# Rights Review

**Promoting Human Rights by providing information and discussion across the DMR community**

**Newsletter of the DMR Human Rights Advisory Committee and the DMR Office for Human Rights**

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## Escort Practices When Using Emergency Physical Restraints

**By *Richard Salandrea*, Human Rights Specialist (Northeast Region and Fernald Developmental Center)**

The Office for Human Rights is delegated responsibility under the DMR regulations to oversee the Commissioner's Review of Restraints. As a Human Rights Specialist my colleagues and I frequently see the use of escorts reported as emergency restraints. This can be a valid practice, but statewide there is inconsistency regarding the boundaries between escorts for the purpose of emergency restraint and those escorts meant to assist in implementing treatment.

**I. Background**

Limitations of movement are permissible if they fall into one of the following categories (see 115 CMR 2.01 "Limitation of Movement") and meet the regulatory requirements for each: (1) support needed to achieve proper body position, balance, or alignment; (2) health-related protections; (3) transportation restraint; (4) holds implemented in accordance with behavior modification plans with a treatment purpose; and (5) emergency restraint.

Emergency physical restraint includes the use of bodily physical force to limit freedom of movement in the event of an emergency that is not guided by a treatment intervention of a behavior plan.

A limitation of movement is likely a physical restraint if: (1) the bodily contact is a firm, but gentle hold lasting over 5 minutes; (2) more than two staff are holding the individual; (3) physical force is used to overcome active resistance; (4) physical force is used to interrupt then-occurring movement toward a particular destination. If any of these conditions are met during an emergency, and physical holding is not implemented subject to a behavior modification plan that states a treatment purpose for the hold, the hold is a physical restraint. Such use of physical restraint is only allowed in an emergency.

Upon the occurrence of an emergency, after the failure of less restrictive alternatives or a professional determination the alternatives would be ineffective under the circumstances, the use of force to overcome active resistance, in the form of physical restraint, may be implemented. The degree of force used and the duration of the physical restraint may at maximum reach only the extent necessary to avoid harm while the emergency continues.

**II. Moving a person in crisis**

When considering course of action in an emergency, the first consideration must be the least restrictive alternative (115 CMR 5.11 (4) (b). Why is it necessary to move the individual and are there less risky, yet effective, means for addressing the emergency? If a stationary hold

## Included In This Issue:

is possible, safe and likely to be effective in addressing the emergency behavior, then baring specific needs of the individual that would be compromised by such hold at this location (or if the space is too small to provide adequate space for a safe use of stationary restraint), the risks of moving the person outweighs the risk presented by a stationary hold.

When a decision is made to move a person in an emergency and force is used to overcome active resistance of that individual, the question of duration of restraint needs to be considered. An emergency restraint may only be implemented "for the period of time necessary to accomplish its purpose," (115 CMR 5.11 (4) (c)). In all cases, therefore, the end of the emergency requires the immediate release of the restraint. Typically this can mean to the nearest hallway, or a corner of the same room. In any case, it must be only the closest destination available to meet the purpose of removing the person from people and spaces that reinforce the emergency, makes control of the emergency safer, or otherwise divert the individual's attention so they may bring their selves under control.

If at any point staff anticipates a destination toward which the person is to be brought, should the emergency resolve itself before they reach that destination, the restraint must be ended (still 115 CMR 5.11 (4) (c)). They could voluntarily continue to that destination but the force to accomplish this must end.

Such destinations must withstand examination under the standards above. Conversely, if the person arrives at a destination that was pre-determined, or judged to be the closest place to accomplish a safe stationary restraint, and the emergency continues, a stationary restraint may be warranted. The staff still needs to continue to assess whether they have resolved the emergency or they have found a safer location and/or situation for a different type of hold. Does an emergency exist?

