# 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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## *Understanding Abuse and Mistreatment!*

### *Clarifying the Meanings of These for Investigations*

**By Hae Young Cho, Human Rights Specialist Covering Parts of the DMR Southeastern Region**

Both abuse and mistreatment are outcomes no one wants to condone. However, investigations of abuse and mistreatment are regulated by different agencies, based on different standards. These differences can create confusion when reviewing investigations, disposition letters and decision letters or determining which route to pursue when following up on filed complaints. Therefore, it is important to understand the differences.

### DPPC and DMR
**Roles and Responsibilities**

The Disabled Persons Protection Commission (DPPC) and DMR are independent state agencies. They were created for very different purposes even though both agencies share some of the same consumer pools and have common interest in protecting individuals with disabilities from harm.

DPPC is a state agency created (by the authority of M.G.L.c.19C) to protect persons with disabilities, between the ages of 18 and 59 years old, from abuse or neglect ***by their caregivers.*** DPPC has oversight authority for all abuse investigations for individuals served by DMR, MRC, and DMH. DMR and DPPC worked cooperatively and have agreed to have DPPC become the sole point of entry for complaints in relation to persons with mental retardation. ***All complaints of abuse, neglect or mistreatment, must be reported to DPPC*** !

DMR is a state agency created (by the authority of M.G.L.123 and 19B) to take cognizance of the general welfare of all persons with mental retardation and to provide services and supports (primarily to adults with mental retardation). In doing so, DMR is committed to providing a safe environment, free from abuse and mistreatment. Fredom from abuse and mistreatment allows individuals with mental retardation to concentrate on becoming valued members of their community, as in the DMR Mission Statement. DMR also has a mandate to investigate allegations of abuse and mistreatment under DMR regulations found within 115 CMR 9.00.

The authority of DPPC encompasses the following:

1) Persons with mental or physical disabilities, and
2) Between the ages of 18 through 59.
3) DPPC has the power to screen all allegations of abuse or neglect by a caretaker that result in serious physical or emotional injury and to determine who will investigate, if an investigation is warranted.

## Included In This Issue:

4) DPPC has the power to investigate, or oversee agency investigations of cases involving abuse or neglect by caretakers that result in serious physical or emotional injury.

The authority of DMR is as follows:

1) to provide safe and effective supports, primarily to adult persons with mental retardation,
2) to investigate complaints of abuse and neglect as assigned by DPPC,
3) to review complaints screened out by DPPC as not meeting the standard for abuse and neglect, for evidence of mistreatment.
4) to investigate complaints of mistreatment under DMR's regulations.

Obviously, DMR has a broad mission to provide services, but it also has a work unit for investigating complaints. DPPC has a narrower mission to protect persons with disabilities by screening, and investigating complaints and by providing training on abuse prevention. DPPC oversees the most serious complaints and has a state police unit to facilitate criminal investigations of abuse or neglect. The DMR Investigations unit is assigned by DPPC the performance of many abuse investigations, under DPPC's supervision and handles complaints with less serious direct outcomes under DMR regulations, with the goal of preventing harm or improving services.

## Abuse and Mistreatment Compared

DPPC defines abuse according to 19c and as follows:

*An act or omission, which results in serious physical or emotional injury to a disabled person.*

There are two elements in the above statement that are important to keep in mind:

1) While there are cases where persons act willfully to hurt someone, an "act" includes a reckless or negligent behavior, which may not be intended to cause harm to others. Contrary to the belief of some, an act **does not have to be intentional to qualify as abuse**. An action is reckless when it is taken without proper regard for the consequences that a reasonable person would recognize. For example, let's say you are staff to an agency and are angry. You get into the van loaded with individuals to go to the grocery store. You drive 100 MPH in a zone for 65 MPH and got into an accident and an individual was hurt. You would have been engaged in reckless action because you didn't care to think about whether your action would hurt other people. A reasonable person, however, would believe that such speeds put one at risk for harm. Likewise, Omission can be intentional or unintentional. If you fail to take an action to protect or provide for the daily living needs of a disabled person intentionally or unintentionally, it is an omission. Say you got in the van and drove the speed limit, but failed to tie a wheelchair down properly (omitted this step) and a person got hurt when you turned a corner. You would have been negligent because you knew the tie down is an important step, you failed to take, even though you never intended to cause harm.

