

NEWS

WHY THEY DIE: LITTLE TRAINING, POOR STAFFING PUT LIVES AT RISK

By

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

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

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

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

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

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

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

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

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

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

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

In the Edith Campos case, aide Daniel Thomas Walsh successfully fought negligent homicide charges by arguing he had followed hospital guidelines

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

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

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

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

The death rate should come as no surprise.

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

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

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

Yet children are both a vulnerable and challenging population.

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

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

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

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

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

And troubled children are the ones who lose.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Especially when the work can be demanding and dangerous.

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

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

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

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

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

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

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

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

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

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

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

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

In the wards, staffers feel the pressure.

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

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

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

Across the nation, the commitment is too often absent.

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

Or much interest in doing it correctly.

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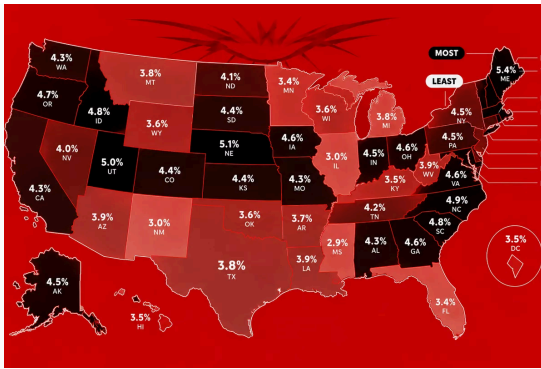
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"I didn't get hired," he said, "for all this bull-crap interacting with people or

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