**III. Planned Destinations**

Frequently, Human Rights Specialists find emergency restraint forms that note the removal of the restraint due to the arrival of the person at a particular location, such as a quiet room, bedroom, or time out room. If the program did pre-select an area to take people in crisis and the record shows that an individual was not allowed to leave once in the area, the result may be seclusion, which is disallowed in DMR, or an unsanctioned time out. If bodily physical contact is used over active resistance of the individual, it could also be a further use of emergency restraint.

Time out is a behavior modification technique that may ***only be used in conjunction with a behavior modification plan*** (115 CMR 5.14 (2) Time Out). If an escort requiring the use of physical force is required to get someone to treatment it is seen as a feature of this treatment (guidance on this was issued by Amanda Chalmers, then DMR Director of Quality Control and Kim E. Murdock, then DMR General Counsel, June 22, 1992) and subject to safeguarding as a behavior modification intervention, not as an emergency restraint. Relaxation is also a behavior modification technique (115 CMR 5.14 (3) (b) 2. b.), which reaches a Level II designation when force is used to transport the individual to the place to relax, or keep him/her in the designated location. In these circumstances the holding is not ended because the emergency has ended, but because they are at a location chosen for treatment purposes. What is being described on an emergency restraint form when the emergency behavior continues, but the person is released and required to stay in the site for relaxation, is the enforcement of a behavioral intervention. There must be such a plan in place (115 CMR (4) (c)) and ***if force is needed to ensure its implementation then the clinician must recognize this in assigning a level of intrusiveness to the intervention (115 CMR 5.14 (3) (c) 1. a.). Time out and relaxation procedures may not be implemented with emergency techniques, absent inclusion in a plan (115 CMR 5.14 (4) (b) 6.).*** To do this may reach beyond the boundaries of the regulations and, if so, can be found to be a condition reportable to DPPC.

**IV. Risks and Safeguards:**

Moving someone against their will during an emergency situation, which by definition is most often not a planned response, is riskier than moving someone in a planned way to a point where a treatment intervention awaits. This is because the treatment escort may take place when the person is not exhibiting emergency behavior.

***DMR restraint statistics for FY '03 show that there is a higher rate of injury associated with emergency escorts than most other forms of emergency restraint.*** This supports the need to move individuals using emergency restraints no further than necessary to address the emergency. Safeguards call for review of restraint forms by a range of parties (115 CMR 5.11 (8)). Also, if the restraint use is frequent enough the treatment must review the needs of the individual and develop a teaching strategy to mitigate the need for the emergency restraint (115 CMR 5.11 (7)).

On the other hand, if the team meets and believes there is a ***treatment purpose*** (115 CMR 5.14 (4) (a) 1.) to moving an individual to a particular location, then the escort should be documented in the behavior plan and safeguarded by the required rigorous procedures for this. If a plan doesn't exist, then the team should develop one. The obligation is also to ensure that this strategy is effective. The treating clinician will monitor the effectiveness of the plan at least weekly (115 CMR 5.14 (4) (c) 5.) and the HRC and Peer Review

Committee will each evaluate the intervention for regulatory compliance and efficacy (115 CMR 5.14 (4) (d)). Restraint forms needn't be filled out if there is an approved Level II plan that meets the requirements above.

Emergency restraint is less well planned for and a critical response to dangerous situations. The risks are high enough that safeguarding standards require the review of each episode of its use by the program, HRC, and DMR. The risks of behavior modification, on the other hand, are safeguarded by requirements that the clinician, HRC and the team, review interventions on the basis of aggregated data, not episodic. To remove a non-emergency forced escort from the process of behavior planning could be quite dangerous and must not be allowed to occur.

**V. Conclusions:**

Best practices foster integration of behavior planning with other modalities of treatment. They also require the rigor of professional standards that should always be applied in affording people meaningful assistance in the pursuit of a 'life like any other'.

Uses of restraint, while permissible under certain emergency circumstances, must in fact prompt more holistic planning when a person is subject to more than one restraint (beyond the first 24-hour period) in a week; or more than two in a month (115 CMR 5.11 (7)). Such interventions, when they involve the use of behavior modification, require functional analysis of the target behaviors (115 CMR 5.14 (4) (c) 3.); and must be crafted by someone experienced in behavior modification techniques. Safeguards include review by both a peer review committee and a human rights committee.