Then, it becomes clear why "Oh, it was only an accident, 'the caretaker' did not mean to hurt anyone" is not a good yardstick for determining whether or not abuse occurred. The question that needs to be asked is, "Did the caretaker take the necessary steps to protect individuals from harm or provide for the adequate daily living needs as a reasonable person would have done?" Regardless how conscientious a person might be, if he/she failed to take what could reasonably be seen as *the usual steps* in providing support for an individual at any time, for whatever the reason, causing injury to a disabled person, it is safe to assume that abuse might have occurred. In this case there are standard procedures for chair tie downs and these weren't followed. It would be reasonable to expect they would be. A more common example is when a person has a behavior plan guiding staff as to how to work with the individual in a certain type of crisis, but the plan wasn't followed. In this case, the staff should have known how to handle the situation but neglected to be familiar with the plan and the person got injured.

2) For an "act" or "omission" to be considered abuse, there has to be signs of physical or emotional injury. This means that while one piece of the standard is present, when you drive around illegally at high speeds or with a chair improperly secured, it may be a reckless or negligent act, it is still not abuse unless someone gets hurt. And for the purposes of DPPC, that someone has to be a person with disability between ages of 18 to 59. Many people are surprised when they file a complaint with DPPC and it gets "screened out" on the ground there is no evidence of injury. We must, therefore, be thorough and complete in our description when we file a complaint. Our description should include not

only what category of incident occurred (abuse, neglect or mistreatment), but also what evidence of physical or emotional harm we may have.

This does not mean it is permissible to use excessive force or verbal abuse as long as there are no signs of harm done! This is where the DMR Investigations Unit comes in. The DMR regulations at 115 CMR 9.00, covers the investigation of acts of mistreatment in addition to acts causing harm. When DPPC "screens out" a case from abuse or neglect charges the complaint process continues. DMR will take the case and complete screening for possible mistreatment.

Mistreatment defined in 115 CMR 5.05 (1) is as follows:

> *"Mistreatment includes any intentional or negligent action or omission which exposes an individual to a serious risk of physical or emotional harm."*

This indicates that mistreatment includes intentional or unintentional action/omission but there does not have to be a proof of actual harm done to a person. It speaks to "risk" of harm. This is a crucial difference from DPPC's abuse and neglect standard. Therefore, even if DPPC screens a complaint out for abuse, DMR has, by the authority of its regulations, an obligation to protect individuals from "mistreatment" as well. Identifying "mistreatment" before harm is done can prevent actual harm from occurring.

## The Whole Process

Once a complaint is filed, the State police unit assigned to DPPC reviews each complaint and takes jurisdiction over all cases that may involve a felony. Each Regional Investigation team of DMR has an investigator assigned as a liaison to DPPC and to the law enforcement community. The investigator liaison will assist District Attorney's Office and criminal investigator in their investigation as well as serving as a key person in monitoring its progress, ensuring rights and protection of individuals during the investigation and keeping DMR abreast of that progress.

Any complaint that State police does not take jurisdiction over, will be reviewed by DPPC for determination of abuse. If the complaint meets the criteria for abuse as defined above, and the alleged victim is a person with a disability who is between the ages of 18 and 59, a 19c investigation will be conducted. If it is determined that it qualifies as 19c investigation, DPPC has a decision to make - to assign one of their investigators or to ask the responsible agency to investigate. Either way, whether investigated by DPPC or DMR investigator, if it is determined to be a 19C investigation, the charges of abuse are investigated. DPPC monitors these investigations.

After DPPC makes the above determination, all complaints they did not take jurisdiction over will be referred to appropriate agencies. If the complaint is filed on behalf of individuals with mental retardation, DPPC will refer these cases to DMR. DMR then determines whether the condition meets the criteria of "mistreatment" and dispositions the case accordingly (dismissal, investigate or relates to ISP or administrative issues to be handled by region or area). In the decision letter (a letter stating the findings of the investigation that parties to the complaint will receive with the letter from the area office noting what actions were taken), it clearly indicates whether or not a 19c investigation was conducted and if so, whether the charges of abuse were substantiated. If 19c abuse charge was not substantiated, the decision letter further indicates what conclusion was made for the Chapter 9 investigation, regarding an allegation of Mistreatment.

If the complaint is about a nursing home or hospital, the Department of Public Health (DPH) has the authority to investigate. Complaints should be filed with DPPC, just the same, however, and DPPC will refer the case to appropriate agencies i.e. Department of Social Services (0-21 year olds), DPH or Executive Office for Elder Affairs (60 year olds and above). This allows DMR to be able to track the outcomes of investigations done outside of DMR and DPPC.

