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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When is a Hold an Emergency or a Behavioral Intervention?

By Christine Wood, Human Rights Specialist, DMR Central Region

The Department is ready to move forward with the next step in its initiative to reform physical holding practices. There are two types of holds we typically find in behavior plans. One type is a physical restraint, which is done for the purpose of managing or controlling a person in an emergency. The other is a therapeutic hold, done for treatment, or behavior modification purposes.

This article is the first step in advancing the project by clarifying the standard for reporting each type. There is some confusion about when to report a hold as a restraint, or record it as a therapeutic hold. The definition of physical restraint which appears in 115 CMR 2.01, states: "Physical restraint does not include a limitation of movement pursuant to a behavior modification plan reviewed and approved in accordance..." with the regulations for behavior plans.

The key words here are, "in accordance," which means we must consult behavior modification regulations to draw our conclusions. We find the answer in 115 CMR 5.14 (4) (a) (1) and (2).

5.14(a) (1) says, "interventions that limit an individuals freedom of movement and that are consented to, approved, and implemented for *treatment purposes* (emphasis is mine) as part of a Behavior Modification Plan for an individual …constitute

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reasonable limitations on freedom of movement. Such interventions are not subject to 115 CMR 5.11" (restraint).

5.14 (4) (a) (2) says, "Procedures that are used, or that are proposed for use, for the *purpose of protecting* (again, emphasis is mine) an individual or others from harm and not for Behavior Modification purposes {SIC i.e., "treatment"} may be used subject to 115 CMR 5.11." (restraint)

In 1992 the Department issued Behavior Modification guidelines which clarified holding for treatment purposes and holds which should be documented as restraint. Here are some excerpts from that document:

"Behavior Modification V. Restraint

The relationship between the behavior modification regulations and the restraint regulations seem to be the most difficult to understand. To keep the scope of the two sets of regulations clear one should always keep in mind the following two principles:

Behavior modification is treatment. If an intervention is intended to treat (that is, it is intended to cause a long term change in behavior) it is governed by the behavior modification regulations.

Restraint responds to an emergency. If a hold or a drug is administered to stop, or prevent the imminent occurrence of an emergency, it is governed by the restraint regulations. The term emergency is defined in the restraint regulations but a good guideline is to ask, is there a genuine risk that the individual, if not restrained, will engage in seriously endangering violence or cause serious personal injury? If not, there is no emergency.

A clinician may suggest a behavior intervention intended to treat which has, as a component, a hold. For example, an individual who destroys property is expected to clean up the damage if she does not clean when verbally prompted, staff will escort her to the site of the damage and direct her to clean. This "escort" is one or two employees walking arm in arm with the individual.

Obviously, there is no emergency here, so the escort is not a restraint. Rather it is part of a behavior plan. Accordingly, the restraint regulations do not apply and the behavior modification regulations do. Under the behavior modification regulations we ask is there some active resistance to the escort on the part of the individual? That is, is physical force necessary to overcome the active resistance of the individual? If so, the intervention will likely be a level II and the behavior modification regulations would require implementation of all the procedural safeguards of a level II intervention (peer review, human rights review, etc.).

Now, suppose on one occasion in response to the escort the individual becomes assaultive and the two staff members find themselves tightening their grip and having to hold the individual for several minutes while she strains for a chance to strike out. This has turned into an emergency, triggering application of the restraint regulations.

The staff will have to ensure that the restraint regulations are followed (e.g., decision to restrain made or approved by authorized staff, restraint

form completed, etc). The fact that a restraint became necessary during implementation of a behavior treatment intervention does not make it any less of a restraint.

Further along these same lines, if a clinician sets forth in a behavior plan a 'recommended' type of restraint that is effective for a particular individual because there is a possibility that implementation of the behavior plan may result in an emergency, the recommended restraint is not part of the behavior plan. The restraint will only be applied if an emergency results from the plan and therefore it must comply with the restraint regulations.

