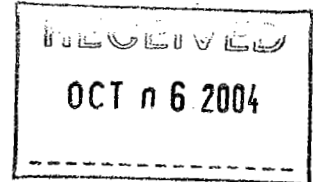


**SUMMARY OF FINDINGS REGARDING  
NORTHSTAR BEHAVIORAL HEALTH SYSTEM**



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*Kathleen Myers MD 10/4/04*

**I. MAJOR CONCERNS REGARDING TREATMENT AT NORTH STAR  
BEHAVIORAL HEALTH (“NORTH STAR”)**

- A. Has North Star “abused” or “neglected” children at its facilities, as those terms are defined in the PAIMI law and in the “DD Act”?
- B. Has North Star followed state and federal law with respect to treatment planning?
- C. Has North Star followed state and federal law with regard to discharge planning?
- D. Has North Star followed state and federal law with respect to the use of restraints and seclusion?
- E. Has North Star appropriately medicated children in compliance with state and federal law and consistent with the standard of care?
- F. Has North Star provided a safe environment to children consistent with the standard of care?
- G. Has North Star provided adequate numbers of appropriately trained staff?

**II. SOURCES OF INFORMATION FOR REPORT INCLUDE**

- A. Interview with parents of selected patients previously hospitalized on the acute or residential units of North Star Behavioral Health (“North Star”)
- B. Interview with selected patients currently hospitalized on the acute or residential units of North Star
- C. Interview of selected staff working on acute or residential units of North Star
- D. Interview of GALs and/or Case Managers of selected youth previously or currently hospitalized at North Star
- E. Review of North Star’s patient charts of youth for whom allegations of inappropriate treatment have been made by parents, GALs, Case Workers, or other individuals
- F. Review of seclusion and restraint records at North Star for the past 3 months

### **III. SPECIAL CIRCUMSTANCES REGARDING THE NORTH STAR POPULATION, AS PRESENTED BY NORTH STAR STAFF, AND CONSIDERED IN DRAWING CONCLUSIONS AND PREPARING THIS SUMMARY**

- A. Compared with other psychiatrically hospitalized youth, youth at North Star are likely to have a higher rate of fetal alcohol and drug exposure resulting in greater central nervous system toxicity, and thus greater risk for harmful behaviors with decreased possibility of responding to usual interventions for de-escalation, as well as decreased possibility of learning from their behavior and consequences.
- B. Families are likely to not reside locally, and often reside quite remotely, making their participation in treatment planning difficult
- C. Follow-up resources for discharge planning are often minimal, especially in remote or rural communities
- D. Follow-up appointments with psychiatrists or even primary care physicians may take many weeks to obtain, thus necessitating interim pharmacotherapy strategies to assure safety, and risking oversedation.

### **IV. STRENGTHS OF NORTH STAR PROGRAM**

One strength of the program that is immediately evident in reviewing patients' charts is the development of standardized forms for each function, e.g., team meetings, progress notes, shift behaviors, precautions, goals of treatment, emergency medications, etc. Such a standard forms ensures appropriate charting by staff.

Another strength is that discharge planning is considered very early in the hospitalization, i.e., in the Admission Report

Admission Reports are comprehensive and well written

The program has a solid core

### **V. FINDINGS WITH RESPECT TO MAJOR ISSUES RAISED ABOUT TREATMENT AT NORTH STAR:**

- A. **Has North Star "abused" or "neglected" children at its facilities, as those terms are defined in the PAIMI law and in the "DD Act"?**  
The PAIMI laws are broad, somewhat vague, leaving considerable room for interpretation. There are several areas in which one could argue that under PAIMI the patients' bill of rights has been violated or at least not optimally upheld. Major issues are outlined below.
- B. **Has North Star followed state and federal law with respect to treatment planning?**