## Follow up and Time Lines

Once a complaint is filed, and after initial work to determine if protective services are needed, there has to be an investigation within reasonable time line for any protection to be effective. These timelines are found in 115 CMR 9.00.

Disposition of the case (documentation of assignment of case to state police, DPPC Investigator, or referred back to DMR, who may assign an Investigator or send on for administrative review): by the Senior Investigator, no later than 3 days after receipt of the complaint.

Assignment of investigator if warranted: By Sr. Investigator no later than 24 hours after receiving complaints.

Decision Letter: By Sr. Investigator to Regional Director within 30 days of the investigator's appointment.

Action Plan: Within 10 days of receipt of decision letter from Regional Director, the Complaint Resolution Team (group of citizens and DMR staff who review all complaints to safeguard process) who will generate an action plan under the direction and signature of the area office director.

There are exceptions to these rules. For facilities, standards of the federal Center for Medicaid and Medicare Services (CMS) govern and complaints must be disposed with an expedited resolution.

In order to monitor investigative process appropriately, it is important to know who the parties are to the complaints and what their authorities and responsibilities are. According to 115 CMR 9:00, the party to the complaint is as follows:

1. The complainant (reporter):
2. The person or persons complained of or thought or found to be responsible for any incident or condition subject to investigation:
3. The guardian of the complainant or person complained of, if any:
4. Any other individuals harmed (or reasonably believed to be harmed) as a result of the incident or condition, and his or her guardian, if any:
5. The human rights committee of the involved provider.

The parties have the right to the following information throughout the process:

- Complaint and disposition letter
- Decision letter
- Action letter
- Right to request a redacted copy of investigative reports if desired, in writing.

Likewise, the parties have the rights to appeal disposition of the case, decision, and actions to be taken. Generally, the appeal process begins by asking for reconsideration from the Regional Director. If it cannot be resolved satisfactorily at this level, an appeal can be filed with the Commissioner. The standards for appeal can be found in DMR regulation 115 CMR 9.11.

Others receive information regarding complaint, disposition letter, and decision and action letters. These are the Directors of the provider/designee and Director of Area office/designee. The reason they receive this information is so that they can take timely and adequate protective actions for the individuals involved. The major difference between this group and the parties to the complaint is that this group does not have rights to appeal. They have responsibilities to immediately protect individuals involved and implement protective measure as indicated in the action letter.

If you are one of the above identified, it becomes important for you to know what is happening with the complaint at all times. There appears to be a lot of questions regarding whom to contact for follow-up. It is actually quite simple if you remember who took jurisdiction to investigate. That is the agency that you should contact for information. If DMR is responsible for the case (if it is a case pertaining to persons with mental retardation) and you have not received information after the timeline specified above, you can contact Regional Investigation office for follow-up. One exception is if a party to the complaint wishes to request investigation report generated for 19c (abuse) allegation, the request must be made to DPPC and not DMR. Likewise, if the complaint was about the program within a nursing home or hospitals, follow-up should be done with DPH (or DPH and DMH if at a psychiatric unit or hospital), or if filed through DPPC, they can follow up for the parties.

As you can see, there are many differences in how agencies are required to follow-up on cases. However, there are a few that are very important for us to remember when we file a complaint:

1. File all complaints, abuse and mistreatment with DPPC.
2. For a follow up on disposition status, contact DPPC or DMR regional Senior Investigator.
3. For follow up for which DPH or other agencies are responsible, consult DPPC, if filed through their office, or contact those agencies directly.
4. For any other information, contact, DMR Regional investigation unit.

Ensure your complaints are accurately reflected by following-up with written complaints to DPPC.

Once you secure information as to which agency is responsible for investigation, forward a copy of the complaint to that agency. It never hurts to double check the intake process, as this is the foundation for the decisions made for disposition of the complaint.

**Editor's note: Each issue of Rights Review is reviewed and edited by Senior Staff of DMR to ensure the articles, particularly technical reports, reflect current DMR views. It's truly a product of the DMR community!**

## *Culturing Commitment From the Human Rights Specialist's Perspective*

**By Martin Rachels, Human Rights Specialist Covering the DMR Western Region**

(Editor's Note: The author has just celebrated the 20th anniversary of his service to the Department in the field of Human Rights.)