If program staff determines that the best way to address potentially dangerous behavioral outbursts is with a relaxation program, or a time out intervention, then these should be brought back to the team for consideration for use in a treatment program. If this requires using force over active resistance to move the person to treatment (such as documented in the restraint forms discussed earlier) and these risks aren't disclosed in the plan, the clinician won't have the information about the restraints. This denies the clinician the information on the individual's true response to the intervention and invalidates consent procedures.

All involved in DMR services should be on the look out for un-sanctioned treatment interventions and helping to promote clarity on this issue. Promoting behavior planning over emergency responses is usually safer, likely to be more effective and responds to a basic principle that guides our services, ***the right to habilitative care and treatment.***

# HRAC Has Busy Year

**Todd Kates**
**Vice-Chairperson**
**DMR Human Rights Advisory Committee (HRAC)**

For the last two years HRAC has been reviewing medication policies and practices from a number of fronts. An outcome of HRAC's work with Deputy Commissioner Mark A. Fridovich, Ph.D., is that the Department will now look at data systems related to tracking of anti-psychotic medications. The goal was to match this information with legal databases to see how many people on anti-psychotic medications had a Rogers Monitor.

The Department is now looking beyond HRAC's concerns to further systemic needs for data on use of all psychotropic medications and the Department is close to being able to obtain significant data on medication practices within the Department as a whole and in individual cases for those receiving support from DMR.

The committee has been evaluating the efficacy of having community HRCs be mandated to review medication practices, as required for facility HRCs. While we have been moving cautiously toward this goal, the initiative was put on hold when it identified a broader problem with DMR regulations requiring medication treatment plans under 115 CMR 5.15 (4) (b). The regulations were written to require documentation of **the behavior to change**, which is consistent with facility practice, where individuals have more difficulty in reporting their symptoms, but varies significantly from community psychiatry.

In the community, most psychiatrists prescribe on the basis of symptoms and diagnosis, not behavior. This means that those agencies developing medication treatment plans have been required to seek information that many community psychiatrists were not able to provide. DMR strategic management is aggressively reviewing this situation and preparing solutions on several fronts. ***DMR has assured us that programs seeking to provide information on the behavior that the medication is trying to change can naturally utilize data on symptoms and diagnosis to satisfy these requirements. This data is substantially equivalent to that sought in the regulation***

The committee is also working on providing standards for information to be shared with individuals and family members, etc., regarding the human rights of persons served by DMR. HRAC would like to spur outreach to individuals and family members requiring them to be informed of the role of HRAC and the human rights specialists. Oversight of human rights committee training standards is a formal role of HRAC.

This year HRAC also responded to a number of issues raised by HRCs and others. In one case, the HRC was evaluating a waiver for the use of mechanical restraints for an individual in their care. The HRC was concerned about team dynamics and sought HRAC's assistance in evaluating the appropriateness of the waiver. HRAC directed OHR to intervene with the DMR Legal Office to ensure adequate support for clinical decision-making.

In another case, HRAC reviewed standards for meeting HRC membership requirements. OHR and the Survey and Certification Office collaborated to respond to provider concerns with several common sense recommendations for altering the standards, supported by HRAC.

Overall it was a busy year that saw HRAC responding to the staff reductions in OHR and solidifying its own internal procedures. Anyone reading this newsletter should feel free to contact HRAC to respond to specific concerns of policy issues that may have systemic implications. HRAC reports to the Commissioner and supports the operation of OHR. We are here to support you in your role to fulfill the rights of persons supported by DMR!

