due to a very short attention span, along with having an anxiety disorder, and ADHD. Six psychiatric medications were listed on the initial assessment worksheet, but that number dropped to five on the treatment plan without comment or explanation. In his assessment, RLDTTC's psychologist reported that Angie had developmental delays, fidgeted, rocked, appeared very restless, with poor concentration, and could not remember the day of the week 5 minutes after it was told to her. The RLDTTC psychologist also noted that Angie was experiencing chronic daily headaches, a fact that was not mentioned again for almost a month.

Despite this long list of diagnoses, symptoms and medications, RLDTTC staff never raised any concern about Angie's appropriateness for a Level I program. Even though Angie was on either five or six psychiatric medications, no medication plan was ever discussed and no follow up was planned with either Angie's pediatrician or psychiatrist, in spite of the fact that one of the primary reasons for sending Angie to RLDTTC was ostensibly to monitor her medications for effectiveness and possible side effects.

According to the Medical Assistance Prior Authorization form submitted by RLDTTC, Angie was to receive mental health services for five hours per day five days a week, plus an additional two hours per day of specialized educational services which were not billed to MA. The day treatment mental health services included in the request for Angie were intensive individual and group counseling, intensive supervision and behavior modification services.

That first day, April 24, 2006, less than 2 hours into the program, Angie was placed in the time-out room for hitting her own chin with her hand. No self-injury was noted in the record and she stopped this behavior within 5 minutes. When she continued to fidget in her chair she was threatened with a physical control hold if she didn't stop. This was the standard admonition given by RLDTTC staff in response to the occurrence of any behavior to be discouraged, along with the admonition "you know what the expectations are." When Angie didn't stop, eventually kicking off her right shoe, she was immediately placed in a prone restraint for 85 minutes. By the end of her first day at RLDTTC, Angie had spent 5 hours either isolated in time-out or being restrained, and less than 2 hours engaged in actual activities.

Over the next 23 days until her death, this same pattern would be repeated over and over, with Angie spending many hours in cool downs or prone restraints. The RLDTTC records substantiate a minimum of 20 hours in cool downs and 14 hours in prone restraint, with at

least 15 of these restraints lasting from 35 minutes to over 2 hours. However, judging from other written comments as well as notable omissions in the record, it is likely that the incidence of isolation and restraint were under-reported in her RLDTTC record. Nonetheless, even using these reported amounts, Angie was subjected to far more restraint than was appropriate for a 7 year-old child, as recognized by the NWCGC Emergency Intervention policy issued in June of 2007, more than a year after Angie's death, which limits its use to one minute per every year of age up to a maximum of 15 minutes.

### **Cool downs**

Every day that Angie attended RLDTTC she spent some amount of time in various cool downs. Some of these lasted for five minutes, other sessions totaled up to three hours. Behaviors RLDTTC staff noted as requiring cool downs for Angie included: not listening, making noises, being off task, not sitting appropriately still, throwing an unspecified object, not being able to follow directions, drawing on pants, not participating in group, standing up without permission, having her hood on, gargling milk, talking to peers at lunch, kicking table, using baby talk, putting arms inside shirt, touching a staff person's balloon without permission and being inattentive, most of which were listed under the category of being "disruptive." It is important to note the disconnect between the manner in which RLDTTC staff were actually responding to these types of behaviors and what they knew, or should have known, about Angie's functioning level, diagnoses and behavioral problems at the time of her admission, and which were subsequently included in her treatment plan.

Under NWCGC's Day Treatment Programs Clinical/Behavioral Plan Policy dated 7-19-04, (Behavior Plan) cool downs were instituted as consequences to give children the time and space to problem solve, manage anger, and accept responsibility for their actions. This short time period also gave staff a chance to evaluate whether the client was able to return to his or her prior activities. Cool downs were to begin in the five-minute range unless the child was eight years old or younger, then two-minute cool downs were to be used. In "rare circumstances" NWCGC policy allowed for this time limit to be altered. In Angie's case, cool downs were usually precipitated by her failure to follow staff rules. Staff notes made contemporaneous with these cool downs did not document any "rare circumstances" to justify such long cool down times. Nor were there any attempts to try alternative approaches to deal with Angie in order to limit either the duration or frequency of these cool downs. A month after Angie's death retroactive notes were added to the file indicating that there had been ongoing informal discussions about alternative ways to deal with Angie's "wiggles." However, no clinical or medical leadership was exercised at the time to arrive at a better approach to handle these issues.

RLDTTC staff usually reacted to Angie's behaviors by giving her a short in-room cool down. Then, when she did not behave according to staff expectations during this initial period, she was escorted to a special cool-down room. It was here that many of the cool downs would escalate to prone restraint holds. The Rice Lake Police Department

investigation described the room as containing nothing but a chair, with a hard cement floor covered by a thin glued-down carpet. NWCGC Day Treatment Behavioral Plan states that the client must be given a minimum of 15 minutes to cool down and get back on task. This time period did not begin until the client was sitting appropriately. If at any time the child did not meet the expectations of the staff and acted inappropriately in the eyes of the staff, the time period started over. In Angie's case, despite Angie's diagnosed ADHD, anxiety disorder and mood swings, RLDTC staff had a firm expectation that Angie must sit straight and still, with her feet on the floor, her hands in her lap, for the duration of the 15 minute period. Cool downs did not begin until Angie had met these expectations, and if she did not comply for the entirety of the cool-down, additional 15 minute periods were added, but did not begin until Angie again met these expectations. Expectations of total body control were daunting and unrealistic for a seven year-old child with ADHD as well as a host of other problems. Therefore, it was not surprising that these cool-down periods could last for hours, and sometimes end in a physical take down and control hold.

### **Restraints/Control Holds**

In addition to long periods spent in cool downs, Angie was subjected to restraints known as control holds. From Angie's records, NWCGC policies and accounts of control holds by other clients who were put in such holds by NWCGC staff, a typical control hold would begin with staff quickly grabbing both of Angie's arms or hands, then turning them out in order to lock them behind and above her back, while applying pressure so she would bend over into what staff called a "half down" hold. (This "half down" hold is not part of the NWCGC policy and procedure manual.) They would then immediately place Angie face down on the floor. One person would lie across her legs, while a second person put his or her knees and legs on one of Angie's arms, and then laid sideways across Angie's lower back grabbing her other hand, resting an arm on hers to secure it to the floor. This would leave the second arm of the person restraining Angie's torso free to hold Angie's head if she would move it. This was usually done on a thinly carpeted concrete floor. Floor burns and bruises were common. Angie was expected to be quiet and calm during this hold and staff would not release her till she was calm and quiet for 10 minutes. Angie complained often that her arms, ankles, eyes and chest hurt during these control holds. Staff recorded in her record that Angie often warned them that she thought she was going to vomit, and in fact did many times during these holds. However, these same staff notations reflect that no measures were taken to reduce this and make things less stressful for Angie during these holds. After these holds Angie was frequently left with bruises and floor burns on her knees and arms, and red marks and abrasions on her head.

Angie was placed in this type of restraint control hold for extended periods of time on at least nine occasions by one or more of the RLDTC staff, which DHFS investigators documented as all lasting between one and two hours, with the final episode that lead to her death continuing for 90 minutes. Some of these restraint incidents were precipitated by Angie's inability to sit still in the cool down chair. She would often wiggle her feet or otherwise fidget in the chair, sometimes she pulled her feet up onto the chair or would

refuse to sit altogether. RLDTTC records also reflect additional behaviors that staff felt warranted prone floor restraint as: not staying awake, not responding to a question, pulling her shirt over her head, putting her arms inside shirt, her hands down front of pants, or simply kicking off her shoe.

Under NWCGC's Day Treatment Behavioral Plan physical holds were to be used only in cases when clients became a threat to themselves, others or property. They were never to be used as a form of consequence for behaviors that fell short of dangerousness, even if inappropriate. In NWCGC's Emergency De-escalation and Control Informed Consent form, dated 3-12-04, it is clearly stated that physical control is never to be used as a disciplinary practice, but only as a safety and security measure. Despite this limitation on its use, all nine of the documented physical control holds used on Angie seem to have been precipitated by behaviors that do not appear to contain any real physical threat to staff, other children, Angie or even property. (E.g. "client refused to sit as proscribed - placed head inside of shirt ...placed in physical hold to ensure everyone's safety.")

After Angie's death her treatment foster mother was upset to discover the extent and frequency of RLDTTC's restraint of Angie. She felt that Angie's behaviors had never amounted to being a threat to herself or others to justify the use of physical restraint, and had been under the impression that the foster placement agency had strong rules against restraint in their programs, which should have prohibited NWCGC from engaging in such practices. While RLDTTC records document that voice messages were left for both Angie's treatment foster parents and her New Visions social worker after many of these instances of extended cool-down and prone restraint, Angie's treatment foster mother felt that she had not been given sufficient information by RLDTTC staff about the intensity and frequency of the restraints that were used on Angie. She was unsure whether she had signed a release authorizing the use of physical restraints on Angie, and stated that she would not have knowingly consented to such practices, and felt certain that if she had, it was hidden in the many forms they had signed, or that perhaps Milwaukee County had approved the practice.

## **WEEK 1**

Despite the fact that one of the reasons expressed for placing Angie at RLDTTC was to monitor the use of Tenex, given when she became agitated to determine if it would help her to calm down, Tenex was only documented as having been given to Angie three times at the beginning of her time at RLDTTC. With no medical notes as to its side effects or effectiveness and without consultation with Angie's psychiatrist or other RLDTTC professional medical staff, program mental health technicians discontinued the use of Tenex on May 1. Case management notes written after Angie's death reflect a conversation with Angie's foster mother about giving the PRN medication, and the request that it be used later in the day because it might make Angie too tired to participate in programming.

After the first two control holds administered to Angie on April 24, case notes state that the

next day Angie's case worker from New Visions checked on Angie's placement and talked to RLDTC and expressed concern that self abuse, such as that recorded by staff to support the control holds the day before, was a new behavior for Angie. No records indicate that this concern was relayed to any of the staff working with Angie, nor did anyone further investigate whether Angie was getting worse.

By the end of her first week at RLDTC seven year-old Angie had been placed in prone restraint control holds on four separate occasions, some lasting for over 1 ½ hours. Most of these sessions were precipitated by not sitting still or standing without permission while in cool-down for some classroom rules infraction, such as not following directions. Only three of these generated incident reports, which all alleged that Angie exhibited extremely aggressive behavior and was not only a danger to herself, but to others as well. The first prone control hold occurred around ten in the morning of April 24, and was reported to Angie's foster parents and foster care case worker around three that afternoon. Documentation regarding a second prone restraint from this same day indicated that it was not reported until two days after its occurrence. According to NWCGC behavior plan rules, all appropriate parties must be notified of a physical hold before the end of the same treatment day.

In addition, that first week the child and adolescent functional assessment was completed and the RLDTC psychologist performed a mental status examination. His notes mention Angie's fidgeting and short attention span, raising questions about sensory issues, fetal alcohol syndrome and ADHD. He also noted the use of Tenex for agitation, but there is no mention of control holds of any type. While the psychologist made a note of Angie's report of headaches, a common side effect of low blood pressure, this was not followed up for a month, despite the fact that Angie was on 5 medications, several of which are known to have a side effect of lowered blood pressure. RLDTC had a form listing 23 symptoms, such as headaches, that required monitoring for side effects that should have been included in Angie's chart. There was only one entry in nursing notes, dated 4/22/06, prior to Angie's first day at RLDTC, regarding headaches. There were no other entries on this form, after this date, which indicated that staff were monitoring either the effectiveness or side effects of Angie's many psychotropic medications.

On Friday of that first week, Angie had play therapy for one hour with the need for only one redirect. The therapist noted that staff should engage Angie in more play therapy.

## **WEEK 2**

On Monday, May 1, the case notes and daily log mentioned that Angie was placed in a prone restraint control hold for an undetermined period of time. No reason was given for this restraint, and messages were left with her foster mother and the New Visions social worker. Tenex was given, and Angie calmed down. This is the final incident documenting the use of the new PRN medication by RLDTC staff. There is no reason given anywhere in Angie's record for this cessation, despite the fact that this was one of the primary



reasons cited for sending Angie to RLDTTC. Angie was placed in a prone restraint hold a second time that week on Wednesday, May 3, for 50 minutes after pulling her shirt over her head.

Work was started on an initial treatment plan; however, it remained unsigned by some team members until May 24, the day before the events leading to Angie's death. The team meeting to discuss this treatment plan was not scheduled to occur until June 2, days after Angie's death, and it is unclear whether there was any other informal team meeting to discuss the formation or implementation of the plan. The treatment plan identified two long-term goals for Angie: 1) Angie would maintain appropriate boundaries and 2) Angie would demonstrate an improved mood leading to decreased irritability. A uniform short term goal used for both of these long term goals was for Angie to score 65% on her daily care plans in such areas as following rules, respectful interactions with others, practicing good boundaries, honest and appropriate participation and maintaining concentration and completing assignments. The Treatment Plan was, for the most part, devoid of detail on how RLDTTC staff were going to help Angie to accomplish these goals or therapeutic measures that would be employed. Interventions listed in the plan for both of Angie's goals were exact copies of each other. Angie's initial treatment plan interventions were: monitor whether Angie reached her goal of 65% compliance on her Daily Care Plan, medication monitoring, a reward system for behavior, processing of incidents with staff and peers, daily goals for school work and behaviors, group and individual therapy, and consistent contact with outside service providers/care givers.