The only times a hold is not subject to the restraint regulations are:

1. the hold is intended to protect the individual or others, is not against the active resistance of the individual and is for less than 5 minutes. 115 CMR 2.01; or

2. the hold is a supportive or protective device within the meaning set forth in 115 CMR 5.12 (1) {though, if the hold is over active resistance, it becomes emergency restraint.}; or

3. the hold is incorporated into a behavior plan and its implementation is not dependent on the occurrence of an emergency (in this case, the behavior modification regulations apply and may require the plan to be treated as a level II or even III, depending on the nature of the hold and the risks it presents to the individual)."

The Behavior Modification Guidelines contain a question and answer section, which also is useful in helping us sort out how the difference between a hold in a behavior plan and holding as restraint can "play out" in different situations. Please contact a Human Rights Specialist if you would like a copy of the full document.

I wish to address another question frequently asked of specialists. People ask if they can reduce the number of restraint forms they submit for an individual if they incorporate the hold being used as restraint, into a Level II behavior plan. The answer is dependent on the purpose of the hold. If it is not for treatment purposes, but needed to manage an emergency, a restraint form would still need to be completed.

Also, it is important to note the language used in the regulations pertaining to our obligation if the frequency of holding reaches minimal thresholds (115 CMR 5.11 (7)). The ISP team must meet and develop an "intervention strategy" to lessen the need for restraint. This strategy may not necessarily involve behavior modification at all. It might be to change something environmentally, or to rule out pain or medical problems. It should be a priority to take a very holistic look at the life of a person with a high number of restraints and discern what is being communicated by the emergency behavior. It is important to reduce the need for all physical holding, not just the number of documented restraints.

Some other examples of a hold for a treatment purpose are :

- **As per her behavior plan, an individual is held over active resistance early in her particular behavioral chain of activity and is able to calm down in seconds, at which time staff can proceed with helpful intervention. In the absence of this hold, her behavioral chain would escalate and she would be out of control for hours. Because the hold prevented significant emotional escalation**

(including a greater risk of physical harm) and the necessity of more intrusive measures it is classified as treatment. It had a theraputic benefit, or effect.

-An individual's behavior plan specifies that he is to be held over his active resistance when he engages in mild self-injurious behavior. He does not like being held and the rate of self-injury decreases. The hold has a positive effect on the behavior to decrease, and thus has a therapeutic value.

In each of these cases the clinician is responsible for defining the intended purpose of the hold. As a practical matter, ask what the clinician is telling you the purpose is? Is there data from previous experience that leads them to this? Are they speculating that the person likes the holding, or the struggle and the plan seeks to address this? Do you see that by holding the person you can avoid the outcome the individual seeks by the behavior so that the individual might over time forget they liked this outcome? The purpose of the hold should be well spelled out in the plan. If it has a treatment purpose, then it should not be reported as an emergency restraint. If it is intended to keep someone safe, then it should.

Once you have determined there is a treatment purpose, you still have an obligation to see if all of the components to the behavior plan are present. Behavior modification requires a structure to be in place that includes a functional analysis of the role of the target behavior for decrease, a replacement behavior, consent and a number of other provisions.

I won't spend more time on this than to remind the reader that this is only part of the analysis one needs to go through when reviewing such plans.

Since restraint data has been disseminated by the Office many have asked us to also look at holding inside of behavior plans, as well as emergency holding. The Department will soon be in a position to carefully examine all holding authorized by behavior plans and discern what can be done to foster positive reforms.

When analyzing the data, however, we should be comparing apples to apples and oranges to oranges. The goal is to reduce holding, improve safety when holding is necessary, and identify additional supports which might be needed, so the quality of life for individuals can be improved!

I hope his has been helpful in clarifying whether a hold should be documented as a restraint, or (as will be possible on the new restraint forms to be issued late Fall) as a hold for a treatment purposes.

It is the hope of the Office for Human Rights that an outcome of this clarity will be that we will all pay better attention to the reasons we are holding people and that plans will better spell out the intended effect of the holding. People receiving such supports will only be better off as a result of this clarity.

If you have further questions, please consult the Human Rights Specialist in your region.

