Abuse and Restraint in a Regulatory Context: Applying the PICAR Method to Measure Compliance

January 4, 2013

Introduction

"Abuse" and "Restraint" are powerful words. The terms conjure images of gross and graphic mistreatment of vulnerable persons, and produce visceral reactions of anger and disgust. This is especially so as it relates to out-of-home care settings. Consumers of human services and their families fear mistreatment more than any other potential danger posed by such settings. They are terrified by the specter of the abusive childcare worker, the belligerent direct-support professional, or the healthcare aide that is "rough" with an elderly parent. In some cases, the fear is so great that out-of-home care is avoided altogether, possibly to the detriment of both the informal caregiver and the person-in-care. Strong licensing – the judicious and efficient enforcement of human services regulations – alleviates these fears, and, more important, protects persons-in-care from being mistreated[i].

Investigating any allegation of abuse or improper restraint use can be challenging for regulators. When allegations of abuse or improper restraint use are disputed by an out-of-home care setting or by the alleged perpetrator, the regulatory investigator must collect evidence to determine whether the setting was in compliance with applicable regulations related to the event, which also serves to prove specific facts. For example, let us say that a child in a residential facility is alleged to have been struck by a staff person. The allegation may be disputed, but a mark left on the victim subsequently shown to be a handprint would clearly prove that *someone* hit the child. Thus, if the facility saw the mark and took no action, regulatory violations exist even if the actual perpetrator is never identified, e.g. failure to report suspected abuse, failure to conduct an internal investigation, etc. Moreover, even if it cannot be established that the child in our example was struck at all, the alleged abuser's record *may* show that (s)he never received training on abuse prevention and de-escalation techniques – another potential violation. Allegations where the facility does not dispute the facts of an event but rejects that the event included an abusive act can be extremely problematic. When a facility acknowledges that an event occurred and fully cooperates with a regulatory investigation, the regulator is forced to make a qualitative decision beyond the simple facts: If the event has occurred to the recipient of services that meets the definition of abuse (whatever that may be), then abuse has occurred, but is it "abuse" for the purposes of citing a regulatory violation if the out-of-home care setting has met all regulatory requirements relating to preventing and responding to abuse events? One may say that the decision isn't qualitative at all, that the regulator need only establish whether the event meets the definition of abuse or restraint set forth in the regulations that govern the facility's operation. Perhaps – but the definitions of abuse and restraint rarely establish firm inclusionary standards. Consider how "child abuse" is defined in the Federal Child Abuse Prevention and Treatment Act (CAPTA)[1] :

> Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.

Or consider the Centers for Medicare and Medicaid Services (CMS) definition of "restraint" for hospitals:

> Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).[2]

[1] 42 U.S.C.A. § 5106(g)
[2] Medicare and Medicaid Programs: Hospitals Conditions of Participation (42 CFR Part 482), published in the Federal Register on July 2, 1999 (Volume 64, Number 129; pages 36069-36089).

Like most definitions of the terms, these allow for a considerable amount of discretionary interpretation. What is "serious" harm? What does it mean to be able to move one's body parts "freely"? This is not necessarily bad for the regulator. Regulatory oversight agencies must be able to apply regulations to a variety of events and situations. Given the wide array of possible abuses and restraints that persons-in-care could be subjected to, a rigid and finite definition would either be too exclusive or infinitely long. However, a definition that allows for discretionary interpretation also allows moral, ethical, and philosophical perspectives to influence such discretion, which may in turn impact inter-rater reliability and equitable treatment of licensees. If a staff person is attacked by a person-in-care who manifests aggressive behavior as a result of a traumatic brain injury, and the staff person strikes the person-in-care in self-defense which results in serious injury, did the staff person abuse the person-in-care? If a child in a juvenile detention center tries to punch a direct-service worker, and the latter grabs the former's arm to stop the punch, did the worker not use a manual method to reduce the ability of the child to move his arm, constituting a restraint? These are the kinds of questions that make regulatory investigations of abuse or improper restraint use so difficult, and, as is frequently the case in matters of determining regulatory compliance, the answer to both is "maybe – it depends."