Notes only added after her death referred to a staff meeting held during this week, during where concerns over the number of control holds Angie was undergoing were supposed to have been raised. However, there were no contemporaneous notations corroborating the occurrence of such a meeting, nor was there any noticeable change in Angie's treatment.

### **WEEK 3**

The RLDTTC records document that Angie was placed in prone control holds twice during this week, one for 65 minutes on Monday, May 8, for putting her feet up on the chair, and a second on Friday, May 12, for an unspecified reason and period of time. Despite Angie's prior success in play therapy sessions, the sessions set for these two days when she was restrained are cancelled due to "scheduling" problems.

On Wednesday, May 10, the initial assessment and treatment plan were completed and sent to staff, family, guardian and doctor for approval. The RLDTTC staff author of the plan signed the document on this day. Three of the signatures are dated May 5, five days before the writer completed the initial assessment and treatment plan. The first outside records are stamped as received from Ladysmith and West Bend School Districts on May 9. Once again, there is no record of anyone looking at or discussing these records, they are simply stamped "received" and placed in the file.

At this point, after eight control holds and many cool downs, RLDTTC still did not have any records from Angie's medical doctors, psychologists, or psychiatrist. There had been no contemporaneous record of concern about the high use of control holds with Angie. During this week staff took pictures of Angie during a control hold so that they could show them to her later, to aid staff in demonstrating the consequences of Angie's behaviors to her.

#### **WEEK 4**

There were four reported incidents precipitating prone restraint during this week. On Monday, May 15, Angie was distracting in class and received a cool down. After she moved her bottom off the cool down chair she was placed in prone restraint for 85 minutes. On Tuesday, May 16, her restraint time was brought about when Angie appeared to stand up while in the cool down chair. Thursday's episode began when Angie blurted out in class, then hit her head on the back of the cool down chair. This time Angie vomited while being held down in prone restraints, after which she appeared to fall asleep. According to Dennison Tucker, President of NWCGC, they did not consider it unusual for children to vomit while in a control hold. Angie was left in the hold for 25 minutes while she slept, and was only released when she awoke so that she could process why she was restrained. In all these cases phone messages were left for Angie's foster mother and the New Visions social worker.

On May 16, the RLDTTC program coordinator observed Angie and took notes on what seemed to be working in her treatment. These observations do not appear to be informed by a review of past school records which clearly spelled out a behavior plan that had worked in the past. These notes were taken after Angie's foster mother had called RLDTTC to question the amount of control holds being used on Angie by RLDTTC staff. She indicated that she had not been aware that the control measures being used were, in fact, prone restraints or that they lasted for over an hour on a number of occasions. While there is no record at RLDTTC addressing her concerns, according to the foster mother, the call prompted a scheduling of the treatment team. The program coordinator then called Angie's foster mother to set up a date for the multi-disciplinary team planning meeting.

Angie's progress was discussed at the weekly staff meeting, held on May 17, as reported in the case management notes recollected and written by the RLDTTC program coordinator a month after Angie's death. However staff did not have time to discuss de-escalation suggestions and alternatives at this meeting. These same notes indicate that the program coordinator discussed recently-received records from Angie's schools and her list of behavior observations with staff on May 18, and the RLDTTC team decided that in the future, when Angie was placed in the cool down room, her behavior would be ignored unless it was deemed unsafe. Specific behaviors that staff identified as unsafe to the point of requiring invention with a prone restraint control hold were: being off the cool down chair completely, hands or head completely hidden in her clothing, hands down the

front or back of her pants, and attempting to hit herself or staff while in cool down.

Despite this agreed-upon course of action, the following day Angie was placed in cool down for not participating in class. While in cool down Angie was placed in a control hold for 25 minutes for kicking legs back and forth while sitting in the cool down chair. Another phone message was left for the Angie's foster mother and the New Visions social worker notifying them of the hold.

Angie had play therapy again on Friday. There were no incidents or behaviors reported during this time period. A note was put in the file to do more play therapy.

## **WEEK 5**

This would be Angie's final week at RLDTTC. On Monday May 22, Angie was placed in cool down for making noises in class. Angie was then placed in prone restraint for 35 minutes for sitting back forcefully in the time-out chair.

The RLDTTC clinical supervision team met that same day. The meeting lasted a total of 13 minutes, with six out of nine team members in attendance. The summary did state that RLDTTC staff would monitor medication effectiveness and communicate findings to the prescribing physician. This is the only date that psychotropic medications side effects were recorded and the only date that the RLDTTC nurse noted that Angie's vitals were taken, although they do not appear to have been written in her record. A fax was then sent to Angie's psychiatrist asking if the medications were correct. This was the first contact with a doctor recorded in Angie's clinical record. Nothing was mentioned to the psychiatrist about the use of prone restraint control holds on Angie, or the use of Tenex as PRN. RLDTTC did not have the correct signed release to communicate with outside doctors prior to this.

That Tuesday Angie did not attend RLDTTC due to other appointments. In the notes written by the RLDTTC program coordinator a month after Angie's death, there is mention of a meeting that day with staff about Angie's behavior. Staff mentioned to the coordinator that Angie's behaviors were becoming much worse, and brought up the idea that Angie needed material geared to a 4 to 5 year-old for Angie to understand it. The program coordinator's note reflect that staff did not have any past psychological testing records, behavioral information from either the county or past treatment foster care or sleep information. The note went on to state that all new plans were to be implemented the next day, May 24, on Angie's return. The note does not mention whether staff had received training on these new plans, nor does it outline exactly what these new plans were.

On Wednesday, May 24 Angie was placed in cool-down for not following directions. While in cool-down Angie was placed in prone restraint for 107 minutes for throwing herself back

into the chair. That same day, Angie's play therapist noted that, although Angie worked well in individual therapy without problems, she needed more intensive services and encouraged staff to do more play therapy. This was the only professional staff to express concern in the records over the use of control holds. Notice regarding Angie's first multidisciplinary team meeting was finally sent out, scheduling the meeting for June 6, 2006.

### **INCIDENT LEADING TO ANGIE'S DEATH**

The reconstruction of the events leading to Angie's death is based on the incident report written by RLDTC the day after Angie's death. According to the report, around 11:44 a.m., on Thursday, May 25, Angie was reprimanded during lunch period for gurgling her milk and talking to peers. Angie was on a "no peer casual socialization" status because of her behavior the day before. When Angie continued to talk to her peers after two warnings she was given a 5 minute in-room cool down for not following directions. Angie went to the cool-down chair and sat down with her feet up on the chair seat and her arms wrapped around legs and her head down resting on her knees. When staff insisted that she sit in her chair with her head up and feet on the floor, Angie refused, shaking her head "no."

Staff then insisted that she go to the special cool-down room. Angie continued to refuse, covering her ears with her hands. Staff proceeded to walk her down the hall to the cool-down room, holding her arms and put her in the cool down chair. Angie immediately leaned forward in the chair, her chest touching her legs, and covered her face with her hands. Staff reminded her that her cool down time didn't begin until she was sitting up, with her hands in her lap or at her side and her legs uncrossed. Angie covered her ears with her hands and began to cry. She curled up in the chair and soon appeared to staff to fall asleep.

After about five minutes staff woke Angie up and again told her to sit upright in the chair to begin the 15 minute cool-down period. Angie complained of being tired and was told by staff that she could discuss being tired with staff after she finished her cool down. Angie refused to sit in the chair in the manner prescribed for her cool-down, and began to kick her feet, appearing to staff to be attempting to sleep. Staff told her that if she continued she would be placed in a hold for everyone's safety; however, Angie continued to cry and swing her legs.

Staff then placed Angie in a half-down physical hold, with a staff person on each side of the client, securing her arms behind her back to force her torso forward in the cool-down chair so her chest was close to her upper legs. Angie began to cry loudly and tried to pull her arms away from the staff holding her. Staff told her to stop struggling and that she would be released when she agreed to sit properly in the cool-down chair. Angie continued to cry but stopped struggling with her arms and told staff that she would sit in her cool-down. Angie was released from the half-down hold about two minutes after it had started.

Angie sat in the chair in the proper position for her cool-down, but started crying and shaking her head back and forth as if indicating “no.” Staff reminded her that she had said she was ready to start her cool-down, but soon Angie started to kick her legs again. At some point staff reported that Angie turned to them in an aggressive manner, so they attempted to put her in another half-down physical control hold. As staff set out to do this, Angie moved forward out of the chair landing on her knees on the ground. Angie was immediately put in a prone restraint control hold and one of the staff pushed her call button to summon more staff to assist with the restraint.

While in the prone control hold, Angie screamed names at staff and said “I hate this school.” She also complained at various times that her ankles, chest and eye hurt during the hold. As Angie fought off staff, a third person was placed on Angie to help hold her legs. Angie continued to resist for the next 23 minutes, telling staff that she felt like she was “going to puke.” Angie then urinated in her pants and told staff that she was going to “poop in my pants.” The staff incident report states that around 1:16 p.m. Angie started to calm down, responding positively to unspecified staff prompts. Staff members continued to restrain Angie for another five minutes, then got off of Angie and tried to get her to the cool-down chair. Staff reported that Angie began to make “cooing noises” and got herself into a more comfortable position. Staff waited for approximately five minutes, thinking the client had fallen asleep. It was noted that it was not uncommon for Angie to fall asleep after prone restraint holds in the past.

A member of the staff then asked Angie a question. She did not respond. This was repeated several times with no response from Angie. A staff member then shook Angie’s shoulder and told her to get ready to start her cool-down. After no response, one of the staff rolled Angie over and noticed that Angie’s lips were turning blue. Another staff checked for breathing and could detect none. The program coordinator arrived at the scene and instructed that 911 be called and that rescue breathing be undertaken. At this point Angie did not have a pulse and CPR was performed until the EMTs arrived and CPR continued to be performed as they took Angie from the building.

Angie was taken to the Pediatric Intensive Care Unit of Children’s Hospitals and Clinics in Minneapolis, Minnesota by Life Link Transport in full cardiac arrest and was pronounced dead on May 26, 2006, never regaining consciousness.

## **AFTERMATH OF ANGIE'S DEATH**

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### **RLDTC Closure**

Immediately after Angie's death RLDTC suspended its operations, which at the time was reported as a temporary measure. On June 15, DHFS issued its original statement of deficiency and required a Plan of Correction to NWCGC, the parent company of RLDTC, which was cited for a number of regulatory violations. On July 28, the Department issued a six-month suspension to continue the closure on an interim basis after it rejected NWCGC's Plan of Correction as incomplete. An amended Plan of Correction was submitted on August 7, but DHFS, expressing concern over NWCGC's lack of commitment to changing the control hold practice, again rejected the plan. On August 15, 2006, the Department suspended the funding for RLDTC. Finally, on November 10, 2006, NWCGC wrote to DHFS informing the state that it would not reopen the Rice Lake facility. Although RLDTC was one of twelve day treatment sites operated by NWCGC, and operating under common NWCGC policies, the DHFS violations and closure proceedings related to only the single RLDTC facility, and the remaining eleven NWCGC locations continue to receive state and federal funding.

On September 11, 2006, the Bureau of Quality Assurance for DHFS issued an official memo titled "Interim Guidance on Use of Seclusion and Restraints in Certified Day Treatment Programs for Children." In it, the Department outlined current law governing children's day treatment facilities, and indicated its intent to issue additional policy clarification and information on training and technical assistance at a later date. To date, nothing further has been issued.

### **Criminal Charges**

Criminal investigations into Angie's death were conducted by the Rice Lake Police, Barron County prosecutor and State of Wisconsin Department of Justice. As a result of these investigations, charges of criminal negligence were brought against one of the RLDTC staff members who restrained Angie that day, and Northwest Counseling and Guidance Clinics, the legal entity under which RLDTC operated. Both the staff member and Northwest Counseling and Guidance Clinics pleaded no contest to the charges.

The Barron County Circuit Court Judge in the case imposed the maximum fine of \$100,000 against Northwest Counseling and Guidance Clinics for one felony count of negligent abuse of a resident. The staff person was sentenced to 60 days in jail and one year probation for the misdemeanor negligence charge. During sentencing the judge remarked that "there were a lot of other people who made decisions that led up to her death."