As I think about this year's annual DMR Human Rights Conference, and it's theme – "Human Rights Is Everyone's Job" I can't help but think that if at all levels of the community of people providing services we

"walked the talk," Human Rights Specialists (HRS) might not be needed. I would be remiss to not point out that the staff who work in the Office for Human Rights of DMR are the only folks who have the "luxury" of doing human rights work full time and wear no other hats. This is unlike other people involved in human rights who have various job titles and responsibilities within DMR and the system of providers (including human rights staff at the provider level). This is part of what makes the job so precious.

When I first started working for DMR in the position of Human Rights Officer I thought I was knowledgeable in a number of areas including the rights of individuals supported by the service delivery system. I found then, and continue to find, that many questions posed to the HRS are also opportunities for us to learn something about rights not known before the question is posed. We are supposed to be the experts in how the regulations support the rights of individuals, this also means, however, we have the opportunity to help the community bring the regulations to life in all their parts. This is a significant challenge and part of what keeps me going.

The first responsibility of an HRS is "to effectively advocate for the rights of people receiving services from the Department." This translates into responding in a respectful, prompt, and timely manner when questions, or requests for assistance are posed. Questions may come from anyone, individuals, family members, provider staff, or area/regional staff, etc., so the specialists need to be ready to not just answer the question, but help folks figure out how to use the information we may share.

On many occasions I get a question that may appear on it's face to the person asking it to be one that they hope will be a straight yes, or no answer. Quite often, my initial response is "it depends." Over the years I have learned that there's usually more to the question being asked and that sometimes we need to prod to pull out some important details, or facts along the way. Sometimes we are the "shop of last resort," in that questioners are really stuck, but have learned that we will "roll up our shirtsleeves," as needed. This means not only listening to their concerns in a particular matter but also to work along side of them trying to get at the facts and seeing where the issue or question "fits," within the "Rights" context and within the DMR regulations.

Depending on who is asking for help and what they are looking for, we may need to actively follow a case, or support the family member, individual or staff person who is challenged by the circumstances. Depending on the question, we also need to be knowledgeable of a variety of areas such as the use of behavioral interventions, psychotropic medication, interventions that are used to limit, or restrict movement or the basic rights of individuals etc. to give that support.

I am fortunate in that I had people who taught and shared and mentored me. When I go out to do my homework I take their wisdom with me. Sometimes I find more questions or issues than I was originally brought in on. This is part of my training that has stayed with me over the years.

Staff and supervisors don't always have smiles on their faces when an HRS is in the neighborhood. It is never easy to have someone from outside of your unit or agency looking over your shoulder to see if your work meets with the standards set for it. Whether its an HRS, or an HRO, agencies need to understand that we are there to support the rights of the individual in the middle of the concern. Usually we are there because someone effected raised a concern. I'm confident they can recognize that supports are improved by my asking questions that might come from a different direction. We all have the same desire to support what's in the best interests of the individual. We aren't invested in judging the work of others, but to ensure that due process, another view on full thinking, has been applied.

Sometimes the staff person who came to us with the question will have used the possibility of bringing in OHR as a threat to manipulate the situation. This is not helpful it is much preferred that professionals use a more positive or affirmative approach. Where staff have been manipulative or threatening, we also need to be a states-person, in the sense of being able to strategize how to get people to tell us things they may be afraid to tell us. We must get at the real facts, and/or, achieve resolution so that as many parties as possible feel that an issue was addressed in a way that makes sense. We must also do our work in the most respectful manner toward all people involved. Over the years I have found it necessary and important to demonstrate respect for all, (including at difficult moments), and to act with the assumption that we all must be working to the same ends.

Sometimes it can be uncomfortable for me when I go into a particular case regarding an individual or situation when I am not as close to the facts as the immediate staff. This distance enables the specialist, however, to have a "fresh eyes" approach as we review the restraint, and incident reports that document a situation. This is what the regulations were trying to achieve by creating this additional safeguard found in the Commissioner's Review of Restraints, for what can be very dangerous restraint practices.