This document will offer definitions of abuse and restraint that are more easily applied in a regulatory context, and will establish a methodology (the "PICAR" method) to determine regulatory compliance or noncompliance that can be applied in both disputed and undisputed cases of abuse and improper use of restraints.

Abuse

Traditional definitions of "abuse" pose difficulties to the human care regulator in two ways: one, the definitions are based on the degree of injury sustained by the victim, and two, the definitions do not contemplate environmental or agency-wide culpability in abuse events. Consider the following examples from the Commonwealth of Pennsylvania:

> Abuse is the occurrence of one or more of the following acts: the infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish; the willful deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health; and sexual harassment, rape or abuse, as defined in 23 Pa.C.S. Chapter 61 (relating to Protection From Abuse Act)[3].

> Abuse is the occurrence of one or more of the following acts: the infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish; the willful deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health; and sexual harassment, rape or "abuse" as defined in 23 Pa.C.S. § 6102 (relating to definitions)[4].

> The term child abuse means any of the following: any recent act or failure to act by a perpetrator which causes nonaccidental serious physical injury to a child; an act or failure to act by a perpetrator which causes nonaccidental serious mental injury to or sexual abuse or exploitation of a child; a recent act, failure to act or series of the acts or failures to act by a perpetrator which creates an imminent risk of serious physical injury to or sexual abuse or exploitation of a child; serious physical neglect by a perpetrator constituting prolonged or repeated lack of supervision or the failure to provide the essentials of life, including adequate medical care, which endangers a child's life or development or impairs the child's functioning[5].

[3] 35 P.S. § 10225.103 This definition and the two that follow come from person-protection administrative statutes. They are written so as to allow the Commonwealth to intervene and protect individuals who are unable to protect themselves, or who do not have others to protect them.
[4] Act 70 of 2010, the "Adult Protective Services Act"
[5] 55 Pa.Code Ch. 3490 (relating to child protective services)

> Abuse is the occurrence of one or more of the following acts: the infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish; the willful deprivation by the assisted living residence or its staff persons of goods or services which are necessary to maintain physical or mental health; sexual harassment, rape or abuse, as defined in 23 Pa.C.S. Chapter 61 (relating to protection from abuse); exploitation by an act or a course of conduct, including misrepresentation or failure to obtain informed consent which results in monetary, personal or other benefit, gain or profit for the perpetrator, or monetary or personal loss to the resident; neglect of the resident, which results in physical harm, pain or mental anguish; abandonment or desertion by the assisted living residence or its staff persons[6]

In each of the above examples, an act is not abusive unless some degree of "serious harm" occurs as a result of the act. Moreover, only the definition of abuse in Pennsylvania's assisted living regulations contemplates a facility-wide act of abuse ("abandonment or desertion by the assisted living residence").

A functional definition of abuse for the human care regulator must include specific parameters that can be measured the same way by different people in different settings, and that clarifies how facility action or inaction will impact whether "abuse" is cited as a regulatory violation. We offer the following:

Abuse is a deliberate or careless act[7] by a person in power which results in significant mental or physical harm to one or more disempowered persons. For an act to be "abusive" in a regulatory context, it must:

1. Be deliberately or carelessly performed
2. Be performed by a person who has authority (perpetrator) to a person who does not (victim)
3. Result in physical or mental harm such that
    a. The victim needs medical or psychological evaluation or treatment, as established by a clinician or caregiver, or
    b. A layperson would reasonably conclude that the person be professionally evaluated to determine whether or not medical or psychological treatment is required.

For an abusive act to rise to the level of a regulatory violation, the act must result from or be associated with an agency failure before, during, or after the act occurred.