Direct Care Staff and Human Rights

By Pat Freedman, Chair
Human Rights Advisory Committee

Protecting the human rights of people served by

the Department of Mental Retardation is the responsibility of many people. Everyone connected with any aspect of the life of someone served by DMR has a role to play to ensure that human rights are protected and enhanced. For some people, their primary responsibility is the protection of these human rights.

These people include Human Rights Officers, Human Rights Coordinators, members of Human Rights Committees and members of the Statewide Human Rights Advisory Committee. However there are people whose job titles may not include "human rights", but who also play a significant role in protecting the human rights of people served by DMR.

One group that plays a particularly significant role is direct care staff. In fact, direct care staff are often the most important people in the lives of people served by DMR. This is especially the case for the majority of people served by DMR, who now live and work in community based programs.

The close relationship that direct care staff have with people served by DMR places them in an unique position to notice clues that may indicate abuse or violation of human rights. Direct care staff promote human rights by helping their clients take pride and pleasure in what they are doing. Direct care staff play a significant role in reporting human rights violations and in advancing the human rights of some of our most vulnerable citizens.

Unfortunately, the reimbursement rate that direct care staff receives does not accurately reflect the significance of the role that they play in the lives of people served by DMR. In a recent U.S. Bureau of Labor Statistics study of salaries paid in Massachusetts, the average hourly wage for human service workers was $9.47. This translates into an average annual salary of $19,700.

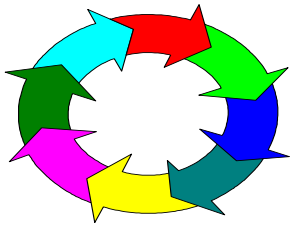
Contrast this with Lab Animal Caretakers and Pest Controllers who have average annual salaries of $2,000 to $8,000 more than the average human service worker.

We all recognize that these are difficult times for human services budgets. We also know that these difficult times are not likely to end soon. With these difficult budgetary times, there is a need to thoughtfully and carefully set spending priorities that reflect objective economic data and that will best help ensure the safety and human rights of people served by DMR. When there is a budgetary crisis, we need to be on guard against decisions that will undermine the fragile infrastructure that serves people with mental retardation.

If we are to continue to have a strong human rights system, we need to have people throughout the system who are skilled, experienced, trained, and adequately compensated. Without direct care staff that are adequately skilled, trained, and compensated, the quality of life for people served by DMR is likely to diminish.

At this time of serious budgetary constraints, all people interested in human rights need to be vigilant about ensuring that there are not cuts to salaries for direct care staff. Human rights advocates need to work to make sure that direct care workers are highly qualified and trained to meet the needs of people served by DMR.

Direct care staffs are an indispensable link to our efforts to protect and advance the human rights of people served by DMR. All of us involved with human rights need to work to make sure that this link remains strong.



Director's Update

By Tom Anzer, DMR Director for Human Rights

At the end of the annual human rights conference in June, another human rights town meeting was held. These are always lively exchanges that struggle with hard issues facing the human rights system and the Department.

This year, following up on previous discussions on the support to the Human Rights Officers, we discussed the role of the Officer.

On one side of the room was a person who was an officer at a community program who felt her colleagues treated her as a pariah. She had been involved in filing a complaint against a colleague and her treatment was a result of this. She felt that the structure was a set up and didn't feel like it paid off to act appropriately and follow through on her mandate.

On the other side of the room was a person who was also an officer of a private agency. He felt that he wasn't isolated, though he was sure it could happen, but felt we needed to be more focused on using the observations of officers as a learning opportunity.

He felt observations should be shared directly with a person, who may not understand they are mistreating someone, rather than always simply running for the complaint form and saying, "I've gotcha." As appropriate to the situation, he continued, he could share the observation with supervisors, particularly if the person refused to cooperate or listen.

This dialogue takes place all the time. How do I do my job as an officer without being seen as the rights police? One part of the answer is for the administration of the agency to be committed to human rights and make it part of the agency's operating protocol that HRO's be accepted for raising tough questions.

Advocacy in its very nature is about questioning the decisions of someone in authority to make those decisions.