**(HRAC can be contacted through Tom Anzer at the Office for Human Rights, 617-624-7738.)**

## Individuals Can Prevent Abuse

**Leo V. Sarkissian, Executive Director, The Arc of Massachusetts**

It is all too common for individuals with intellectual or cognitive disabilities to experience abuse. This discussion is about the prevention of abuse by staff or others who play a supportive role to individuals with disabilities. The DPPC (Disabled Persons' Protection Commission) has documented a rise in reports and substantiated incidents over the past three years. The Arc's position statement on "Protection", notes that, "When an adult needs protective assistance, the best protection usually comes from the person's family, community, and friends. Protection services should be provided through adult protective agencies or advocacy groups. Individuals should be trained to better protect themselves."

The first step in preventing abuse is recognizing that the larger society is filled with negative messages about individuals with cognitive and intellectual impairments. It is *in this larger society* that children and adults with disabilities must participate. It is *from this larger society* that we recruit staff of all levels, from professionals to direct support staff. Individuals still face taunting and rejection, sometimes even from neighbors and extended family members. Two years ago, a news report documented that, children who attended a school for autistic students in New York were bombarded by rocks from other children. Every week we hear another celebrity talking about "retards", using it in a derogatory fashion.

Recent writing on abuse emphasizes prevention. An article posted at the site of the National Clearinghouse on Child Abuse and Neglect (funded by Admin. on Children and Families) includes several recommendations which also apply to protection of adults: careful screening of job applicants, training for staff in positive behavior management techniques, realistic staff expectations, strong supervision and support, and an explicit commitment to protection. Although these recommendations apply to prevention work with adults, they don't go far enough.

Other writers/researchers talk about developing a culture (Sobsey and others) which counteracts the negative connotations that we have learned and helps to develop a culture that supports diversity. Culture or community building must start with where we live. Regardless of our role, an individual with a disability, a family member or friend, or a staff person, we can begin our community building around ourselves or those we care about. PALS (http://www.palsinc.org) is an organization with a specific approach to accomplishing this through the development of personal networks. David and Faye Weatherow talk about the "importance of engagement, companionship, contribution, and affiliation." These concepts or characteristics can have very practical consequences in people's lives.

Let's go to an imaginary house where Ben, 33 years old has lived for six years. Ben happens to live with two roommates who, like him, need staff support for certain household and self care tasks. Over the past year, Ben has become progressively quieter. His and his sister, Amy get together weekly and he brightens when she arrives to take him out. Ben no longer smiles at the end of their visits together. But it wasn't always like this. Amy has noticed several new staff over the past few months. When she arrives, she is not greeted as she was in the past. They are busy preparing dinner but in the past, the staff always greeted her. Amy, though involved, doesn't realize that things have changed in other ways too so that Ben is no longer attending a food pantry where he volunteered. He misses seeing a friend who lives 3 miles away.

No wonder Ben is sad. The specific situation with new staff and an apparent lack of continuity also translates into potential for risk for Ben. During periods of stress, staff may have a higher probability to react negatively or in a disrespectful manner. In addition, the lack of positive interactions between visitors, friends and staff means that all

parties, including staff, are losing out on a sense of community and positive recognition.

Take a second to evaluate where you live or where someone you work with or care about (family or friend) lives. Here are some ways that you can make a difference in building a culture of affiliation which will prevent disrespect and abuse.

<u>If you are an individual, family member or friend:</u>

1. Are there affiliations beyond the staff-support and roommate relationships? If the answer to these questions is yes, then your work is to support it. Recognize staff which show positive regard and work to build relationships both inside the home and with the surrounding community.
2. Get involved in efforts that will build engagement and a strong sense of companionship. Look for signs that the person is respected. Respond quickly to signs that show disrespect. (e.g. individuals with disabilities are encouraged to speak up and staff/friends wait for or help facilitate opinions; individuals with disabilities encouraged to contribute to activities or the community)
3. Raise concerns to the relevant direct support staff if the environment changes in a negative way or if relationship building is not a priority. Take further steps if needed with those in responsible roles. (This includes supervisory staff and may include human rights committee, DMR service coordinator, etc.)