One may reasonably ask why power and authority are important to establishing abuse in a regulatory context. The concept of a stronger person dominating a weaker person is needed to exclude mutually-instigated acts of violence between two or more persons-in-care; in short, an "authority filter" is needed to exclude acts of shared responsibility such as fighting[8]. While it may be difficult to accept, physical fights are a part of out-of-home care, especially residential care. This is true regardless of the population served – while older adults typically do not resort to violence with the same frequency as delinquent youth, physical violence can and does occur across human services settings. Limiting abuse to relationships of disparate power ensures that all staff-to-person-in-care acts that result in harm are included in regulatory investigations; also, by excluding mutually-engaged acts of violence, there can be little doubt that person-to-person acts that are motivated by the perpetrator and unwanted by the victim *are* included in the regulatory investigation. Both acts that require evaluation and treatment and acts that a layperson would reasonably conclude to require evaluation must be included in the definition to include cases where a potentially-abusive act was also neglected by the facility. For example, if a staff person strikes a person-in-care and breaks the person's nose, and the facility subsequently fails to secure medical treatment for the person, the act may not be excluded from evaluation as an abusive act simply because the facility failed in its duty. Two wrongs do not make an exclusionary factor.

Agency failure is critical in establishing a regulatory violation. Even if all of the criteria are met such that an act is abusive in a regulatory context, it may be that the facility is not in violation of regulatory requirements. A fundamental tenet of licensing is "protection through prevention." The regulator attempts to prevent negative actions or events before they occur by enforcing regulatory requirements. So, if a facility has met every

[6] 55 Pa.Code Ch. 2800 (relating to assisted living residences) This definition is similar to those above, but it is designed to be part of a regulatory licensing structure and sets standards for providers of out-of-home services to secure licenses to operate. As such, this body of law is not concerned to intervene and protect any category of person. It is designed to regulate providers who have met minimum standards to receive licenses. The three definitions represent two different bodies of law seeking to achieve different immediate ends: one to immediately protect special classes of people who may be endangered; and the other to set standards for who may and may not have a license.

[7] The Pennsylvania crimes code recognizes four types of culpability: intentional conduct, where the perpetrator intends the harm to occur; knowing conduct, where the perpetrator does not intend the harm to occur but given his conduct and the facts that he knows it is almost certain that the harm will occur; reckless conduct, where the perpetrator ignores a substantial and unjustifiable risk that the harm will occur given his conduct and what he knows; and negligent conduct where the perpetrator should be aware of the risk that the harm will occur as a consequence of his conduct. For the purposes of this document, the latter three types of culpability are collectively labeled "careless."

[8] That is, fighting in the sense of "mutual combat," as opposed to fighting to protect oneself from an attacker or fighting that results from behavioral disorders where the service provider has not properly assessed or developed adequate service plans for the persons involved.

requirement before an abusive act occurred (such as verifying the absence of criminal offenses that prohibit hire and ensuring that staff are properly trained and supervised), during the period when the act is occurring (e.g., sufficient staffing and active supervisory oversight), and after the act (adequate and accurate) self-investigations and reporting to oversight agencies) – in other words, the facility has done everything required by regulation to prevent and respond to abuse – then the regulatory oversight agency achieves nothing by citing the facility for a regulatory violation. That said, abuse did occur, and many regulations prohibit abuse, so what is the regulatory oversight agency to do? The agency should respond by providing formal notification to the facility that, while an abusive act occurred, the agency's investigation found that the facility was in compliance with applicable regulations relating to preventing and responding to abuse. The notification may refer to the abusive act as a "noncompliant event," or some other term that reflects technical noncompliance that does not rise to the level of regulatory violation[ii]

On the other hand, if a single failure occurred in the agency's preventative or responsive measures to the abusive act, then abuse must be cited as a regulatory violation. If a facility retained an employee who was not qualified to work there, or admitted a resident with dangerous behaviors that the facility could not control, and another person-in-care is harmed as a result, then the facility's failure to meet regulatory requirements directly contributed to the abuse. The abuser may have thrown the punch, but the facility created a situation where the punch may be thrown. Likewise, failure to properly respond to an abuse event after the fact reflects an inability to safely operate a facility that is free of abusive acts. In order to cite corresponding violations of pre- or post-event regulations, the regulator must cite a violation for abuse as a basis for the corresponding actions and because the facility's inaction contributed to it.