## **INVESTIGATION FINDINGS**

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### **1. Autopsy**

After Angie's death, an autopsy was performed by the Hennepin County Medical Examiner. At the time of her death, Angie was only 4 feet two inches tall and weighed 67 pounds. The autopsy and related medical reports indicated that Angie died from complications of chest compression asphyxia. She had received a grave anoxic brain injury which resulted in brain death. She had hemorrhages of the pancreas, colon, stomach, and duodenum from abdominal trauma from the hold. There were also several bruises on her head and knees. The Medical Examiner ruled Angie's death a homicide because the restraint impaired her ability to breath.

The primary cause of these injuries would have been the weight of a person or persons crushing her abdominal area. The anoxic brain injury Angie sustained may well have accumulated over the course of more than one of the prone control holds from the symptoms that were reported by Angie and staff after a hold. Symptoms would have been eyes hurting, loss of consciousness (falling asleep and hard to awake), and others which were common during Angie's holds. She appears to have had a reduction of oxygen to the brain over a period of time and increasing brain injury from the number of holds. Medical records state she had been in holds nearly daily for the last 2 weeks of her life and by history had "fallen asleep" during these holds. Angie's reactions to each hold got progressively worse, which would seem to indicate that she was suffering more each time.

### **2. Investigation by DHFS**

Immediately after Angie's death the Department of Health and Family Services Bureau of Quality Assurance (now Division of Quality Assurance) initiated a death investigation as required under state regulation. Additionally, DHFS contracted for a child psychiatrist to conduct a program review of RLDTC and produce a report of his findings. Between the dates of May 25, 2006 and July 27, 2006, investigators conducted an onsite review at RLDTC, including a review of the client record, NWCGC's Policies and Procedures, and interviews of staff members. The investigation identified a number of violations of the Wisconsin Administrative Code regulations for Mental Health Day Treatment for Children, Care Giver Background Check and Patients Rights and resolution of Patient Grievances. A Statement of Deficiencies was issued to NWCGC on June 15, 2006. The Department cited RLDTC and NWCGC in a number of different areas related to Angie's assessment, treatment plan, restraint and staff supervision.

## **A. Bureau of Quality Assurance Deficiency Citations**

- **Angie had documented emotional and behavioral needs that exceeded those of a Level I facility.**

According to HFS Chapter 40 regulations for Children's Day Treatment Programs, Level I services means services designed for clients whose primary needs are derived from conduct disorders or oppositional disorders. Services for clients in this group should include extended participation in a therapeutic milieu of structured services including individual, group and family counseling, education support or direct academic instruction and recreational therapy.

Given Angie's clinical record diagnoses of Reactive Attachment Disorder, Mood Disorder, ADHD and R/O (rule out) Anxiety Disorder, and the program's response of frequent restraint, Angie was not appropriate for RLDTC's Level I program.

- **RLDTC did not follow required assessment procedures prior to admitting Angie to the program**

Under HFS Chapter 40 regulations, admission to the RLDTC program required the referring agency to provide all available reports and evaluations that identify the child's need for services. Furthermore, the assessment must include procedures for assessing and monitoring the effects and side effects of psychotropic medications.

RLDTC's Initial Assessment for Angie did not require or review current or prior treatment information. There is no evidence that there was any collaboration with Angie's treating psychiatrist, other than a request for records. Since there were no procedures set out for monitoring Angie's medications, staff did not document monitoring either the effectiveness or side effects of Angie's psychotropic medications. RLDTC had a form listing 23 symptoms that require monitoring for side effects. There was only one notation, prior to Angie's first day at RLDTC regarding headaches, and no other entries after that date.

- **RLDTC failed to provided required medical oversight of Angie and other program clients.**

Level I programs such as RLDTC must provide at least one hour per week of services by an M.D. or R.N. for every four full-time clients in the program. Additionally, these programs must arrange for emergency, medical and nursing services to be readily available at all times clients are present.

At the maximum number of children (22) documented to have attended RLDTC, there would have to have been over four hours of medical services logged every week at this



location. The consulting providers log revealed there were often weeks where there was no R.N. or M.D. on site for the entire week. The log also indicated that the NWCGC's R.N. was on-site on only one date when control holds were used on Angie. Angie was never evaluated by a nurse or physician following any of the control holds, even though it was documented in Angie's record that she had complained of dizziness, pain in her legs, ankle and thighs and eyes during restraints. By failing to provide nursing or other medical services as required, Angie and the other children in this program were subjected to medical triage and evaluation by staff untrained to provide this service.

- **RLDTC staff failed to convene a multi-disciplinary team meeting to review the high frequency of control holds placed on Angie and the continued appropriateness of the initial treatment plan.**

The RLDTC had the responsibility of convening Angie's multi-disciplinary treatment planning team within 30 days following the approval of the treatment plan, and then to reconvene the team if indicated by the client's condition, or other factors. Angie's multi-disciplinary team had the responsibility to consider the continued appropriateness of the original treatment plan, and to modify the objectives, interventions and actions as needed.

Angie's clinical record showed eighteen different time-outs (cool downs) and nine days with control hold totals of over 90 minutes. Angie's chart had daily notations identifying her behavior problems with staff. However, there was no documentation that indicated that the multi-disciplinary team was ever called upon to review Angie's behavior in light of the clinical record's clear evidence that RLDTC's original approach with Angie did not seem to be working. There were no modifications made to the treatment plan, even in light of documentation of repeated staff interventions. There was no evidence of any discussion by the team of treatment plan changes, or alternative interventions, despite the clear evidence that Angie was not responding to the original plan or showing progress over her time at RLDTC.

- **Angie's Treatment record did not contain required information relevant to the administration of medication by RLDTC**

One necessary element of Angie's treatment record at RLDTC was a medication record documenting the ongoing monitoring of the administration of medication and detection of any adverse drug reactions. Angie was on five medications that needed to be monitored for side effects, as well as a PRN that was to be given by RLDTC staff to help her settle herself when she became agitated.

Based on a review of Angie's record and interview with the RLDTC psychiatrist and Medical Director, her chart was incomplete since there was no documentation of the medication administered PRN and no information on adverse side effects of Angie's other medications. Furthermore, Angie's treatment plan called for vital signs to be taken by

RLDTC's registered nurse. However the form dedicated to this purpose was blank except for the date, and contained no information on Angie's blood pressure, heart rate, glucose level, or other vital functions.

- **Angie was not provided the least restrictive treatment and conditions.**

According to both regulation (HFS 94) and state statute (Wis Stat §51.61), Angie was entitled to be provided the least restrictive treatment and conditions which allow the maximum amount of personal and physical freedom.

The few times that the Tenex PRN was used at RLDTC to help Angie calm down, she was reported to have been able to regain her composure. This medication was an intervention technique that had previously demonstrated a positive effect on Angie's behavior. It is unclear why it was not given after May 1, yet its use might have prevented or shortened the time of future prone restraints, each of which lasted at least ninety minutes.

- **The Isolation and Restraint of Angie by RLDTC Staff violated Wisconsin Law**

Service providers using isolation or physical restraint must comply with state law and regulation regarding their use. Under state law, isolation and/or restraint are allowed only in an emergency when it is likely that the patient may physically harm herself or others, or when part of a treatment program. In a community placement such as Angie's, specific approval of DHFS was required.

RLDTC staff failed to follow state law in the use of physical restraint in an emergency. Angie's records showed no plan for the use of restraint as part of her treatment plan, nor had RLDTC applied to DHFS for approval of such a plan as required by state regulation. Therefore, staff could legally restrain Angie only in an emergency situation, and then for the shortest time possible. RLDTC failed to demonstrate that the use of each isolation and prone restraint was due to an emergency. None of the behaviors described in Angie's clinical record met the statutory definition of an emergency.

Under NWCGC's policies for De-Escalation and Non-Violent Physical Control Holds, Angie should only have been isolated in cool down for a 10-minute period at the most, and they gave no guidance or description of emergencies which would indicate when physical restraint was allowed and no guidelines on how long restraint could be used. The length of a prone restraint control hold was determined by staff's identification of Angie's particular behavior and was not influenced by other factors such as her relative young age, medications or medical condition.

- **RLDTC failed to provide direct clinical supervision of two staff involved in Angie's fatal prone restraint.**

Proper clinical supervision of program staff must include direct clinical review and

assessment of each staff person's performance in providing treatment services to the children in the program. Clinical supervision is to be accomplished by either individual face-to-face or side-by-side sessions with a supervisor.

RLDTC's log of supervision showed that RLDTC failed to provide direct clinical review and assessment of two of the employees directly involved in holding Angie down in what would become a fatal prone restraint, including the staff person criminally charged in Angie's death. There was no evidence that any face-to-face or side-by-side supervision was ever done at RLDTC, and both the Program Director and Internal Operations Manager confirmed that it was the practice of RLDTC to only provide group supervision.

- **RLDTC failed to get the required number of character references for one of the employees directly involved in the fatal prone restraint of Angie.**

DHFS regulations required that RLDTC get character references from two people and employment references from all employers within the last five years, and verification from educational institutions of degrees obtained.

Based on a review of employee personnel files, only one character reference was obtained for one of the staff who was directly involved in the prone restraint that caused Angie's death.

## **B. Expert Consultant Report**

The Department of Health and Family Services, through the Bureaus of Quality Assurance and Mental Health and Substance Abuse Services, engaged the services of a consultant, Child Psychiatrist Dr. Randall Cullen, M.D., to conduct an overall program review of RLDTC and their use of control holds specifically, to offer technical assistance and to submit a written report on the RLDTC program. In the case of some of the conclusions, this would apply to NWCGC day treatment programs as well. It should be noted that this is the same Department consultant who had originally signed the Prior Authorization submitted by RLDTC to admit Angie to their facility in the first place. Dr. Cullen interviewed staff and parents of other children in the program and reviewed Angie's medical record, submitting his report to the Department on July 17, 2006. In summary form, the DHFS expert observed the following:

### **Expert's Findings and Assessment**

#### **1) Assessment Process**

- Despite the fact that the initial assessment began on April 11, 2006, and Angie was admitted to RLDTC on April 24, the Assessment report was not written until April 28 and

was signed off on by staff over the next 30 days. This seemed to indicate that the assessment process was haphazard and not taken seriously, with possibly no meeting to discuss the assessment.

- The assessment process was rushed (with no underlying medical urgency) which resulted in poor, neglectful information-gathering and precluded a more careful review. Information from Angie's foster mother seemed to be ignored.
- Angie was on a total of six medications. The medication verification form signed by Angie's pediatrician requested that RLDTC contact Angie's psychiatrist to discuss Angie's medications and possible side effects. There was no attempt to ascertain prior or future psychiatric appointments, and no calls were made to either Angie's primary care doctor or psychiatrist for 60 days, only three days before Angie died.
- Given Angie's diagnoses, symptoms and medications, she was not appropriate for a Level I program, which would have been made clear through proper assessment.
- The Initial Mental Status Exam by the RLDTC consulting psychologist noted that Angie complained of chronic daily headaches. There were no documented calls to Angie's primary care doctor or prescribing psychiatrist to question potential side effects. There did not appear to be any other reference to this complaint in Angie's record, including the treatment plan or nursing notes until May 22, which called RLDTC medical practice and procedures into question.

## **2) Angie's Treatment Plan**

- The fact that staff signed off on Angie's initial treatment plan over a period of 30 days indicated that it was not taken seriously or only given a haphazard review with possibly no actual meeting to discuss the assessment or plan.
- The retroactive clinic notes written by RLDTC program coordinator indicate debate and confusion about whether to use the PRN medication (Tenex) to help Angie settle when agitated. The release to communicate with the psychiatrist was obtained from the guardian on May 16, over three weeks after her admission, and the RN finally requested information from the psychiatrist on May 22, almost four weeks after Angie's admission.
- Another portion of the retroactive notes related the staff struggle to try alternate approaches to cool downs, which often lead to prone restraint. These discussions were, unfortunately, informal, and documented informally after the fact. They showed a lack of clinical and medical leadership to more urgently pursue a better plan, gather information and make decisions.
- The only seemingly formal discussion of Angie's progress occurred on May 22, after a month of repeated physical holds and mounting staff frustration. Yet, the clinical leader of the team did not sign off on the summary until a month later on June 22, 2006. This

meeting did not produce any changes that were recorded for problems and goals, fixed barriers to treatment, interventions or risk levels. This is at odds with the informal notes which indicated many proposed changes in these areas. The lack of urgency with no change in plans seemed to indicate to the DHFS expert that there was a failure of clinical leadership.

- The first and only note by a medical professional is dated May 22, when the RN noted the current medications, but did not record Angie's vital signs. A client with this many medications should have had ongoing medical monitoring. There was no scheduled recording of vital signs. This was especially problematic since several of Angie's medications can lower blood pressure and pulse. Given her medications and her complaints of headaches, vital signs should have been monitored closely.
- The expert noted that for a client on five or six medications, gathering information should not have taken a month. Angie was on too many medications with too severe problems to allow for such a passive, lethargic information-gathering process.
- The Medical Verification form, signed by Angie's pediatrician on March 22, requested that RLDTTC contact the prescribing psychiatrist regarding Angie's medication. However, it took 60 days for contact to be made after this note was signed.
- West Bend School District records, received by RLDTTC on May 9, contained a history of Angie inserting objects into her body. The DHFS expert could find no note anywhere in RLDTTC documentation indicating that staff knew about this or monitored Angie in any way for this issue.