<u>If you are a staff person or agency volunteer (human rights, board, etc.):</u>

1. Set benchmarks in affiliation and building community that you can evaluate as a team. Value each others' positive work and recognize it verbally and in writing.
2. Be a good role model. Don't be shy to point out small incidents that reflect disrespect. Use staff meetings, even informal ones, as opportunities to discuss such failings and to insure that individuals understand the importance of their role.
3. Report patterns of disrespect immediately to a supervisor and ask that they be reviewed by the human rights committee at your organization. They may reflect the need for further review or change.
4. Find ways to involve individuals with disabilities, family members and friends constructively in reviewing activities and building relationships with community. It can be fun and rewarding in addition to the right thing to do!

## *From the Desk of the Director*

## Restructuring and Rededication

By Tom Anzer, Director of the Office for Human Rights

Fall 2003 saw the Office for Human Rights confronted with a significant challenge, how to oversee the safeguarding of the rights of persons served by the Department while absorbing a 35% reduction in staffing, much to available time of Human Rights Specialists (specialists). DMR used an Ad Hoc group to look at quality systems and provide guidance to OHR, OQE and Investigations to address this and other cuts, I sent out a memorandum to the community detailing how OHR would respond.

The measures instituted included the following:

1. DMR facilities would provide more support to their HR Coordinators (Specialists) by taking HRC minutes, improving databases and assigning HROs where they didn't exist to take over the eyes and ears functions.
2. Providers can be certified to provide their own human rights training, particularly the required officer training done by specialists.
3. That OHR would review restraints on-line and only sample actual copies of individual restraint forms as they deem appropriate.
4. Provide outreach to family members and others to inform them of the ombudsperson's role that specialists can fill, to help achieve resolution to concerns they may have that rights are being violated.
5. Provide outreach to HRCs regarding the ability to contact the DMR Human Rights Advisory Committee (HRAC) about significant policy issues that are not getting resolved.

The Office initiated most of these changes, but very few agencies have picked up on the offer to have their agency trainers get their human rights curriculum certified to meet DMR regulatory requirements. This January, the DMR Training Department has taken over the basic

human rights training and OHR continues to offer agencies the chance to provide their own training. This initiative continues to evolve.

This Winter HRAC has met to develop standards for outreach to family members by provider agencies that inform families, guardians and individuals of the mechanisms to support human rights in DMR. As a part of this initiative OHR will be distributing these standards that include the promotion of the specialist's ombudsperson's role and the availability of HRAC for assisting with policy issues, both mentioned earlier.

Specialists continue to be available to provide technical assistance and support to providers and area office staff. Their time in area offices has been more limited, but nothing should keep someone from picking up the phone, or sending an e-mail if consultation or answers to other questions are needed.

Specialists devote significant energy in providing Networking sessions in each region that providers should take more advantage of. Networking is a mix of guest speakers and problem-solving case questions that arise. It can be a valuable forum for refreshing your skills, learning new developments in the field and dialoguing around some of the more challenging issues you face.

Specialists spend between 31% and 46% of their time either on the phone, on e-mail, or in meetings regarding specific individuals. They have less time for case finding and need to rely on families, providers and area staff to let them know when they could be needed. They address knotty issues providing appropriately for the safety of an individual without unnecessarily impinging on their rights. They also can help resolve problems or disputes over rights, or an individual's voice, when team members are in significant disagreement.

While specialist time is limited, they still can be reached and are available to all of you. Just have some patience. If you are not sure who your specialist is you can go to the home page of the DMR web-site and click on the link to "Major Departments." In the "Deputy Commissioner" listing you will find the OHR site. The specialist list is at the bottom of the OHR page.

Or call me at 617-624-7738 and I can point you in the right direction. Despite the increase in workload, specialists are there for you so that you may better protect the rights of individuals supported by DMR.

(Hae Young Cho and Susan Moriarty being feted by the OHR staff October 2003)

## To reach Rights Review, please contact:

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**Editor's note:** Each issue of the "Rights Review" is reviewed by DMR senior staff and represents the views and regulatory interpretations of the Department as a whole.

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