- a. Failure to include Guardian ad Litem (GALs) in treatment planning. This complaint was made by several GALs, and thus suggests a broader problem, not just an issue specific to a selected youth. *Such exclusion, particularly when GALs had asked to be involved, directly violates state guidelines AS 47.30.825b1*
- b. Inappropriate programming for autistic children: The units seem quite over-stimulating, as might be expected for such a large group of young impaired children. In such a setting autistic, and potentially other developmentally delayed, children do not appear to receive appropriate treatment planning. In such stimulating settings away from familiar environments, such youth progress better if programmed “out of the milieu”, i.e., have special programming on the unit but apart from other children’s programs with the opportunity to buffer from high levels of stimulation. Such opportunity does not appear to exist at North Star. It is difficult to justify admitting such youth without more appropriate individualized treatment planning, including the use of staff trained to work specifically with autistic youth. *Thus, there is evidence to suggest that North Star exercises neglect in “failure to establish, or carry out an appropriate individual program plan or treatment plan for an individual with mental illness...including failure to maintain adequate numbers of appropriately trained staff. [42 USC 10802 (5)]*
- c. Psychological Testing: There appears to be a lack of psychological/cognitive testing to aid in diagnosis and treatment planning. Specifically, psychological testing to establish intellectual capacity or speech and language ability is not a routine part of the patients’ evaluation. Any such needed testing is referred out, and reportedly infrequently so. As many youth with psychiatric illness, and particularly those with disruptive behaviors, have subaverage intellect and/or language deficits, more frequent testing would be expected. In particular, as intellectual and language problems are so common for youth with fetal alcohol exposure, a common presenting problem for the North Star patients, such testing would be expected to be well integrated into the treatment plans. One caveat: such testing may be allocated to the school’s responsibility. In this case, such testing might not have been readily evident in our review of North Star’s program as school was not in session and the opportunity to formally meet with school representatives was not available. Some patients’ records did include psychological testing results, but others with profiles suggestive of deficits did not. *Thus, the apparent suboptimal use of intellectual and language testing is a concern that needs clarification with respect to treatment planning per 42 USC 10841*
- d. Behavioral Management on the acute units: Behavioral plans appear to be developed and modified by line staff under the direct supervision

of a Social Worker, with only remote supervision by a doctoral level psychologist (if at all). Considering the possibility that these youth are more complex than other psychiatrically hospitalized youth, especially neuropsychiatrically due to fetal alcohol effects, direct supervision from a doctoral level psychologist seems appropriate. The lack of such routine supervision by a doctoral level psychologist suggests suboptimal treatment planning and may relate to the high level of restraints used with these youth. *Although the lack of direct supervision by a doctoral level psychologist does not violate any specific statute, the requirement of 42 CFR 441.154 that inpatient services involve a supervised individual plan of care suggests individualized behavioral planning. Traditionally, this has been the purview of doctoral level psychologists.*

**C. Has North Star followed state and federal law with regard to discharge planning?**

This is obviously a difficult issue as many youth are returning to underserved areas with few resources and it may be difficult to find appropriate professionals with whom to collaborate regarding discharge. However, as several families, GALs, and Case Workers complained about the discharge planning, there appears to be a problem.

- a. Inadequate discharge planning. Discharge plans were found in all reviewed charts. For youth transitioned from North Star Acute Program to the Residential Program, discharge planning was clear. However, for patients discharged from the acute units to community settings, the discharge plans are skimpy focusing on pharmacological treatment and briefly stating the need for outpatient therapy or other services. Often the discharge summary indicates that outpatient care will be arranged by the Case Worker. This sounds as if appropriate care was not in place at time of discharge. Of course, this risks lack of follow through. Thus, it is not always clear how and where other services would be obtained, in how timely a fashion, whether parents/guardians were involved in discharge planning, perceived impediments to obtaining such care, alternatives or crisis planning until services established in the community. It is not clear how closely these discharge plans are discussed with parents/guardians, or receiving therapists. *Thus, the universal presence of discharge plans generally meets the statute 7AAC 12.890 (a) (13). However, North Star appears to need to develop more effective discharge planning in collaboration with community resources.*
- b. Pharmacological issues. Many youth were discharged on several medications and youth were sedated by these medications at discharge. The goal appeared to have been to keep youth somewhat sedated until appropriate follow-up was in place. *This is a suboptimal strategy with*

*high potential for medication non-compliance once out of the hospital, (and makes for poor relations with referring agencies). It also indicated that timely follow-up was not arranged, i.e., discharge was not adequately arranged with community providers. Such sedation suggests that the patient may not have optimally participated in discharge planning in violation of AS 47.30.825(i) and 7AAC 12.890(a) (13)*