The HRO's can help too, however, by being understanding that what they have most often is a question, not a firm judgment, or a demand. We must assume that most people in this field don't want to cause harm to any individual. People aren't usually mistreating individuals out of malice. When obscene acts of deliberate abuse do take place, there is no gray area for action. The abuse must be stopped, the individual protected and the abuse reported to appropriate authorities through the DPPC abuse hotline.

With most complaints, however, the inappropriateness of the action complained of isn't always as clear to everyone. Investigations statistics show that the largest category of substantiated complaints is the result of situations where the alleged abuser was unaware that their actions actually constituted abuse or mistreatment.

There needs to be a way to integrate the knowledge of the HRO into the supervisory structure of the agency.

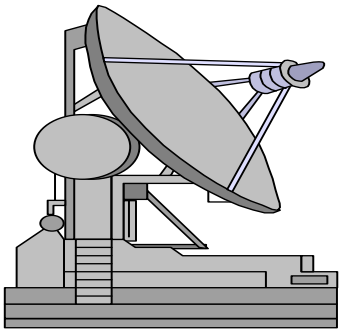
Support should exist for HROs throughout the system so that an HRO can be supported if they filed a complaint. Many agencies may do this, but it would be helpful, where appropriate, for the supervisor of the alleged abuser to meet with the reporter and the alleged abuser, after the investigators complete their work. This way both could better understand the situation and thinking of the other.

The HRO from the private agency had a further point, which felt important on this evening and I want to share his insights with you. He said that sometimes it's really about bringing the observations of HROs back into the team meetings and to supervisors of the agency, or house. The real key to making the HRO seen as a valuable resource in an agency is to recognize the role they have inside the team.

Team meetings, or staff meetings within the house or program, should periodically include special topic times that can be used by the HRO to raise trends or general issues that they have seen in their setting.

These last two points help to define good human rights practices. Too often we say that we need support from administrators to make the human rights system work, but we don't offer guidance as to what this means. The following are examples of the support of the administration of an agency for its human rights system:

- ensure that the HROs and the human rights coordinator have the time to follow up on the details of their HR responsibilities
- integrate the work of HROs and the HR Coordinator into management meetings of the agency and other vehicles for internal communications
- create an affirmative feedback loop between HROs and those accused by the HROs (or others, anyone who has filed a complaint, as appropriate to the circumstances) as alleged abusers in formal complaints, through supervisory lines
- provide opportunities for recognition for the HROs, it should be a reward to be appointed to the role, not a burden.



Fast Breaking News

In other actions, an appeal officer in an ISP hearing held that there is an internal inconsistency between the Department's governing statute and the DMR regulations.

The case involved an individual who wanted to move into a less restrictive setting against the wishes of his guardian. The ISP regulations at 115 CMR 6.32 (1) (b) state that the individual and their guardian may appeal together, but suggests that the individual who is subject to guardianship, may not appeal on his own.

Under this reading, the individual would have to go to court to remove their guardian, as the only remedy for such a disagreement.

Under the statute, Massachusetts General Law Chapter 123 B, Section 3, if the ISP "cannot be fully implemented because of the guardian's objection to a proposed transfer, the department shall … request… an adjudicatory proceeding … Said mentally retarded person shall have the right to be represented by counsel."

This means that rather than challenge the guardianship, the individual has the opportunity to be represented by counsel in the appeal hearing. The individual and guardian can both be present at the hearing, though they have different views of the issues at hand. In the case where this was settled, there was a good relationship between the guardian and their ward, just a disagreement over this important piece of planning.

While the circumstances raised are probably rare, it is helpful to know there is a remedy short of challenging the guardianship when differences appear between guardians and their wards.

We need to do more to support these relationships, not look for more and more reasons to push guardians away. This is a reasoned approach to resolving such disputes.

Rights Review is a product of the DMR Human Rights Advisory Committee (HRAC) and the DMR Office for Human Rights. To comment on the contents, submit an article, or otherwise reach the newsletter, please feel free to contact:
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Want clarity on a regulatory issue that has been bugging you? Have an idea to share with your colleagues? Write us at the above address, or call Tom to talk about your ideas for the next issue!

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