To be sure: we are not advocating that perpetrators of abuse not be appropriately sanctioned as a result of their conduct, only that the regulatory oversight agency is not always the proper authority to do so . A person who abuses another person, in particular a person under the authority of the abuser, must be punished by the appropriate oversight authority. The concept outlined here relates only to facility responsibility.

Restraints

Human services regulations typically approach restraint use in one of two ways: restraints (also called "restrictive procedures") are either expressly forbidden, or their use is permissible only if specific procedures are followed. The simplest definition of "restraint" is "something that prevents a person from moving" (refer to the CMS definition cited above as an illustration), although this definition is far too simplistic to be of value in human services licensing. Restraints or restrictive procedures generally include seclusion, exclusion, manual restraint, mechanical restraint, chemical restraint, aversive conditioning, and pressure point techniques. *Seclusion* is the involuntary, solitary confinement of a person-in-care in a room or area which the person is physically prevented to leave. *Exclusion* is the removal of a person-in-care from his or her immediate environment and restricting the person alone to a room or area. Exclusion differs from seclusion in that the person-in-care is not physically prevented from leaving the area. *Manual restraints* are physical means employed by a person towards a person-in-care that restricts, immobilizes or reduces the person-in-care's ability to move his or her arms, legs, head or other body parts freely. *Mechanical restraints* restrict the movement or function of a person-in-care or portion of a person's body. Manual restraints use another person's body to restrict a person-in-care, while mechanical restraints use a device. *Chemical restraint* is the use of drugs or chemicals for the singular purpose of controlling acute or episodic behavior of a person-in-care. *Aversive conditioning* is the application of startling, painful or noxious stimuli. *Pressure point techniques* are methods of applying pressure to certain parts of a person-in-care's body to produce pain or to immobilize so as to control the person's behavior. Aversive conditioning and pressure point techniques are no longer considered appropriate, and we are unaware of any set of regulations that permits their use. Chemical restraint is becoming increasingly rare as a means of managing chronic behaviors, and is usually limited to episodic use under medical supervision to prevent a person-in-care from harming himself or others (at least in theory). The remaining types of restraint use – seclusion, exclusion, mechanical, and manual restraints – continue to be used in human services settings, particularly those that serve persons with dangerous or harmful behaviors which occasionally or consistently cannot be managed through positive interventions.

This document will not address the ethical issues of restraint use, and is not meant to condemn or condone restraints that are used in accordance with applicable regulations. If the governing regulatory requirements allow restraint use, and an out-of-home care setting uses restraints in accordance with those requirements, regulators will enforce those requirements. Use of prohibited techniques or restraint use that is noncompliant with regulatory requirements is, of course, met with prompt and stringent enforcement.

As is the case with definitions of abuse, the definitions of the different types of restraints are wanting in that they do not speak to facility culpability. Unlike abuse, the criteria for what constitutes a restraint or restrictive procedure are quite clear – but they do not speak to degree or circumstance. Holding an attacking person-in-care against a wall for the purposes of self-defense and holding a person-in-care against a wall because there is insufficient staff to use positive interventions to control a behavioral outburst and monitor all persons served (i.e., for the convenience of staff) are both examples of manual restraint, but clearly there is a stark difference in the specific circumstances of each event and in acceptable regulatory remedies.

A functional definition of "restraint" or "restrictive procedures" for the human care regulator must include qualifiers that establish an act as an act of restraint and that clarify how facility action or inaction will impact whether improper restraint use is cited as a regulatory violation. We offer the following:

Restraint / Restrictive Procedures are deliberate acts by a person in power to control a disempowered person by impeding or altering physical, emotional, or cognitive functioning. For an act of restraint to rise to the level of a regulatory violation, the act must result from or be associated with an agency failure before, during, or after the act occurred which caused or contributed to the act of restraint.