### **3) Angie's Restraint and Seclusion**

- All of the control holds that Angie was subjected to were precipitated by behavior that did not seem to exhibit the level of dangerousness necessary to require the emergency use of a restraint hold. Most behaviors reported as justification for the holds did not seem to pose any real physical threat to Angie or staff.
- In order to successfully complete a cool down, Angie had to exhibit total body control, sitting perfectly still, feet on the ground, hands in her lap for the duration of the cool-down session. This was an unreasonable demand to place on any seven year-old child, especially one with Angie's diagnoses and trauma history. Dr. Cullen was of the opinion that such expectations were not even appropriate for pre-teens with impulse control problems, attention problems and often devastating histories of extreme abuse and control issues. Moreover, such demands such as those made by RLDTTC staff seemed to invite oppositional behaviors, and many of these escalations could have possibly been avoided if expectations were more age-appropriate. It was likely that Angie would have settled on her own if there had been an option to a time out in a quiet, safe, padded room.

## **Selected Expert Recommendations**

1. Prior authorization process should include a review of client's appropriateness for admission to Level I, II, or III programs.
2. No child should be admitted until all assessment material has been gathered and reviewed to determine whether the admission is appropriate for the program. Material should include summaries of previous mental health care in the past year, psychological testing reports, and psychiatric evaluations.
3. Once a child is admitted, a treatment plan meeting must be held with all team members at the table to establish the treatment plan with measurable goals.
4. If the child is on two or more medications, the medical director of the program must consult with the prescriber and document diagnosis, medication plan, target symptoms for medications, monitoring, etc. and vital signs should be done at time of admission and weekly thereafter.
5. Physical holds for children under the age of 12 should be replaced by the use of time out. Physical holds of older children should never last more than 15 minutes.
6. All children requiring more than one physical hold in a month should be reviewed for treatment planning by senior clinical and administrative staff.
7. There should be more emphasis on noticing and praising safe and positive behaviors while ignoring negative behaviors unless safety is an issue.
8. Families should feel welcomed by the program and given opportunities to learn parenting skills from other families and/or by observing from a behavioral program that can be easily translated to the home.

## **HOW THE SYSTEM FAILED ANGIE: ISSUES AND FINDINGS**

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### **A. Criteria for Effective Children’s Mental Health Day Treatment Programs**

Day treatment is recognized as an element in a system of care for children and youth with severe emotional disturbances. However, it is the most restrictive form of community mental health services for children and thus should be used only when less restrictive interventions are inappropriate. According to Stroul and Freedman, “Day treatment is a service that provides an integrated set of educational, counseling, and family interventions which typically involve a youngster for at least five hours a day. Day treatment programs frequently involve collaboration between mental health and education agencies. Even where such a formal collaboration does not exist, day treatment involves an integration of educational and mental health services.”<sup>1</sup>

Typical services provided in day treatment include special education services, group and individual counseling, family services, including family counseling, parent training, and assistance with tangible needs, vocational training for adolescents, crisis intervention, personal skill building, positive behavior modification approaches, and recreational, art, and music therapy.<sup>2</sup>

Individual programs vary widely, but research has found that day treatment programs may be effective in preventing out of home placement. However, most studies have found that treatment gains are less likely for children with severe behavior problems than for children with other disabilities. Involvement of the family appears to be critical in achieving positive outcomes for children in day treatment. Unfortunately, treatment gains do not appear to generalize to mainstreamed school settings.<sup>3</sup>

In reviewing what standards of care should guide children’s community mental health programs, the 2006 guidelines developed by the American Academy of Child and Adolescent Psychiatry (AACAP) provide a useful framework. These should be seriously considered when reviewing the Wisconsin day treatment standards that were developed a decade ago.

The AACAP recommends the following for children’s community mental health treatment programs:

- Clinical assessment and treatment approaches should be guided by an understanding of the ecological context of the child and family, incorporating information from all community systems in which they are involved, including both formal services and natural supports. Since children may be involved in many systems of care adequate time must be taken to gather data and communicate with other providers.
- Clinicians must develop collaborative and strengths-based relationships with families,

emphasizing partnership in case planning.

- Mental health interventions should be actively coordinated with services by other providers and whenever possible integrated with interventions provided by other social service agencies.
- Services should be culturally competent and should address the needs of under served, culturally diverse, at-risk populations.
- Clinicians should consider a wraparound planning process to achieve individualization of care for children with significant and complex mental health needs. There should be a comprehensive assessment, using a strengths-based approach, and treatment planning that knits together services from all involved providers.
- Treatment planning should incorporate effective interventions supported by the available evidence base. The wraparound planning process may not be effective if the interventions themselves are not effective or the skills or training of the clinicians are not adequate. Evidence-based interventions such as cognitive-behavioral, interpersonal, and other therapies for specific disorders and multi systemic therapy should be incorporated whenever possible.
- Pharmacotherapy should be performed by a physician or medical practitioner who is incorporated into the interdisciplinary process and has completed a biopsychosocial assessment, including interviewing the child and parent or care giver and reviewing other relevant data.
- Services should be delivered in the most normative and least restrictive setting that is clinically appropriate. The intensity of services should be determined by clinically informed decision-making.
- Significant attention should be paid to transitions between levels of care, services, agencies, or systems to ensure that care is appropriate, emphasizing continuity of care.<sup>4</sup>

Children's day treatment may be an effective program for some children. However, it may be over-utilized if other treatment options are not available. Thus, care needs to be taken to ensure that it is the most effective, least restrictive approach for the individual. In order for the program to provide quality care there must be comprehensive strength-based assessment, individualized treatment planning that involves the child and family as well as other service providers, culturally competent programming that is based on what research has shown to be the most effective interventions, quality medical care including medication management, close collaboration with other services especially schools, highly trained competent and caring staff, and attention to transitions both in and out of the program to ensure continuity of care.



## **Findings**

Unfortunately, the care provided to Angie fell far short of these criteria. Data from other service providers and her foster family were not gathered in a timely manner and were not incorporated into her assessment and treatment plan. Angie's plan did not focus on her strengths: it focused on discipline and negative consequences rather than focusing on the established principles of reinforcing positive behavior. Her treatment was not based on an evidence-based approach. Medical oversight was not incorporated into her treatment and there was no attempt to record information required for the responsible administration of medication by RLDTC. Her foster family was not involved in a collaborative relationship with the day treatment program. Her treatment was not coordinated with other service providers, such as her psychiatrist, school, social worker, and former counselors. Little attention was paid to her transition into the program and why she was there. Angie had documented emotional and behavioral needs that were beyond the services provided in a Level I Day Treatment facility; therefore, the services provided by the program were not appropriate for her needs.

## **B. Elements of Proper Comprehensive Assessment and Individualized Treatment Planning**

The goals of comprehensive assessment and individualized treatment planning are simple. However, understanding the purpose of the process and ensuring effective implementation is more complicated.

First, the initial assessment of a client is the initial evaluation of the individual's mental and functional status, the effectiveness of past and current treatment, and support service needs. This information-gathering and analysis of information is completed by experienced clinical staff (psychiatrist, psychologist, and masters level clinicians with experience in the treatment of children with mental disorders). It is used to establish the initial treatment plan to support recovery and help the client achieve individual goals, no matter what their age. Completed at the time of admission, the client's initial assessment and treatment plan guide the services by the team until the comprehensive assessment and treatment plan are completed. The initial assessment should serve to identify whether the program is appropriate for the child being admitted. The HFS Chapter 40 standards call for the initial assessment to be done in 30 days; however this initial assessment should be completed very early on, in part to determine whether the client is appropriately referred to the correct level of program services or even the program of services itself (in this case, mental health day treatment for children).

Next, the comprehensive assessment is the organized process of thoroughly gathering and analyzing current and past information with each client and the client's family, support systems, and other significant people (a) to evaluate mental and functional status; (b) to evaluate effectiveness of past treatments; and (c) to identify current treatment and support

needs to achieve individual client goals and support recovery. The results of the information-gathering and analysis are used with each client to establish service needs, to set goals, and to develop the first individualized treatment plan with each client. Goals need to be measurable. They provide a basis for review to determine whether strategies and interventions are working effectively and they provide a context in which to evaluate progress.

Because of its labor-intensive nature, the step of obtaining of information via interviews and obtaining records is usually completed in the first month following the client's admission to the program. The assessment process allows the clinician and professional staff time to get to know the client apart from the reported symptoms and problem behaviors which generated the referral. Further, it supports development of the therapeutic relationship between the individual child and the clinician. Additionally, the assessment process enables the clinician to understand the client (child) within the context of the family and community (home, school, child welfare system, juvenile justice system, etc.) and it provides the treatment team with valuable information for analysis.

A good assessment typically requires a clear identification of the presenting problem, including client self-assessment of the problem; the reason for the treatment request and the referral source; availability of social supports and resources; history of psychiatric illness and previous services; developmental and social history; current functioning, etc. Assessment of the mental functioning of the child, as for an adult, requires the skills and competencies of a child psychiatrist, psychiatrist or psychologist and has the goal of learning the unique and functional characteristics of each individual (sometimes called formulation) and of diagnosing signs and symptoms that suggest the presence of a mental disorder.

Masters level clinicians with competencies in children's mental health may also participate in gathering information from the family, school system, primary care physician, previous mental health treaters, child welfare system, or anyone else who can provide information regarding the child's level of functioning and interaction. Other staff who have expertise in specific areas of childhood functioning are also logical additional team members. For example, the teacher on the team could conduct an assessment interview with the school teacher referring the child; likewise, an RN could interview the child's primary care M.D. or clinic to obtain a health and medication history; and the recreational therapist of the program might interview the child and family members to determine what play time or free time is like for them at home.

This information-gathering should be designed to get to know the child (client). This information should always be written up and presented at the team meeting which always includes professional clinical staff. The team members then participate in the analysis of this information at a team meeting called to review all the assessment components and formulate an individualized treatment plan, complete with short term and long term goals and strategies and interventions to be utilized by the team.

A noteworthy observation is that the clinical leadership and professional staff are not clearly defined in the current children's day standard, as compared to the clear definition of the roles in the community support program standards (HFS Ch 63). Clinical leadership is essential to implementation of the important clinical functions of comprehensive assessment and individualized treatment planning. Clear standards of clinical leadership and oversight are needed to ensure program interventions are effective and evidence-based and not loosely defined generalists standards that result in inadequate patient care. A telling example is the lack of attention to and follow through on recommendations for more play therapy and intensive treatment for Angie.

A comprehensive assessment should always include a medical health assessment to be completed by appropriate medical staff of the program. However, current mental health day treatment regulations do not require this aspect of evaluation of its clients, despite having the requirement of a physician medical director and the registered nurse as members of the program team.

There must be accountability by the professional clinical staff in charge of the overall care and treatment of all the children in the program, as well as all care provided by all staff of the program. This accountability is usually provided by the medical director and clinical coordinator of the program. It is required that they participate in the assessment process directly as documented by their signatures on both the comprehensive assessment and treatment plan of each client in the program.

There is no short cut in this process. The assessment of mental function alone takes hours and usually several meetings. It also requires the team to obtain the records and information from past providers and others in the community in order to get a thorough understanding of the child's life in the context of family and community. In addition, the speed at which children change and proceed through developmental changes requires thorough attention to both past and present assessment of their functioning. For example, what might have seemed somewhat inappropriate one year ago at school may now represent something more troublesome or indicative of a problem behavior requiring appropriate evaluation.

Finally, the granting of waivers in Angie's care was highly inappropriate. Comprehensive assessment and individualized treatment planning represents the standard of care for good quality clinical practice in community settings. Clinicians may need to seek consultation to learn this process, such as the Assertive Community Treatment (ACT) Start up Manual.<sup>5</sup> Although different in the clients served, the descriptions of the clinical process related to comprehensive assessment and individualized treatment planning could be the basis of learning. Implementing comprehensive assessment and individualized treatment planning in practice will require direct consultation from experienced clinicians who know how to do this work in community settings. A certified ACT program could provide consultation on how to incorporate this process into children's community mental health programs.

## **Findings**

RLDTC did not conduct a minimally adequate assessment of Angie prior to admitting her to their Level I program. The pressure to take higher need children than RLDTC was equipped to deal with in light of staff experience led to a hurried assessment process that was not taken seriously. This resulted in poor information gathering and precluded a more careful review. Without a proper assessment, there were no underpinnings for the development of an individualized treatment plan that addressed Angie's needs. Finally, the failure to convene a multi-disciplinary team meeting to review Angie's progress at RLDTC foreclosed a proper review of whether her initial treatment plan was appropriate, given the disturbingly high number of control holds placed on Angie in such a short amount of time.