Sometimes our reviews of the restraint form, incident reports,

minutes of HRC meetings, observations, or other sources of information, also indicate a situation that should be reported to the DPPC. As mandated reporters all of our, (DMR and provider staff's), "toolboxes" should contain a consistent view of the DMR and DPPC definitions of Mistreatment and Abuse. For the specialist, this circumstance becomes an opportunity to provide technical assistance to the person(s) closest to the situation, so they may appropriately follow up. Sometimes the person(s), to whose attention these issues are brought, will disagree with us. The specialist then has to act accordingly, and if the matter involves something that is reportable, (and our information gives us "a reason to believe"); we become the person who must and will do the reporting

Once a month on a regular basis, I visit, and spend time at the area offices I am responsible for within Region 1. This is an opportunity to meet with staff and work on issues with them. They all play a part in affirming, promoting, and protecting the rights of individuals supported by DMR. In essence, they are a part of the formal and informal "Human Rights System" at the local level.

The specialist's job also includes a responsibility to establish and maintain contact with, and develop supportive relationships with, the Human Rights Committees of providers. This duty includes establishing and maintaining a Human Rights Network on a Regional or Area level that assists Human Rights Coordinators and Human Rights Officers in not only understanding and fulfilling their responsibilities, but also as a support when "the going gets tough."

Each of the specialists is responsible not only to support the workings of the provider's Human Rights Committee but also to monitor their activities in a supportive manner. We do this by spending many evenings attending Human Rights Committees meetings. HRC meeting minutes are sent to the Area Offices and the specialist assigned to that provider. As we review this material, we may find issues that require advocacy and technical assistance, concerns or incidents that we think merit more fact finding, or that the HRC doesn't show evidence of critical thinking. On some occasions we have found that the information that comes before them may be shaped, in it's presentation to the committee, in that the members of the committee do not get to see and read for themselves the actual document that tells the story. Sometimes we have found committees don't have the necessary information, training, or tools enabling them to adequately safeguard the individual's rights in the matter before them. This is another one of those opportunities to be the states-person, or ambassador of good will, and provide the supports in such a manner that the groups or, individuals feel supported and assisted, rather than criticized.

The HRS spends a great deal of time providing training. This is done both formally and informally. Our formal training work is done through our providing Human Rights Overview and Human Rights Officer training's in our respective regions. Each of us has also developed expertise in other topics that we provide training in, such as "Liberty, Privacy, Human Rights and Behavior Modification, Prevention of Abuse and Mistreatment etc. When we present training on clinical topics, such as behavior modification, we try to do so in partnership with a local clinician. This approach helps staff obtain the whole picture rather than that of one discipline.

At these trainings, various questions or concerns will be raised for group discussion. Sometimes the questions are the "What if?" type. Other times, real life situations are questioned that have been uncomfortable for the participant for a while and either they don't know where to take it, or they are not receiving adequate support for raising the issue through the supervisory chain of command or Human Rights system at the provider level.

There are also occasions when a provider will ask us to do what we call a house call. This will be a special training just for the provider and their staff. Sometimes agencies ask for this to fill a need that they have seen and other times they have been encouraged to call us by the DMR Survey and Certification Team that recently performed a review of their agency.

One understanding I have with providers is that for house calls the Executive Director and or senior management staff of the provider must be in attendance for the training to occur. Doing it this way puts everyone on the same line. When staff see management and supervisory staff contributing to the conversations and agreeing with what is said---this is a powerful message to staff about the commitment to human rights by the leadership of their agency.

We also provide regular and ongoing Human Rights Coordinator (HRc) and Human Rights Officer (HRO) networking meeting in every region. These are meetings where the HRc and HRO can receive information, share ideas, concerns, questions or positive projects with others. It is also meant to be a safe place to share frustration with colleagues, and receive ideas about how they can resolve them. It can also be a place where one can develop a supportive, collegial relationship with another Human Rights person that one can call, or maybe turn to for assistance with an issue.

I have the fortune of having another set of responsibilities, the

planning and co-coordinating of the annual DMR Human Rights Conference. This would not be the success it is, if it were not for the people who have been part of the planning committee for this event. Their ideas and constructive criticisms have been integral to what we are able to accomplish. The group meets twice a month to plan this event.

When I think about what are the qualities a human rights person should have in order to be successful at this work, I think of the "P's of the powers of good Advocacy." This is a concept that Christine Woods, (another HRS), shared with me a number of years ago. Position, Presence, Persistence, Persuasion, Patience, and the most important…PASSION. Without these qualities excellence in this work will not be achieved.