As was the case with abuse, power is an important component of restraint from a regulatory perspective. If two children who have been adjudicated delinquent are fighting, and in the process of doing so repeatedly "manually restrain" one another in a technical sense, this is obviously not manual restraint in the sense of a prohibited act because neither is a facility employee. If one child holds the arms of another child behind the victim child's back while a third child punches the victim, then both restraint and abuse have occurred. The critical feature in both cases is the absence of official power in the situation. Moreover, the term "deliberate" is included to stress that an act of restraint must be purposeful rather than accidental and to underscore the power dynamic between the restrainer and the restrained. The terms "impeding or altering" are included in lieu of the term "controlling" because the latter term speaks to intent rather than action. Similarly, the phrase "physical, emotional, or cognitive functioning" is used in lieu of "behavior" in that these types of functioning result in the behavior that is meant to be controlled.

Once again, agency failure is critical in establishing a regulatory violation of restraint use. Even if all of the criteria are met such that an act can be called a restraint in a regulatory context, it may be that the facility is not in violation of regulatory requirements, for all of the reasons set forth in the discussion of abuse.

The PICAR Method

Now that we have established functional definitions of abuse and restraint for the purposes of measuring regulatory compliance, we must apply a consistent methodology for evaluating individual acts that may constitute abuse or restraint and for determining whether such acts constitute regulatory violations. The methodology is an evaluation of the steps the facility took to prevent abuse or restraint, the intent of the person committing the act, the specific circumstances surrounding the event, the actions taken during and after the act, and the result of the act: Prevention, Intent, Circumstances, Actions, and Result, or PICAR.

P*revention* requires measurement of regulatory requirements that are meant to reduce or eliminate risk of abuse or improper use of restraint. Prevention measurement focuses on the facility's actions relating to the perpetrator, the victim, and the development of procedures to address abuse and improper restraint. Prevention questions include, but are not limited to:

1. What are the facility's criteria for admission, and did the victim (and the perpetrator, if the perpetrator is also a person-in-care) meet those criteria? If a facility wrongfully admitted a person who could not be safely cared for at the facility, and the person subsequently abuses or is abused by another or must be restrained to protect the person-in-care from himself or others, then the facility has contributed to the act.
2. If the perpetrator was a staff person at the facility, was the perpetrator eligible to be hired and to work with persons-in-care under applicable law and regulations? If a staff person was prohibited from working in a facility because of prior criminal offenses or other prohibitions set forth by law and agency policy, then the facility is equally if not primarily responsible for the occurrence of the act.
3. Were staff properly trained in abuse prevention or restraint use, and were persons-in-care educated in the facility's rules of conduct? If the parties did not know what was expected of them, the facility is at least partially responsible for the act.
4. Did the facility establish required procedures for preventing abuse and proper use of restraints? Again, if the facility did not make its expectations clear to the parties, then the facility assumes some degree of responsibility for the act.

***I**ntent* involves examination of the motive for the act. Was the act committed as a matter normal course of business, self-defense, masochistic pleasure for the perpetrator, or some other reason? Intent is an essential component in establishing whether the facility created a "culture of mistreatment" that allowed the act to occur, and to understand the motive(s) of the perpetrator.

***C**ircumstances* means an assessment of the specifics of the act. Circumstances questions include, but are not limited to:

1. Is the event unique, or part of a recurring pattern? Recurrence is evidence of prior inaction or ineffective action by a facility that may have contributed to the act.
2. Was the inciting behavior or the responsive behavior known to the facility? If not, why not?, If so, what measures were taken to address them – and to address them systemically, rather than in isolation, to prevent recurrence of similar events? If the person-in-care was restrained to manage a foreseeable or recurring behavior, the facility had a responsibility to prepare a response to the behavior that required the least-restrictive response. Likewise, if the perpetrator had a history of aggressive or inappropriate acts, the facility was responsible to address those acts prior to an instance of abuse or unauthorized restraints.
3. Were there any environmental anomalies at the time of the event? "Environmental" in this sense means "relating to the facility's physical plant and general operations." For example, a power failure may have allowed a known abuser to access a victim that would otherwise be inaccessible. If a power failure occurred, the regulator must establish whether the facility was in compliance with regulations relating to the facility's responsibilities in the event of a power outage.
4. Were there any unforeseeable threats towards the victim by the perpetrator? If a person-in-care who is white assaults a person-in-care who is black because the former subscribes to white supremacist beliefs, did the facility know of the perpetrator's history as a white supremacist? If the facility did know the perpetrator's history but did not factor that history into its plan of care, the facility is at least partially responsible for the assault.