### **C. Use of Restraints and Seclusion in Mental Health Programs Serving Children and Youth**

There is a consensus among both national and state mental health organizations, including the Wisconsin Department of Health and Family Services<sup>6</sup>, that restraints and seclusion are not treatment interventions, but are safety interventions of the last resort.<sup>7</sup> Use of such interventions creates significant risks for persons with psychiatric disabilities, including serious injury or death, retraumatization of persons with a history of trauma, and loss of dignity and other psychological harm.

The use of restraints and seclusion with children is especially troubling. Children are still developing psychologically and physically and the use of seclusion or restraints can significantly impair this development. In addition, children receiving mental health services have high rates of trauma in their backgrounds which can be exacerbated by the use of restraints and seclusion. However, children are twice as likely as adults to be restrained. Research has shown that children who are restrained see it as a form of punishment and are retraumatized by the experience.<sup>8</sup> The Federation of Families for Children's Mental Health, Position on the Use of Seclusion and Restraints states: "We view restraint and seclusion as inhumane, cruel, and ineffective. These techniques, at best, may temporarily relieve stress for the adults in charge and always increase stress for the child or youth. There is no evidence that the use of restraints or seclusion has any therapeutic benefit whatsoever."<sup>9</sup>

Instead of resorting to the use of restraints or seclusion, mental health programs must focus on prevention of behavior that may pose a danger to the child or others. This should include treatment plans and approaches that focus on positive behavior, de-escalation and other crisis intervention approaches, review and revisions of treatment plans on an on-going basis, identification of past traumas and appropriate treatment strategies to promote healing and avoid retraumatization, and collaborative involvement of children and families in the provision of treatment and other services.<sup>10</sup>

There are a number of programs and approaches that promote positive behavior supports with children and youth, that teach de-escalation and other crisis prevention strategies, that provide trauma informed care, and that promote collaborative relationships between service providers and children and families. For example, SAMHSA has made grants to Support Restraint and Seclusion Training in Programs That Serve Children and Youth; the Child Welfare League of America has produced a number of best practice guidelines on behavior support and intervention and seclusion and restraint reduction<sup>11</sup>; the National Child Traumatic Stress Network promotes programming that is trauma informed<sup>12</sup>; training programs such as The Mandt System<sup>13</sup> teach crisis prevention and positive treatment strategies; the SAMHSA Roadmap includes a number of approaches that promote collaboration and peer support. In Wisconsin some programs are implementing these techniques and others to bring about a reduction of the use of restraint and seclusion with children and youth. These should be expanded and supported.

If it becomes necessary to use a restrictive measure in a situation where the child or youth is engaging in behavior that is physically dangerous to self or others, then strict standards and guidelines must be followed.

- There must be clear definitions of when seclusion or restraints can be used, limiting them to legitimate and imminent risk of physical danger to self or others.
- Any order for the use of seclusion or restraints must take into account the child's developmental stage, trauma history, and clinical situation.
- Only qualified clinicians should be able to order, monitor, and terminate restraints or seclusion.
- Use of seclusion or restraints must be closely monitored and a child should not be left alone.
- Any restraint that blocks the airway or otherwise impedes a bodily function should not be used.
- Use of seclusion or restraints must be limited to the shortest time possible.
- Staff must be well trained before they can engage in the use of seclusion or restraints.
- There must be timely documentation and reporting of use and monitoring.
- Families must be notified as soon as possible after each episode of the use of restraints or seclusion.
- There must be timely de-briefing following each episode of the use of seclusion or restraints with staff, the child, and family.

- Treatment plans must be based on a strengths based model and emphasize positive behavior support and a crisis plan that focuses on de-escalation strategies must be included.
- After each episode of seclusion or restraint, the treatment plan should be reviewed and revised to eliminate/reduce the use of seclusion or restraints.
- There must be administrative review of all seclusion and restraint episodes to determine whether changes are needed in staffing, program, training, etc.
- There should be state level oversight of the use of restraints or seclusion in mental health treatment programs for children and youth.

## **Findings**

Unfortunately, in Angie's case almost all of these recommendations were violated. She was repeatedly restrained as part of an ill-conceived treatment approach that does not appear to adhere to any state regulatory or professional standards or to demonstrate any use of current principles of recommended clinical treatment. There was no plan of positive behavior supports or a crisis de-escalation plan. Restraints were used in circumstances when Angie, a mere seven year-old child, whose ADD made it difficult for her to sit still, was by no means an imminent danger to herself or others. Her treatment plan was not reviewed and revised when it was not working. She was not assessed for trauma and was not provided trauma informed care. The use of restraints was not ordered by a physician or other qualified clinician. It was not used for the shortest time possible. There were no de-briefing sessions involving Angie, her foster mother, and the staff. Prone restraints were repeatedly used. There was little to no administrative oversight of the use of restraints. All of these deficiencies tragically led to her death.

## **D. DHFS Oversight**

The Department of Health and Family Services, as the regulating authority for licensed mental health treatment facilities, is charged with oversight responsibility for all children's mental health day treatment programs in Wisconsin. This authority is conferred by Section 51.42(7)(b) of the Wisconsin Statutes and Chapter HFS 40 of the Wisconsin Administrative Code, in order to allow the Department to establish standard definitions, program criteria and patient characteristics and to assure the availability, quality and effectiveness of children's mental health day treatment services. Through the certification process, the Department is responsible for regulating all aspects of these programs, including qualifications and training of personnel, minimum staffing levels, necessary services and program components, client assessments, treatment records, termination of services and client rights. The purpose of such regulation is not to simply verify that some set of policies and procedures exist, but rather to ascertain that these policies meet the

threshold standards necessary to maintain adequate services and assure that there is a safe environment for children in the care of the program.

The initial certification and subsequent renewal processes each give the Department an opportunity to conduct an on-site survey of the program and staff. Information gathered during this process serves as the basis for the Department's determination of the extent of the program's compliance with the regulatory standards. There are standards covering both initial needs assessment and client treatment planning contained in Chapter 40, as well as a direct reference incorporating state law regarding patient's rights requirements.

While there is a definition of restraints in the regulations, there are no standards or other requirements governing the use of restraints in the day treatment regulations. This is in stark contrast to the state regulations for other children's programs, e.g., foster care, group foster care, and residential treatment facilities.

Once the certification has been granted, the Department retains the authority to terminate, suspend or refuse to renew a program's certification for a number of reasons, including if the program fails to maintain compliance with, or is in substantial noncompliance with, one or more of the requirements of Chapter 40. In the case of RLDTTC, an on-going program, there would have been more than one occasion for state surveyors to review NWCGC policies as well as observe the functioning of the program on-site.

While there is no substantive research that supports the effectiveness of restraint as treatment of children with emotional disorders, Wisconsin law allows the use of seclusion, isolation or restraint of children in community mental health programs outside of an emergency situation only when the use is approved by the Department on a case-by-case basis.<sup>14</sup> The Department is directed to review a program's policies on restraint and seclusion for compliance with applicable law, and then authorize the application of those policies to a particular child, on a case-by-case basis, where the community treatment program has applied to the state based on its assessment that one of these highly restrictive measures needs to be included in the treatment or behavioral plan. However, there is no identified body at the Department which has the authority to receive and review these requests for children's day treatment programs. In contrast there is an extensive review process for individuals with developmental disabilities who are served in one of the community based Medicaid waiver programs.

## **Findings**

There were a number of indications that should have alerted The Department to problems with the children's day treatment programs of NWCGC, and the RLDTTC facility in particular. In the Fall of 1998, two NWCGC day treatment facilities received Statements of Deficiency from DHFS which required corrective action regarding their isolation (cool-down rooms) and restraint (control holds) policies. Almost exactly one year before Angie's death the Department had received at least one complaint regarding the use of physical restraint by NWCGC, and DHFS surveyors commented to their superiors that NWCGC

seemed to generate the most requests and notices of restraints of all the programs in that region.

Furthermore, in the course of the certification and renewal process, NWCGC policies and practices regarding isolation, seclusion and restraint, assessment and treatment planning would have been reviewed by DHFS Surveyors. Some of these policies which had already been found to be deficient in 1998, were the source of new citations by the Department issued after the investigation of Angie's death. As part of their time on-site at RLDTTC, surveyors would have had ample opportunity to view RLDTTC's cool-down room, which clearly should have triggered more in-depth analysis of whether the use of such an isolation room was in compliance with Wisconsin law.

Finally, in November of 2005, just five months before Angie arrived at RLDTTC, in response to a query by NWCGC, a DHFS Bureau of Quality Assurance Surveyor erroneously advised NWCGC that the Chapter 51 protections relating to isolation and restraint only applied to inpatient facilities, and not a day treatment program such as RLDTTC. After NWCGC spelled out to DHFS a clearly noncompliant policy for control holds lasting over one hour (which required only a telephone call to a state behavioral specialist to have NWCGC staff get a "feel" for whether the hold could continue) there was no documentation that DHFS ever responded to inform NWCGC of the legal inadequacy of this course of action.



## **PROGRESS SINCE ANGIE'S DEATH**

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Since Angie's death in May of 2006, DHFS has undertaken the following actions to promote the use of positive behavior supports and reduce the use of seclusion and restraints.

- September 11, 2006, DHFS Bureau of Quality Assurance issued memo titled "Interim Guidance on Use of Seclusion and Restraints in Certified Day Treatment Programs for Children." The memo summarized state and federal law on seclusion and restraint use and provided limited information on training resources.
- February 1, 2007, WI Council on Mental Health wrote the DHFS Secretary requesting a day long event to "forge a coordinated approach to the management and treatment of youth with those behavioral and/or emotional disorders that put them at risk for the use of seclusion and restraint."
- March 2007, DHFS declined to apply for federal grant on Alternatives to Restraint and Seclusion.
- June 14, 2007, DHFS held a day long Summit on Promoting Positive Behavior Supports. The goal of the day was to "identify barriers, opportunities and an Action Plan for DHFS, in conjunction with counties, tribes, human service providers, parents, and advocates on ways to improve services for children as it relates to promoting positive behavior supports and reducing the use of seclusion and restraint in community programs and settings."
- August 8, 2007, document titled, "Draft Summary of the Summit Promoting Positive Behavior Supports to Reduce the Use of Seclusion and Restraint in the Department of Health and Family Services Programs for Children, June 13, 2007, " was released. A High Level Work Plan was also released. It identified 2 Work Groups.
  - A Systems Group, having the goals of "improving continuity of care for children and families and a common understanding of definitions around seclusion and restraint" and "standardizing expectations for care planning," was to review definitions across the system, develop a policy memo, and set performance goals by January 2008.
  - An Education and Technical Assistance Group was to establish a plan by July 2007 with the goals of establishing a common philosophy, a common vocabulary, a culture of caring, and introducing EBPs to agency administrators along with the concepts of monitoring, quality assurance and outcome measures.

*It is important to note that as yet a final summary of the summit proceedings has not*

*been issued and the called for memos and plans have not yet been developed.*

- DRW sent a draft of proposed revisions to the current state law on seclusion and restraints to DHFS. Revisions include removing use of seclusion or restraint as part of a treatment plan and incorporating aspects of the federal law/regulations on seclusion and restraint use. A meeting with DHFS representatives from various divisions was held on September 19, 2007. A memo summarizing DHFS concerns dated October 26, 2007, was sent to DRW. Concerns include developing clear definitions of terms, the complexity of developing a statute that covers a wide variety of populations, use in community settings, and DHFS oversight responsibilities, among others.
- October 2, 2007 a DHFS work group on standardizing terms and definitions was established. The initial goal of the group was to standardize terms and definitions related to the practice of seclusion and restraint across DHFS community programs and treatment settings for children, and to issue a joint memo from DHFS disseminating the definitions to community programs and settings.

*By June 2008 the review of definitions was completed, but no document or memo has been issued.*

- November 15, 2007 Wisconsin Family Ties, Grassroots Empowerment Project, NAMI-Wisconsin, Disability Rights Wisconsin, and Mental Health America wrote to the DHFS secretary requesting that he “declare a moratorium on the use of all restraints that restrict breathing by all treatment facilities and providers licensed and/or regulated by DHFS.” On November 16, 2007 a workgroup composed of DHFS staff and others was developed to write a memo on prohibited practices in the use of restraints. A draft memo was written, but the DHFS secretary refused to issue it until a training plan for providers was developed.

*To date such a plan has not been finalized and thus the memo has not been issued.*

- On November 16, 2007, a work group on positive behavior supports and training was created. It is composed of DHFS staff and others. On January 15 and 16, 2008 a training was presented by Beth Caldwell on “Creating Strengths-based and Trauma Sensitive Care: Preventing the Need for Coercive Interventions.” It was very well attended. A training on sensory integration was held; it also was well attended. A training on seclusion and restraint reduction was scheduled for November 17, 2008. As a result of these efforts a number of children’s mental health treatment providers have begun the process of educating staff and developing policies with the goal of reducing seclusion and restraint use.