**D. Has North Star followed state and federal law with respect to the use of restraints and seclusion?**

- a. Records of physical restraint for June through August 2004 indicate 62 episodes of 4 point or 5 point mechanical restraints. It is not fully clear how many of these episodes of mechanical restraint were accompanied by IM medication. Per the provided log of seclusion and restraint, restraint is used for a broad range of children down to 5 years old, although unusual for such a young child. The expected pattern is shown, ie that several youth were restrained multiple times and that many youth were restrained once or a few times (using age and dates of admission to identify individual patient counts). As the census during this time frame was not provided, the rate of mechanical restraint could not be determined. However, even assuming a full census, this is a high rate of physical restraint. *Such a high rate of physical restraint is counter to the national trend away from the use of mechanical restraint. Of course, we did not have access to records to determine whether the current rate might in fact be lower than in the past. Nevertheless, this rate is excessive and appears to violate AS.30.825(d) and 42 CFR 482.13.*
- b. These episodes of mechanical restraint are in addition to 121 episodes of physical restraint, i.e., physical holding. This is the approach most often used with the younger children, i.e., below 7 years old.
- c. These 183 episodes of mechanical or physical restraint are in addition to 78 episodes of seclusion with urgent medication administration, a less physically restrictive intervention.

*Thus the total number of episodes of confinement in one form or another over three months is at least 261. This is quite high. It suggests inadequate behavioral programming, inadequate alternatives to seclusion and restraint, and/or potentially inappropriate uses of seclusion and restraint, e.g., for punitive purposes or due to inadequate staffing.*

**E. Has North Star appropriately medicated children in compliance with state and federal law and consistent with the standard of care? Several issues were raised.**

- a. Consent for urgent prn medication. There were several complaints about this issue. In reviewing the charts, it did indeed appear that

- consent for emergent/urgent medication was not always obtained, or alternatively not always documented in the chart. While tranquilizing medication can be given without prior consent in emergencies to assure safety, such unconsented situations should be infrequent in a psychiatric setting that anticipates disruptive and endangering behaviors. *Thus, the approach to this situation appears suboptimal even if the letter of the law was not violated, i.e., in that the staff did document "emergent situations" requiring rapid tranquilization.*
- b. Change in medication regimen without guardian consent. This also occurred in several cases, particularly ones in which the child was in state custody. One GAL stated that he/she was threatened with discharge of the patient if the consent for medication was not signed. Although it is understandable that guardians were often in remote areas and did not respond in a timely fashion to North Star's attempts to contact them regarding medication changes, *such unconsented medicating of youth is problematic. Some of these youth were over 14 years old and could themselves legally consent to the medication. However, it is doubtful that this vulnerable population could competently give consent. Thus North Star appears in violation of AS 47.30.836. It is unclear how frequent an occurrence this is.*
- c. Overuse of chemical restraint. Tranquilizing medication was frequently administered (orally or intramuscularly) in conjunction with mechanical restraint, although it was also used alone when the patient was agitated but did not require more restrictive interventions. Such "chemical restraint" is common practice in psychiatric inpatient units, especially acute units. The rate of use of such "chemical restraint" could not be determined as full census data were not available. Staff did generally document in the chart that some other verbal intervention had been ineffective. Also, there is a manualized handbook, *Prevention and Management of Aggressive Behavior (PMAB)*, that provides guidelines for staff in dealing with potentially aggressive youth. However, the manual is general and fairly quickly moves to physical interventions. It appears that other strategies are needed. *Over-reliance on psychotropic medication could violate 47.30.836. More comprehensive data would be needed to sort this out*
- d. Choice of chemical restraint. There are two issues here. First, the preferred emergent tranquilizing approach at North Star is a combination of chlorpromazine (Thorazine) and diphenhydramine (Benadryl). The diphenhydramine is apparently given concurrent with the chlorpromazine to prevent side effects from the former although such anticipated side effects are not likely with the low potency chlorpromazine. Thus, universal preventive use of diphenhydramine does not seem clinically indicated or consistent with usual practice. Second, this combination is indeed tranquilizing and will terminate most threats to self or others, but often puts the patient to sleep for hours. Less sedating medication such as lorazepam (a benzodiazepine)

is used much less frequently at North Star; and diphenhydramine is apparently not used alone, i.e., without the chlorpromazine. These and other medication choices seem more appropriate so as to interrupt the disruptive behavior but allow the patient to re-integrate into the program as soon as possible. *The current reliance on chlorpromazine plus diphenhydramine or even chlorpromazine alone is suboptimal and not consistent with usual practice, particularly now that atypical antipsychotics are available. It is not clear why chlorpromazine is being used, but perhaps because it is the least expensive option, especially considering the high cost of the atypical antipsychotics. More consideration seems warranted regarding non-antipsychotic alternatives and/or the use of atypical antipsychotics, including the newer intramuscular preparations.*