I also think about what are the sources of reinforcement for me. Over the course of my employment history, I have held a variety of occupations. Being a Human Rights Specialist is my true love. My fantasy has been that if we do it well enough, that this job would become obsolete. I think about why I do this work in terms of the individuals whose rights we all advocate for.

There are also the people in this field who I have come to know and respect, who have become my mentors. There are also the "Heroes" of the field that I have been fortunate to meet and know – people like Gunnar Dybwad, Stanley Herr, Florence Finkel and Carolyn Barrett.

(Gunnar Dybwad)

There are a number of administrators that I admire that I have worked alongside of when an issue has been brought to our attention requiring our resolution. These are the administrators who have valued the raising of the issues to their attention, and my objectivity in researching and searching for the facts. These are people who have realized that "a healthy creative tension," between administrators and human rights staff benefits all. People like Terry O'Hare, Maureen Kirk and Peter Trayers come to mind One of the most reinforcing things for me, is the "thank you" from the person supported, their family member, or staff person, for supporting them in the resolution of their human rights concern.

## From the Desk of the Director

### Keeping Clear on the Boundaries of our Work

By Tom Anzer, Director of the Office for Human Rights

More and more I get complaints from Human Rights Specialists that they are seeing limitations of movement showing up in regulatory categories where programs aren't authorized to put them. One aspect of the regulations that doesn't get much attention is the definition of "Limitation of Movement" found in 115 CMR 2.01.

Under the regulation, limitations of movement (LOM) is "any restriction on the movement of an individual for the protection of that individual or others, or in accordance with a behavior modification plan meeting the requirements" of 115 CMR 5.14. Someone's movement is either limited for safety, or as part of a behavior plan to advance their personal growth and development. The next part is more intriguing and less well tended.

"Limitations of movement can be categorized on the basis of the reason for the limitation. Each category has its own requirements for implementation of the LOM. The five categories are:"

(a) Emergency Restraint
(b) Transportation Restraint
(c) Supports (115 CMR 5.12)
(d) Health-Related Protections
(e) Holds in a Behavior Plan

The clear message is that if you want to limit someone's freedom of movement, you ***must*** fit the justification of this limitation under one of these categories and safeguard it according to the applicable regulation.

That seems simple enough, so why the confusion? Sometimes we hear that the clinician didn't want to be seen as the one who writes restrictive behavior plans, so they use emergency restraints to escort individuals to treatment, put restrictive portions intended to shape someone's behavior into emergency protocols, or leave some restrictive interventions not well defined, operationally. This can cause problems for staff and undercuts the due process rights of the individuals we serve.

In an odd way, taking what looks to be the high road can actually impede on the individual's right to treatment. If interventions aren't well spelled out this could impede their effectiveness. Also, if less restrictive measures have been tried and failed, it is wrong to deny access to a modality (behavioral treatment) that may possibly improve a person's life, just because it may be unpleasant, or not in vogue. Writing the behavior plan in whole, as desired, helps everyone understand the whole thinking of the intended intervention and permits plans to be reviewed by peer review and human rights committees. This is in the best interests of individuals.

Another aspect of this is when programs take the opposite approach and put emergency restraints in behavior plans to avoid the routine reporting. Emergency restraint use can be thought of as a failure of treatment, so to handle restrictions as a part of treatment when there is no treatment purpose, under-cuts the integrity of the plan. If there is a treatment purpose to the holding, then it is legitimate and indeed desirable, to put it into the plan. Service Coordinators, Peer Review Committees and Human Rights Committees should all be watching over this to ensure that holds inside behavior plans do have a treatment purpose. If the treating clinician makes a reasonable argument regarding the purpose, this suffices and there will be measures in the plan to discern if it is working. If the answer is no, or the argument isn't whole, then the hold should be moved out of the plan and any holding over active resistance should be reported as an emergency restraint.

The goal is to minimize the amount of physical holding in a person's life. ***The best route to reducing restraint is providing quality treatment, of whatever modalities, that is well thought out and specifically tailored to address each person's needs.*** Following the regulations and fitting interventions and supports into the right categories advances this goal and provides for the proper safeguards to be met according to the requirements of the LOM being used. If this is done, the person is also more likely to be successful in removing limiting behaviors from their life and moving on to a more full and productive future. This is clearly what we all want.

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**Bernadette Gomes**
(family member, DMR staff)
**Florence Finkel, Emeritus**
(Governor's Commission on MR)
**Janice Feldman**
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**Joana Johnson-Smith**
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