***A**ction* assesses the specific actions of the perpetrator and the facility. The regulator must determine exactly what happened to the victim, as some acts will not rise to the level of abuse or restraint set forth in our definition. The regulator must ensure that the facility responded as required by regulation, and establish whether the facility made short- and long-term changes to its operations as a result of the event (if appropriate).

***R**esult* refers to the degree of harm or impeded functioning resulting from the act. If a staff person shoves a person-in-care, but the person-in-care does not require treatment or evaluation as a result, then the act is not abuse (that does not mean that the act is permissible – a physical act of violence that does not injure a person-in-care is still mistreatment, which can likely be addressed through regulatory enforcement).

Following application of the PICAR method, a determination can be made concerning whether the act constitutes abuse or unauthorized restraint, and whether a regulatory violation of either should be cited. The case studies below illustrate how PICAR may be applied during a regulatory investigation.

Case #1:
A child in a residential facility is throwing large rocks off of the roof of the facility into the parking lot below. A staff person attempts to intervene by using verbal de-escalation techniques, whereupon the child lifts a rock and threatens to strike the staff person with it. The staff person tackles the child, breaking the child's nose in the process.

Prevention: The staff person had all of the necessary qualifications and training to work at the facility. The child's history of using rocks and sticks as weapons was known to the facility, and a plan to treat the child was in place.

Intent: The staff person tackled the child out of fear for his life.

Circumstances: The child ran from the cafeteria and gained access to the roof via an unlocked door. The staff person in question pursued the child from the cafeteria. There are no concerns about adequate supervision or sufficient staffing.

Action: The staff person was placed on administrative leave pending an investigation. The door to the roof was secured to prevent children from accessing the roof.

Result: The child suffered a broken nose that required inpatient hospitalization.

Determination: The child was abused, as the act was deliberate, performed by a person in power, and resulted in harm that required medical treatment. Although the staff person was properly trained and acted in self-defense, the facility's failure to secure the door to the roof led to the act that resulted in injury. The facility should be cited for abuse.

Case #2:
A hidden camera placed in an assisted living facility captures three staff persons savagely beating an older adult with dementia.

Prevention: The staff persons had all of the necessary qualifications and training to work at the facility.

Intent: The staff persons reported to police that they "just snapped" after the person-in-care defecated in a freshly-changed bed.

Circumstances: The person-in-care's regular incontinence of bowel was documented in her care plan. Staff had access to the care plan and were aware of the resident's needs.

Action: The staff persons were arrested and separated from employment. The facility made the necessary reports to police and to the regulatory oversight agency, and fully cooperated with subsequent legal and regulatory investigations. An internal investigation was launched to ensure that other residents had not been mistreated and that no other staff persons were involved.

Result: The resident suffered three broken ribs and has developed an unspecified anxiety disorder.

Determination: Abuse occurred, but the facility should not be cited for a regulatory violation. Formal notice of a noncompliant event should be provided to the facility. Please note than an extensive regulatory investigation

must be conducted in a case of this type – that three qualified staff persons should "snap" suggests a "culture of abuse" that may be reflected elsewhere in the facility's operations.

Case #3:
During an annual inspection at a community home for persons with intellectual disabilities, inspectors find that a resident of the home is prescribed 0.5 milligrams of alprazolam (a benzodiazepine used to reduce anxiety) to be administered "as needed" for "anger management."

Prevention: The medications were obtained, administered, and recorded in accordance with applicable regulations. Staff had received training in restraint use, but medications prescribed by a physician were not included as possible chemical restraints. The home requested the medication from the physician after the resident broke two lamps in a fit of rage.

Intent: The medication was administered to impede the resident's emotional reactions.

Circumstances: The home was not aware of any aggressive behaviors prior to admitting the resident. Other residents of the home reported being fearful of the victim resident.