*This group has drafted an overall plan for training and technical assistance for children’s mental health treatment providers statewide based on the Massachusetts model of restraint and seclusion reduction.<sup>15</sup> However, the plan has not yet been finalized.*

- On July 1, 2008, a new Department of Children and Families (DCF) was created and DHFS became the Department of Health Services (DHS). DCF now regulates foster care, including group foster care and treatment foster care, and residential care centers. DHS continues to regulate day treatment programs for children, outpatient programs, and inpatient facilities. Thus, it is critical that both departments work closely together to reduce seclusion and restraint use in children's programs and facilities.
- On July 30, 2008, a new work group on the use of restraints and seclusion in foster care settings was convened by DCF. This group is charged with reviewing a draft policy for individual case review of the proposed use of such measures. The work of this group is currently ongoing.

Thus, while DHFS has taken a number of steps to start the process of reducing the use of restraints and seclusion in children's programs, real change is still in the future. There have been some excellent, well-attended trainings, but there is no overall plan for training and technical assistance. The memo on prohibited practices, which was requested a year ago, has not been issued. The issue of the varying definitions of seclusion and restraint has not been fully addressed. Nothing has been done to review or revise the children's day treatment regulations.

## **RECOMMENDATIONS FOR NEXT STEPS**

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### **A. Children's Day Treatment Recommendations**

1) DHS should review the number of children being served in day treatment programs, their treatment needs, and the availability of other community treatment resources to determine whether these programs are the least restrictive most effective treatment approach for the children being served. If not, more funding and training needs to be provided to develop other components of the system of care for children with emotional and behavioral treatment needs.

2) DHS should immediately issue guidance to day treatment providers about the meaning of the level system so that programs are not serving children whose needs cannot be met in the program. Prior authorization requirements should be revised to include a review of the level of the program to be utilized for the child to ensure it is appropriate for the child's needs.

3) DHS should immediately issue guidance to the day treatment programs about the use of restraints and seclusion, clarifying that they should not be used as part of a treatment program and may only be used to prevent imminent physical harm in accordance with state law. A goal of reducing and/or eliminating restraints and seclusion in day treatment should be clearly stated. Continued training and technical assistance on trauma informed care, positive behavior supports and crisis prevention should be made available to day treatment programs. DHS should start to collect data on the use of restraints and seclusion in these programs so that training and technical assistance can be focused on programs with high rates of use and enforcement actions can be taken when necessary.

4) DHS should develop a set of guidelines and a review committee for case by case requests to use seclusion and/or restraints in children's day treatment programs.

5) DHS should issue a memo to all children's day treatment programs emphasizing the importance of a thorough assessment before the child is admitted to the program to ensure the program is appropriate for the child, and to ensure the development of a treatment plan that is based on the assessment, which is strengths-based and trauma informed, and involves the child's family, the provision of evidence-based treatment, the need for medical supervision and monitoring of all psychotropic medications for children in the program, and close coordination with the services provided by other providers, including schools.

6) DHS should convene a work group composed of parents, experts in children's community mental health, regulators, day treatment providers, advocates, and interested others to review the current administrative rules for day treatment, HFS 40. In particular the level system should be reviewed and possibly revised or abandoned. The requirements for assessment and treatment planning should be reviewed to ensure the process is strength

based, family focused, collaborative, comprehensive, culturally competent, and trauma informed. A requirement should be added that programs use evidence based interventions to the greatest extent possible. The requirements for medical oversight and monitoring of psychotropic medications should be strengthened. The issue of the use of restraints and seclusion should be addressed, following the guidelines outlined in the section of this report on Use of Restraints and Seclusion in Mental Health Programs Serving Children and Youth. ( See page 41 of this report) The rules should be rewritten based on the findings from this review.

7) DHS should review the current funding level for children’s day treatment programs to determine whether it is sufficient to provide quality programming for children needing this service.

8) DHS should undertake a thorough review of the policies and practices of each of the remaining NWCGC facilities to ensure there is adequate compliance with day treatment regulations and state restraint and seclusion law.

## **B. Restraint and Seclusion Recommendations**

1) DHS and DCF should immediately adopt a comprehensive plan for the reduction and/or elimination of seclusion and restraints in programs that serve children with mental health needs through a focus on training and technical assistance to increase positive behavioral supports, trauma informed care, and crisis prevention and intervention.

2) DHS and DCF should support changes to the state law on isolation and restraint that clarify that it may only be used to prevent imminent serious physical harm to self or others and that it may not be used as part of a treatment program and that any restraint that blocks the patient’s airway or restricts circulation, does not protect the head, causes chest compression, involves a choke hold, or uses pain to obtain compliance or control may not be used.

3) DHS and DCF should immediately issue the memo on prohibited practices in the application of emergency interventions with children and adolescents (currently draft 7) which states that restraints that block an airway or restrict circulation, that do not protect the head, and cause chest compression, involve a choke hold, or use pain to obtain compliance or control may not be used.

4) DHS should issue the memo on the various definitions of seclusion and restraint and when they may be used in children’s programs and should explore the promulgation of rules or other guidance to provide more consistent requirements. Rules or other guidance, such as numbered memos, should require that use of these measures is limited to situations of imminent serious physical harm to self or others. All the elements listed in the section of this report on Use of

Restraints and Seclusion in Mental Health Programs Serving Children and Youth should be addressed in these rules or memos. (See page 41 of this report) The rules or other guidance should be consistent with best practice guidelines developed by the Child Welfare League of America, SAMHSA, NASMHPD, and other leading organizations.<sup>16</sup>

5) DHS and DCF should require that all incidents of the use of restraints or seclusion in community mental health programs for children be reported to appropriate licensing staff within 72 hours. DHS and DCF should review patterns of use, take appropriate steps to investigate use over certain benchmarks, and annually report to the public on the use of seclusion and restraints in community mental health programs for children.

6) DHS and DCF should require that parents receive notification of the use of seclusion or restraints on their child on the same day that the use occurred. Notification should include information about the measures used, the length of time, the behavior that preceded the use, de-escalation techniques used, identification of personnel involved, and the impact on the child. Parents should also be included in any de-briefing involving the episode.

7) DHS and DCF should require that all staff in children's mental health treatment programs receive training in positive behavior supports and interventions and crisis prevention and de-escalation techniques. DHS and DCF should fund the provision of this training.

8) DHS and DCF should require that all children's mental health treatment program staff become trauma informed; staff should be trained about the effects of trauma; trauma assessments should be incorporated into assessments and treatment planning; steps should be taken to ensure that children are not retraumatized by use of seclusion or restraints or other aspects of the treatment program; evidenced based practices to help children heal and recover from traumatic experiences should be implemented in the programs.<sup>17</sup>

## CONCLUSION

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Angie died on May 26, 2006 due to the inappropriate use of restraint and seclusion in a children's day treatment program. This program did not conduct an appropriate assessment or develop a treatment plan that met Angie's needs. In fact the treatment plan was based on faulty assumptions about how to change behavior and was not developmentally appropriate, trauma informed, or positive in approach. Instead of treatment she was subjected to "cool downs" and "control holds".

The Wisconsin Department of Health and Family Services had opportunities before her death to review the programming at the facility based on deficiencies at other day treatment programs operated by NWCGC, complaints received about isolation and restraints, and their on-site surveys. In addition, DHFS staff gave NWCGC inaccurate information about the applicability of Chapter 51 seclusion and restraint protections.

After Angie's death DHFS did cite the facility for numerous violations, leading to the facility's closure. However, the Department has been slow to take action to decrease the use of seclusion and restraints in children's programs. In June 2007, over a year after Angie's death, a one day Summit on Promoting Behavior Supports was held. In August 2007, a proposed work plan was developed. However, the goals dealing with care planning, training, quality assurance, and monitoring identified in the work plan have not been met. In November 2007, a number of mental health advocacy groups wrote the DHFS secretary requesting a memo that would identify prohibited practices in the use of restraint with children, so that additional deaths such as Angie's would not occur. That memo has not been issued. Instead the Secretary requested the development of a training and technical assistance plan for providers, which has not yet been finalized.

DHFS has not taken steps to review the use of day treatment in Wisconsin to determine whether it is the most appropriate least restrictive treatment for children in the programs. It also has not reviewed or revised the children's day treatment rules or issued guidance to day treatment providers about assessments, treatment plans, use of seclusion or restraint, or program levels and inappropriate admissions. It has not established any guidelines or an entity to review requests to use seclusion or restraints on a case by case basis in day treatment programs, even though this is required by administrative code.

Providing high quality treatment for children with mental health needs in a safe, nurturing environment should be of highest priority. However, Wisconsin is not meeting this goal. It is critical that both the Department of Health Services and the Department of Children and Families take immediate steps to significantly reduce the use of seclusion and restraints with vulnerable children. DRW believes that, as of the writing of this report, the conditions continue to exist in Wisconsin that could precipitate another death like Angie's. Until the necessary steps are taken and safeguards created, children in Wisconsin's day treatment facilities are at risk of following Angie down a similar tragic road.

## **End Notes**

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16. Child Welfare League of American, State Regulations for Behavior Support and Intervention: A Promising Model (2004); SAMHSA Roadmap, NASMHPD, Preventing, Reducing and Eliminating Seclusion and Restraint with Special Needs Populations (2001).
17. Nikulina, Hergenrother, Brown, Doyle, Filton, and Carson, From Efficacy to Effectiveness: The Trajectory of the Treatment Literature for Children with PTSD, *Expert Rev Neurother.* 2008;8(8): 1233-1246.

### **Additional References**

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## **APPENDIX**

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### Selected Wisconsin Statutes and Regulations

#### **Wis.Stat. 51.61(1) Patients Rights**

(1) In this section, "patient" means any individual who is receiving services for mental illness, developmental disabilities, alcoholism or drug dependency, including any individual who is admitted to a treatment facility in accordance with this chapter or ch. 48 or 55 or who is detained, committed or placed under this chapter or ch. 48, 55, 971, 975 or 980, or who is transferred to a treatment facility under s. 51.35 (3) or 51.37 or who is receiving care or treatment for those conditions through the department or a county department under s. 51.42 or 51.437 or in a private treatment facility. "Patient" does not include persons committed under ch. 975 who are transferred to or residing in any state prison listed under s. 302.01. In private hospitals and in public general hospitals, "patient" includes any individual who is admitted for the primary purpose of treatment of mental illness, developmental disability, alcoholism or drug abuse but does not include an individual who receives treatment in a hospital emergency room nor an individual who receives treatment on an outpatient basis at those hospitals, unless the individual is otherwise covered under this subsection.

#### **Wis.Stat. 51.61(1)(i)1 Patients Rights**

1. Except as provided in subd. 2., have a right to be free from physical restraint and isolation except for emergency situations or when isolation or restraint is a part of a treatment program. Isolation or restraint may be used only when less restrictive measures are ineffective or not feasible and shall be used for the shortest time possible. When a patient is placed in isolation or restraint, his or her status shall be reviewed once every 30 minutes. Each facility shall have a written policy covering the use of restraint or isolation that ensures that the dignity of the individual is protected, that the safety of the individual is ensured, and that there is regular, frequent monitoring by trained staff to care for bodily needs as may be required. Isolation or restraint may be used for emergency situations only when it is likely that the patient may physically harm himself or herself or others. The treatment director shall specifically designate physicians who are authorized to order isolation or restraint, and shall specifically designate licensed psychologists who are authorized to order isolation. If the treatment director is not a physician, the medical director shall make the designation. In the case of a center for the developmentally disabled, use shall be authorized by the director of the center. The authorization for emergency use of isolation or restraint shall be in writing, except that isolation or restraint may be authorized in emergencies for not more than one hour, after which time an appropriate order in writing shall be obtained from the physician or licensed psychologist designated by the director, in the case of isolation, or the physician so designated in the

case of restraint. Emergency isolation or restraint may not be continued for more than 24 hours without a new written order. Isolation may be used as part of a treatment program if it is part of a written treatment plan, and the rights specified in this subsection are provided to the patient. The use of isolation as a part of a treatment plan shall be explained to the patient and to his or her guardian, if any, by the person who provides the treatment. A treatment plan that incorporates isolation shall be evaluated at least once every 2 weeks. Patients who have a recent history of physical aggression may be restrained during transport to or from the facility. Persons who are committed or transferred under s. 51.35 (3) or 51.37 or under ch. 971 or 975, or who are detained or committed under ch. 980, and who, while under this status, are transferred to a hospital, as defined in s. 50.33 (2), for medical care may be isolated for security reasons within locked facilities in the hospital. Patients who are committed or transferred under s. 51.35 (3) or 51.37 or under ch. 971 or 975, or who are detained or committed under ch. 980, may be restrained for security reasons during transport to or from the facility.

## **HFS Chapter 40 Mental Health Day Treatment Services for Children**

### **HFS 40.01 Authority and Purpose**

This chapter is promulgated under the authority of s. 51.42 (7) (b), Stats., to establish standard definitions, program criteria and patient characteristics for mental health day treatment services for children in support of full and appropriate use of these services and to assure their availability, quality and effectiveness.