- e. Intramuscular rather than oral chemical restraint: Although this issue was raised by some GALs/Case Workers, and some raised concerns about bruising of patients as a result of IM medication (and possibly physical or mechanical restraint), there was inadequate information to address the issue during this review.

**F. Has North Star provided a safe environment to children consistent with the standard of care?**

There were several complaints by parents, Case Workers and GALs regarding the ability of youth to go AWOL, the safety of the units from peers and from staff (one family alleged that their autistic child was assaulted by staff). In the past, residents had kicked out windows and then went AWOL, certainly compromising their safety. However, North Star recently replaced these windows with more secure windows. Also, although the units themselves are not locked, major entrances and exits are locked, providing some security. When youth do escape, the policy is to not run after them, but to contact police. There are no security staff. Security staff comprise a routine part of general hospitals' staffing and one wonders why security staff are not on the North Star campus to provide some increased degree of security. Although no clear statute appears to be violated, some attention should be given to these complaints regarding safety.

**G. Has North Star provided adequate numbers of appropriately trained staff?**

- a. Physicians. North Star noted that last year there was only one psychiatrist/physician available to treat youth on the acute and residential units (ratio of 1:116 if the census were full). This is an unacceptable ratio and it is not clear why a locum tenens staff was not hired to fill in for the psychiatrists who were on vacation. *This appears to have violated 7AAC 12.215 42 and/or USC 10802 (5) vis a vis inability to deliver optimal care due to inadequate physician staffing.* However, 42 CFR 441.156 notes that staffing requirements could have been met by having a doctoral level psychologist and a licensed

physician available. If Dr. Edney were available, then North Star might have been within state guidelines. With the recent hiring of a new psychiatrist the ratio now is 4:116 or 1 psychiatrist per 29 patients. This is reasonable.

- b. Other Professional Staff. There is one doctoral level psychologist for the entire acute and residential program, and she appears to have a minimal role in the acute program. *This does not avail the staff of appropriate behavioral management individualized to the patient. This appears in violation of 7AAC 12.215*
- c. Line Staffing. This could not be addressed. Although records regarding staffing were requested, they were not made available at this review. It should be noted that the high rate of physical restraint does raise concerns about staffing.

## VI. RECOMMENDATIONS

The difficulties at North Star can be readily improved. Indeed, North Star has already made multiple changes to their program since taking over from Charter North approximately 4 years ago.

1. Take a pro-active role in developing a Quality Improvement program to decrease the use of more restrictive approaches to managing youths' disruptive and aggressive behavior. Implement a new plan, and track the change in use of seclusion and restraint.
2. More emphasis on de-escalation of patients' agitation without resorting to restrictive measures, particularly mechanical restraint. The book "Emotional Coaching" by John Gottesman PhD may be helpful.
3. Review the current approach to emergent medications, with consideration of using atypical neuroleptics, or even non-neuroleptics such as diphenhydramine or lorazepam.
4. Define a role for a doctoral level psychologist in behavioral programming on the acute units. Integrate with the Quality Improvement program to decrease use of seclusion and restraint.
5. Develop special programming for selected groups of youth who are difficult to maintain in usual milieu, eg those with Autism, MR, psychoses.
6. Work with community providers and professionals to educate them about the role of acute psychiatric hospitalization (expectations are likely unrealistic)
7. Work with community providers and professionals to educate them about the need for collaboration in discharge planning (again, expectations are likely unrealistic)
8. Be pro-active in education and incorporation of GALs as their knowledge base is not optimal and expectations are somewhat unrealistic, yet they can be allies for child and for the psychiatrist.

9. As the psychiatrists work full time at North Star and do not have to travel between outpatient practices and the hospital, focus more on psychiatrist – parent contact. Families will have fewer concerns if the psychiatrist, head of the treatment team, is more “real”, more “user friendly”. This is especially important for families that must newly learn unexpected diagnoses or “bad news”.