Action: None, prior to the intervention of the licensing agency. The home did not believe that any wrongdoing had occurred, as the medication was prescribed by a physician.

Result: The resident was medicated whenever he demonstrated aggressive behaviors.

Determination: The resident was chemically restrained. The medication was deliberately administered by persons in power (staff) to impede an undesirable emotional response. The home sought the medication for the sole purpose of restraining the resident. The home should be cited for restraint use.

Case #4:
During an annual inspection at a community home for persons with intellectual disabilities, inspectors find that a resident of the home is prescribed 0.5 milligrams of alprazolam (a benzodiazepine used to reduce anxiety) to be administered "as needed" for "anxiety."

Prevention: The medications were obtained, administered, and recorded in accordance with applicable regulations. Staff had received training in restraint use, but medications prescribed by a physician were not included as possible chemical restraints. The home requested the medication from the physician after the resident reported feeling "afraid all of the time."

Intent: The medication was administered to treat symptoms of anxiety.

Circumstances: The home was not aware of any mental health problems, including anxiety, prior to admitting the resident.

Action: None, prior to the intervention of the licensing agency. The home did not believe that any wrongdoing had occurred, as the medication was prescribed by a physician.

Result: The resident was medicated whenever he reported feeling anxious.

Determination: The resident was not chemically restrained. The medication was deliberately administered by persons in power (staff) to treat symptoms of anxiety. The home sought the medication for the sole purpose of minimizing the resident's anxiety. The home should not be cited for restraint use.

Conclusion

The standard definitions of "abuse" and "restraint" are inadequate to measure regulatory compliance in out-of-home care settings. Regulatory oversight agencies must adopt definitions that address power dynamics between the perpetrators and victims of abuse and unauthorized restraint, and that focus on the facility's actions to prevent and respond to actual or alleged abuse or restraint use. The PICAR method - an evaluation of the steps the facility took to prevent abuse or restraint, the intent of the person committing the act, the specific circumstances surrounding the event, the actions taken during and after the act, and the result of the act – offers regulatory oversight agencies a means to determine whether an act constitutes abuse or restraint in a regulatory context, and to determine if such acts constitute regulatory violations.

About this Document

This document was produced by Ronald Melusky, Director of the Commonwealth of Pennsylvania's Bureau of Human Services Licensing and President-Elect of the National Association for Regulatory Administration. Dr. Ronald Costen, Director of the Pennsylvania Institute on Protective Services at Temple University, and Carolynne Stevens, Vice-President of Professional Development for the National Association for Regulatory Administration.

This document is endorsed by the National Association for Regulatory Administration, but does not necessarily represent the views and opinions of the association membership.

Mr. Melusky can be reached at rmelusky@naralicensing.org

For more information about the National Association for Regulatory Administration, please visit www.naralicensing.org

[i] It should be noted that, in some cases, strong licensing *increases* anxiety about mistreatment of persons-in-care. Consumers of human services may be inclined to optimistically appraise an out-of-home care setting so as to alleviate concerns that the placement may not be safe, and, in the case of an informal caregiver of a prospective person-in-care, to preserve the caregiver's self-image as a caring an conscientious relative despite having to "resort" to out-of-home. To combat the cognitive dissonance that results from anxiety about out-of-home placement and the need to use it, caregivers may ignore precursors to mistreatment and even defend the abuser or care setting once the act is officially reported. Three frequent contributing factors to this type of psychological reaction are the consumers' lack of information about the difference between health and safety standards at out-of-home care settings, economic limitations when selecting out-of-home-care, and a general misunderstanding (if not contempt) for regulation and regulatory oversight.

[ii] There is no distinction (legal or otherwise) between the terms "violation" and "noncompliance." For the purposes of this document, "violation" means "a specific event that is not compliant with one or more applicable regulations that requires corrective action to maintain licensure;" "technical noncompliance" means "a specific event that is not compliant with one or more applicable regulations, but does not require corrective action to maintain licensure." If an out-of-home care setting is found to be technically noncompliant, the setting should review its rules and methods of operation to determine whether these are sufficiently protective and clear in their intent and effect.