### **HFS 40.01(3) Definitions**

(3) An agency providing mental health day treatment services to children may operate a total program of compatible services designed to serve youth with a variety of treatment needs. If this is the case, this chapter applies only to the mental health day services part of that agency's total program.

### **HFS 40.07 Required Personnel and Services**

#### **(1) CLINICAL SERVICES.**

(a) Level I programs. A program operating at Level I shall make available at least the following hours of direct clinical services, provided either by program staff or by professionals under contract to the program:

1. One hour per week of psychiatric or psychological consultation for every 4 full-time clients in the program;

2. One hour per week of services by a physician or registered nurse for every 4 full-time clients in the program. In addition, the program shall arrange for emergency and other necessary medical and nursing services to be readily available at all times clients are present in the program;

3. One hour per week of individual or family therapy by either a clinician or a clinical psychologist for each full-time client in the program. A program may select a particular type of professional or combination of professionals to provide those services based upon the specific needs of the clients served by the program;

4. One hour per week of social work services, including case management, community liaison, family contacts, interagency communication and similar services, for every 2 full-time clients in the program, provided by a person with a bachelor's or master's degree in social work or a qualified mental health professional;

5. Two hours per week of occupational therapy services provided by registered occupational therapists or structured recreational or vocational services for each full-time client in the program. A program may select the specific professional or combination of professionals to provide those services based upon the specific needs of the clients served by the program; and

6. Two hours per week of individual or group counseling by qualified mental health professionals for each full-time client in the program.

(b) Level II programs. A program operating at Level II shall make available at least the following hours of direct clinical services provided either by program staff or professionals under contract to the program:

1. One hour per week of psychiatric or psychological consultation for every 2 full-time clients in the program;

2. One hour per week of services by a registered nurse for each full-time client in the program. In addition the program shall arrange for emergency and other necessary medical and nursing services to be readily available at all times clients are present;

3. Two hours per week of individual or family therapy by either a clinician or a clinical psychologist for each full-time client in the program. A program may select a particular type of professional or combination of professionals to provide those services based upon the specific needs of the clients served by the program;

4. One hour per week of social work services, including case management, community liaison, family contacts, interagency communication and similar services, for every 2 full-time clients in the program, provided by a person with a bachelor's or master's degree in

social work or a qualified mental health professional;

5. Three hours per week of occupational therapy services provided by a registered occupational therapist or 3 hours per week of structured recreational or vocational services provided by specialists in specific areas of therapeutic assistance for each full-time client in the program, or a combination of the 3 services. A program shall select the type and mix of services under this category which best meets the needs of the clients the program is intended to serve; and

6. Three hours per week of individual or group counseling by qualified mental health professionals for each full-time client in the program.

(c) Level III programs. A program operating at Level III shall make available at least the following hours of direct clinical services provided either by program staff or professionals under contract to the program:

1. One hour per week of psychiatric or psychological consultation for every full-time client in the program;

2. A registered nurse on duty at all times that clients are present;

3. Three hours per week of individual or family therapy by either a clinician or a clinical psychologist for each full-time client in the program. A program may select a particular type of professional or combination of professionals to provide those services based upon the specific needs of the clients served by the program;

4. One hour per week of social work services, including case management, community liaison, family contacts, interagency communication and similar services for every full-time client in the program, provided by a person with a bachelor's or master's degree in social work or a qualified mental health professional;

5. Four hours per week of occupational therapy services provided by a registered occupational therapist or 4 hours per week structured recreational or vocational services provided by specialists in specific areas of therapeutic assistance for each full-time client in the program, or a combination of the 3 services. A programs shall select the type and mix of services under this category which best meets the needs of the clients the program is intended to serve; and

6. Four hours per week of individual or group counseling by qualified mental health professionals for each full-time client in the program.

(d) General requirements and conditions. For purposes of this subsection:

1. Two part-time clients shall be calculated as the equivalent of a full-time client;
2. The minimum hours established for service delivery apply to the overall delivery of services by the program. A specific client may receive more or less of a type of service, depending on the individual treatment plan developed for the client;
3. A program providing services at any level shall ensure that qualified professionals are on staff or available through a contract for purchase of services sufficient to meet the specific treatment needs of each child accepted into the program as identified by the child's treatment plan developed pursuant to s. HFS 40.10;
4. In communities where access to psychiatrists is limited, a program may use a psychologist licensed under ch. 445, Stats., to satisfy the requirement for psychiatric services established in this subsection unless the specific duties to be performed require a physician, such as the prescription of medications; and
5. Group counseling and psychotherapeutic groups shall include no more than 10 clients with one qualified mental health professional or a maximum of 12 clients if 2 qualified mental health professionals are present with the group.

## (2) STAFFING LEVELS.

- (a) At all times that clients are present at a program, the program shall have a minimum of 2 staff persons qualified under s. HFS 40.06 (4) on duty, at least one of whom shall be a qualified mental health professional.
- (b) If more than 10 clients are present at a program operating at Level I, an additional staff person qualified under s. HFS 40.06 (4) shall be present for every 10 additional clients or fraction thereof.
- (c) If more than 10 clients are present at a program operating at Level II or III, an additional staff person qualified under s. HFS 40.06 (4) shall be present for every 5 additional clients or fraction thereof.
- (d) At least one male staff member qualified under s. HFS 40.06 shall be present at a program when one or more male clients are present, and at least one similarly qualified female staff member shall be present at a program when one or more female clients are present.

(3) VOLUNTEERS. A program may use volunteers. Volunteers who work directly with clients or their families shall have received a minimum of 10 hours of training and shall be supervised by a qualified mental health professional employed by the program. Volunteers may not be counted in calculation of the staff-to-client ratios for the program.

(4) HOURS OF OPERATION. The amount of time a client spends at a program shall be established by the individual treatment plan developed under s. HFS 40.10 for the client, but a program shall be in operation and able to provide services for the following period:

(a) A Level I program shall be in operation and available to provide services to clients for a minimum of 4 hours a day, 5 days a week, and may suspend operations for no more than 12 weeks each year;

(b) A Level II program shall be in operation and available to provide services to clients for a minimum of 6 hours a day, 5 days a week, and may suspend operations for no more than 10 weeks each year; and

(c) A Level III program shall be in operation and available to provide services to clients for a minimum of 8 hours a day, 5 days a week, and may suspend operations for no more than 4 weeks each year.

#### **HFS 40.08 Admission**

(1) CRITERIA AND PROCEDURES. A program shall establish written criteria and procedures to be used when screening children referred for admission.

(2) ADMISSION POLICIES. A program's admission policies shall identify:

(a) Sources from which referrals may be accepted by the program and the process for making referrals;

(b) Procedures which will be used to screen and assess children who have been referred to the program;

(c) Any funding restrictions which will be applied to admissions such as availability of insurance, required support for the placement from other agencies or the family's ability to pay;

(d) The age range of children the program will serve;

(e) Any diagnostic or behavioral requirements the program will apply when selecting clients for admission;

(f) Any client characteristics for which the program has been specifically designed, including the level or levels of service to be provided, whether male or female clients, or both, may be admitted, the nature or severity of disorders including dually diagnosed conditions which can be managed within the program, and the length of time that services may be provided to a client; and

(g) Any priorities which may be applied in selecting among children referred for admission.

(3) CRITERIA FOR ADMISSION. For a program to admit a child:

(a) The child shall have a primary psychiatric diagnosis of mental illness or severe emotional disorder;

(b) The child shall be unable to obtain sufficient benefit from a less restrictive treatment program;

(c) Based upon the information available at the time of referral, there shall be a reasonable likelihood that the child will benefit from the services being offered by the program;

(d) The child shall meet one or more of the following criteria:

1. Be exhibiting significant dysfunction in 2 or more of the basic domains of his or her life and requiring the services offered by the program in order to acquire or restore the skills necessary to perform adequately in those areas;

2. Be in need of a period of transition from a hospital, residential treatment center or other institutional setting as part of the process of returning to live in the community; or

3. Be experiencing a period of acute crisis or other severe stress, so that without the level of services provided by the program, he or she would be at high risk of hospitalization or other institutional placement.

(4) REFERRAL FOR ADMISSION. Admission to a program shall be arranged through the program director or clinical coordinator or designee. The program director or clinical coordinator or designee shall encourage the child and his or her family or foster family to participate in the intake process, as well as representatives from school, human services and other treatment programs currently serving the child and family. A program shall require the agency referring a child for services to provide all available reports and evaluations that identify the basis for the referral and the child's need for services.

(5) LETTER CONVEYING ADMISSION DECISION. The program shall review a referral, make its decision whether to admit the child to the program, and report its decision by letter to the referral source within 30 days after the date of referral.

(6) ADMISSION PRIORITIES. If a program has a policy on serving some children ahead of other children or has a waiting list of children who have been accepted for admission but for whom space is not yet available, these priorities and the procedures for the operation of the waiting list shall be in writing and maintained on file by the program.



(7) **ADMISSION SUMMARY.** Once a program has completed its screening of a child referred for services and has decided to admit the child, a designated staff member who is a qualified mental health professional shall prepare a written report summarizing the reasons for admission, identifying the services which will be offered while the initial assessment and treatment plan are prepared under ss. HFS 40.09 and 40.10, and setting the date on which the client may begin attending the program.

(8) **CONSENT FOR ADMISSION.** A child may be admitted to a program only with the written consent of the child's parent or guardian, and of the child if the child is 14 years of age or older; pursuant to an order of a court with jurisdiction over the child under ch. 48 or 55, Stats.; or if authorized by a county department under s. 51.42 or 51.437, Stats., to which the child has been committed pursuant to s. 51.20 (13), Stats.

(9) **CASE MANAGEMENT.** Upon admission to a program, a child shall be assigned a case manager. The case manager shall be responsible for:

(a) Providing the client and his or her parents or guardian, if they are available, a thorough explanation of the nature and goals of the program, the initial assessment, treatment planning and reviews and the rights and responsibilities of clients and their families;

(b) Supervising and facilitating the client's initial assessment, developing and implementing the treatment plan, conducting ongoing case reviews, planning for discharge and implementing the aftercare program;

(c) Coordinating the program's operations on behalf of the client with other agencies and schools serving the client;

(d) Maintaining contact and communication with the client's family and facilitating the family's participation in the treatment plan;

(e) Serving as advocate for the client and his and her family with other agencies and programs to help them obtain necessary services and benefits from those other agencies and programs; and

(f) Mediating, if possible, any disputes or conflicts between the client or client's family and the program or with other programs or agencies serving the client and his or her family, and assisting the client and his or her family in asserting or protecting their rights to care and treatment.

### **HFS 40.09 Initial Assessment**

(1) **MULTIDISCIPLINARY TEAM.** The case manager shall within 5 working days assemble a multidisciplinary and multi-agency treatment team to assess the strengths and

the needs of a newly admitted client and his or her family and to prepare a written treatment plan for the client under s. HFS 40.10. The team shall include:

- (a) The client's case manager;
- (b) The program's clinical coordinator;
- (c) An occupational therapist, a clinical social worker or a registered nurse;
- (d) An educational professional from the client's school;
- (e) The client, to the degree the client is willing and able to participate, to the extent appropriate to his or her age, maturity and clinical condition;
- (f) The client's parent or guardian, if available and willing to participate;
- (g) Representatives of any other profession or agency necessary in order to adequately and appropriately respond to the treatment needs of the client and family which were identified in the referral materials or the intake screening process; and
- (h) If the client has been placed under the supervision of a county department or the department by a juvenile court order, the social worker who has been assigned to the case.

(2) ELEMENTS OF THE INITIAL ASSESSMENT. The initial assessment shall be carried out by appropriate professionals identified in s. HFS 40.06 (4) (a) to (h), and shall include:

- (a) Obtaining and reviewing any existing evaluation of the client and his or her family, after having first obtained any necessary consent for their release and use;
- (b) Completing any new test or evaluation which the multidisciplinary team finds is necessary for development of an effective treatment plan for the client and his or her family, including early and periodic screening and diagnosis under s. HFS 107.22; and
- (c) Completing an evaluation of:

1. The client's mental health status by a psychiatrist or a clinical psychologist and the clinical coordinator of the program, resulting in a diagnosis of the client on all 5 axes specified in DSM IV. Principal and secondary diagnoses shall be indicated as described in DSM IV if there are multiple diagnoses within axes I and II. The 5 axes in DSM IV are the following:

- a. Axis I: Clinical syndromes and V codes;
- b. Axis II: Developmental disorders and personality disorders;

- c. Axis III: Physical disorders and conditions;
  - d. Axis IV: Severity of psychosocial stressors; and
  - e. Axis V: Global assessment of functioning;
2. The client's use of drugs or alcohol or both drugs and alcohol;
  3. The client's level of academic functioning;
  4. The client's level of social and behavioral functioning in the home, school and community;
  5. For a client over the age of 15, the client's vocational and independent living skills and needs;
  6. Screening for suicide risk and dangerous reactions to psychotropic medications. The assessment process shall include procedures for determining the level of risk of suicide presented by clients and any risk of harm resulting from a dangerous reaction to a psychotropic medication, including:
    - a. Procedures for assessing and monitoring the effects and side effects of psychotropic medications which the person may be taking, for dealing with the results of a possible medication overdose, an error in medication administration, an unanticipated reaction to the medication or the effects of a concurrent medical illness or condition occurring while the person was receiving the medication;
    - b. Criteria for deciding when the level of risk of suicide or a reaction to a psychotropic medication requires a face to face response, use of mobile services or hospitalization;
    - c. Procedures for notifying those around the person such as family members or people with whom the person is living that he or she may be at risk of harming him or herself;
    - d. Procedures for obtaining a more thorough mental status examination or other forms of in-depth assessment when necessary based on the results of the initial emergency assessment;
    - e. Procedures for gathering as much information as possible, given the nature and circumstances of the emergency, about the person's health, the medications, if any, that the person has been taking, prior incidents of drug reaction or suicidal behavior, and other information which can be used to determine the level of risk and the type of response most likely to help the person;
  7. The client's relationship with his or her family, including an assessment of family strengths and weaknesses which might affect treatment; and

8. Any other assets and needs of the client and his or her family which affect the client's ability to participate effectively in relationships and activities in home, community and school environments.

(3) WRITTEN REPORT. The multi-disciplinary team shall prepare a written report on the initial assessment which:

(a) Describes the client's current mental health status and level of functioning both in terms of assets that the client brings to the treatment program and problems which are to be addressed through treatment;

(b) Provides current baseline data regarding the severity, duration or frequency with which mental health symptoms or problem behaviors have been observed or, if these are not currently evident, describes them as being reported as part of the client's history; and

(c) Establishes primary treatment goals and objectives for the client and his or her family, expressed in measurable terms, which identify the conditions or behaviors which the client will be helped to achieve as well as the dates by which it is anticipated that the client will achieve them.

### **HFS 40.10 Treatment Plan**

(1) REQUIREMENT. The multidisciplinary team shall prepare a written treatment plan for a client based upon the written report under s. HFS 40.09 (3) of the initial assessment of the client. The plan shall be prepared within the following period of time, unless specific factors which require additional time for assessment are documented in the client's record:

(a) Within 30 calendar days after admission for preparation and approval of a Level I or Level II treatment plan; and

(b) Within 10 calendar days after admission for preparation and approval of a Level III treatment plan;

(2) ELEMENTS. The written treatment plan shall:

(a) List the specific services which will be provided by the program;

(b) Include a summary of services the client will receive from his or her school or other educational resource, including educational services provided by the program, and from any other agency that is or will be involved with the child and the family, and the process by which educational and other services provided from outside the program will be coordinated with services provided by the program;

(c) Include a statement of staff actions or interventions which will be provided on behalf of the client and the client's family, the frequency with which or duration over which the actions or interventions will be provided and the staff responsible for delivering those services;

(d) Describe the procedure for monitoring and managing any risk of suicide identified during intake assessment or ongoing treatment of the client;

(e) Include short-term and long-term treatment objectives identified by the initial assessment;

(f) Include criteria for measuring the effectiveness and appropriateness of the treatment plan and for determining when the client has met the objectives of the plan; and

(g) Identify any medication the client will be receiving, the name of the physician prescribing the medication, the purpose for which it is prescribed and the plan for monitoring its administration and effects.

### (3) AGREEMENT OR WILLINGNESS TO PARTICIPATE.

(a) The proposed treatment plan shall be submitted for signature to the client, the client's parent, guardian or legal custodian, the clinical coordinator and any service provider who is to be part of the treatment plan. Each of those parties shall sign the plan to indicate agreement with it or a willingness to participate in it.

(b) Program staff shall document a situation in which the parent, guardian, legal custodian or client will not sign the treatment plan or where they sign but indicate that they do not agree with it. Documentation shall include, if known, the reasons why the person is not in agreement with the plan or refuses to sign the document and shall also indicate, if possible, whether the person will continue to participate in the plan despite the lack of agreement or signature.

(c) If the client, parent, guardian or legal custodian or other member of the treatment team is not in agreement with the treatment plan proposed by the program, or indicates an unwillingness to participate in the plan, program staff shall document the steps which will be taken to attempt to resolve the conflict.

(4) APPROVAL BY PSYCHIATRIST OR PSYCHOLOGIST LICENSED UNDER CH.448, STATS. A client's treatment plan shall be reviewed for approval by the program psychiatrist or psychologist. The program psychiatrist or psychologist shall sign the plan if he or she finds that the services identified in the plan are necessary to meet the mental health needs of the child. Services may be provided pending approval by the program psychiatrist or psychologist but shall be suspended if he or she does not approve them.

(5) REVIEW OF CASE PROGRESS.

(a) Timelines. The case manager shall reconvene the multidisciplinary treatment planning team according to the following schedule to assess the progress of the case:

1. For programs offering Level I services, within 30 calendar days following approval of the treatment plan and every 60 days thereafter;
2. For programs offering Level II services, within 30 calendar days following approval of the treatment plan and every month thereafter;
3. For programs providing Level III services, within 14 calendar days after approval of the treatment plan and every month thereafter; and
4. More frequently if indicated by the client's condition or family's condition or upon request of the client, the client's parent, guardian, attorney or guardian ad litem, program staff, a county department, or the department responsible for supervising the client pursuant to a court order under ch. 48, 51 or 55, Stats. A request for more frequent review than required under subd. 1., 2. or 3. shall be in writing and shall be documented in the client's treatment record.

(b) Elements of review. In reviewing case progress, the multidisciplinary treatment team shall:

1. Identify the client's current status under each of the objectives stated in the original treatment plan and assess the client's progress, lack of progress or regression in each area;
2. Determine the continued appropriateness of the original treatment plan and modify the objectives, proposed achievement dates, interventions, actions or responsible staff in the plan as necessary;
3. Request the participation or assistance of additional community programs or agencies as necessary; and
4. Prepare a written summary of the findings of the review and, if necessary, a revised treatment plan which shall be implemented following approval by the program psychiatrist or psychologist.

(c) Documentation.

1. As part of its review of case progress, the treatment team shall prepare a written report which includes all of the following:
  - a. A description of the client's progress, lack of progress or regression in relation to the

treatment objectives established in the treatment plan;

b. Documentation of clinical client contacts and interventions required as part of the treatment plan; and

c. Identification of all days on which services were actually delivered to the client.

2. The written report shall be prepared:

a. Each month in programs providing Level I and Level II services; and

b. Every 2 weeks in programs providing Level III services.

3. The written report shall be maintained as a permanent part of the client's record.

(6) DISCHARGE PLANNING. The treatment plan shall include a discharge planning component. When it is determined that the client is approaching attainment of the objectives identified in the treatment plan, the treatment team shall prepare a discharge plan which establishes a process for the client's transition back into the community and identifies aftercare services which will be provided to assist in that transition and to support the client's reintegration into family, school and community activities and programs.

(7) TERMINATION OF SERVICES.

(a) Decision. Services provided to a client under an individual treatment plan may be terminated before client goals for discharge are attained under the following circumstances:

1. By agreement of the client, the program director and the clinical coordinator, and by the court if participation in the program has been required by a court order under ch. 48, 51 or 55, Stats.; or

2. By direction of the program director and the clinical coordinator or attending physician acting upon recommendation of the treatment planning team, if the team determines that:

a. Further participation of the client in the program is unlikely to provide any reasonable benefit to the client;

b. The client's condition requires a greater or more restrictive level of care than can be provided by the program; or

c. The client's behavior or condition is such that it creates a serious risk of harm to other clients in the program or to program staff members and no modifications of the program procedures or services are possible which will ensure the safety of other clients or staff.

(b) Notice.

1. Unless the client poses an immediate risk of harm to other clients or staff or subd. 2. applies, the program shall provide the client, his or her parent or guardian, and other agencies providing services to the client pursuant to the treatment plan with at least 7 days prior notice of the intent to end services.

2. When a client has been placed in the program by order of a court under ch. 48, 51 or 55, Stats., the program shall provide that court and the social worker responsible for supervising the implementation of the court order with 14 days prior notice of the intent to end services, unless the client poses an immediate risk of harm to other clients or staff, in order to permit the court to enter an alternative order regarding the care of the client.

(8) REPORTING OF DEATHS. Each program shall adopt written policies and procedures for reporting to the department deaths of clients due to suicide, psychotropic medications or use of physical restraints, as required by s. 51.64 (2), Stats.

#### **HFS 40.11 Program Components**

(1) GENERAL REQUIREMENTS. Each program certified under this chapter shall provide a combination of service components adequate and appropriate to meet a client's treatment objectives identified in the initial assessment and individual treatment plan.

(2) REQUIREMENTS FOR SPECIFIC LEVELS OF SERVICES. A program shall have the following minimum components:

(a) Level I program.

1. A program providing Level I services shall provide by program staff or by professionals under contract with the program at least the following treatment options, although the services provided to a particular client and his or her family shall be based on the individual treatment plan for the client:

a. Individual, group and family counseling provided by qualified mental health professionals;

b. A structured therapeutic milieu supervised by qualified mental health professionals in which a positive pattern of social, educational and personal behaviors and coping skills are taught, reinforced and enhanced through a variety of individual and group activities;

c. Case management services designed to ensure that services offered by the program are coordinated with any other treatment or instructional services in which the client or his or her family may be participating;



d. Crisis response services designed to meet the acute needs of a client during periods of time when the client is not present at the program; and

e. For a minimum of 3 months following completion of the program, aftercare services designed to support the reintegration of a client who has completed the program into family, community and school activities and to prevent recurrence of the problems which led to the original placement in the program.

2. A client may continue to participate in a Level I program as long as the review of the client's treatment plan under s. HFS 40.10 (5) indicates that the client remains appropriate for the level of services offered and has not yet met the objectives identified in his or her treatment plan.

(b) Level II program.

1. A program providing Level II services shall offer the services required under par. (a) for Level I programs but shall structure those services in such a way as to meet the needs of clients for closer supervision and more severe symptomatology. In addition the program shall offer individual, group and family psychotherapy provided or supervised by a person or persons meeting the criteria in s. HFS 40.06 (4) (a) and delivered pursuant to the treatment plan developed for each client.

2. A client may continue to participate in a Level II program long as the review of the client's treatment plan under s. HFS 40.10 (5) indicates that the client remains appropriate for the level of services and has not yet met the objectives identified in his or her treatment plan.

(c) Level III program.

1. A program providing Level III services shall offer the level of services required under par. (b) for Level II programs and, in addition, daily medical rounds, and occupational, speech and language therapy and other medically prescribed therapies as needed pursuant to each client's individual treatment plan.

2. A client may participate in a Level III program for up to 90 days with one extension of an additional 90 days if the treatment planning team documents in writing that this level of service continues to be appropriate for the client and that the client is likely to reach the objectives for treatment within the second 90 day period.

#### **HFS 40.14 Clients Rights**

(1) POLICIES AND PROCEDURES. All programs shall comply with s. 51.61, Stats., and ch. HFS 94 on the rights of clients.

(2) CASE MANAGER'S DUTIES. A client's case manager shall inform and assist the client and the client's parents or guardian in understanding and asserting their rights.

(3) CONFLICT RESOLUTION.

(a) Clients and their parents shall be informed that they have the option of using either formal or informal procedures for resolving complaints and disagreements.

(b) A program shall establish a process for informal management of concerns raised by clients, family members and other agencies involved in the care and treatment of clients.

(c) A program shall establish a formal system for receiving and processing grievances which cannot be managed informally. The system shall provide for impartial review of complaints and shall include an option for mediation of disagreements.

## **HFS 94 Patient Rights and Resolution of Patient Grievances**

### **HFS 94.02 Definitions**

#### **94.02(26)**

(26) "Isolation" means any process by which a person is physically or socially set apart by staff from others but does not include separation for the purpose of controlling contagious disease.

#### **94.02(34)**

(34) "Physical restraint" means any physical hold or apparatus, excluding a medical restraint or mechanical support, that interferes with the free movement of a person's limbs and body.

#### **94.02(40)**

(40) "Seclusion" means that form of isolation in which a person is physically set apart by staff from others through the use of locked doors.

### **HFS 94.10 Isolation, Seclusion and Physical Restraint**

Isolation, seclusion and physical restraints. Any service provider using isolation, seclusion or physical restraint shall have written policies that meet the requirements specified under s. 51.61 (1) (i), Stats., and this chapter. Isolation, seclusion or physical restraint may be used only in an emergency, when part of a treatment program or as provided in s. 51.61 (1) (i) 2., Stats. For a community placement, the use of isolation, seclusion or physical restraint shall be specifically approved by the department on a case-by-case basis and by the county department if the county department has

authorized the community placement. In granting approval, a determination shall be made that use is necessary for continued community placement of the individual and that supports and safeguards necessary for the individual are in place.