

CHAPTER 10 – ARTICLE 3

Browse Responses

 Displaying 8 of 8 respondents

 Jump To: 8

Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: empty

IP Address: 68.99.84.80

Response Started: Sunday, May 5, 2013 8:00:33 PM

Response Modified: Sunday, May 5, 2013 8:03:07 PM

1. What parts of the draft rules do you believe are effective?

Please note that the Office of Human Rights (OHR) is the unit of Arizona Department of Health Services/Division of Behavioral Health Services that provides advocacy to individuals with a Serious Mental Illness (SMI) in Arizona's public behavioral health system. To further our mission – providing advocacy to individuals with a SMI to help them understand, protect and exercise their rights, facilitate self-advocacy through education and obtain access to behavioral health services in the public behavioral system in Arizona – OHR reviews and submits comments on proposed changes to rules, regulations, policies, etc. that affect individuals with a SMI. R9-10-306 I contains important language about staffing levels. R9-10-307 13 emphasizes the need to address whether a person is under a guardianship during the assessment and that is absolutely crucial to ensure informed and general consent during the person's admission and stay. R9-10-308 A 7 & 8 contain important requirements about inviting and participation of the person and any representative in treatment planning. However, we would suggest moving this up in the rule section to place more emphasis on it. R9-10-316.11 specifies that seclusion room cannot be the patient's bedroom or sleeping area – this is important as some facilities have been found using the same room to seclude the patient as their "temporary" bedroom or place to sleep.

2. How can the draft rules be improved?

In general, the use of the word "patient" is not preferred to "client" or even "person" or "individual." R9-10-303 C 2 i i is missing a reference to "or an appeal" when applicable or perhaps should simply list "complaint" (which by definition includes appeals and grievances when applicable), like the Hospitals rules section does. Same section, subsection F 1.2 a has an error that will have significant effect if not corrected. It notes "and" instead of "or" regarding what the facility must do to report alleged or suspected abuse, neglect or exploitation. "Or" means the facility can report to either APS/CPS or law enforcement and this is the preferable language that is consistent with the language in the underlying statute and in other sections being revised (behavioral health residential facilities, assisted living, etc.). The facility administration can certainly deem what reporting is necessary. As it reads in this draft, however, "and" would mean that anytime any "suspected" activity of that sort would have to be reported to law enforcement also no matter what, so in a situation when the alleged individual is a peer this would subject individuals receiving treatment to unnecessary contact with law enforcement and even arrest by a few uninformed officers who do not recognize the connection between symptoms and aggressive behavior in an inpatient setting. R9-10-308 seems to exempt a treatment plan for someone there just to receive crisis services which would be rather short-term, presumably. However, it then seems to reference that someone under court-ordered evaluation and/or treatment (COE/T) would also not need a treatment plan. This is not consistent with good practice or current requirements and should be addressed to be very clear about under what circumstances this could be applied, with strict limits (presumably very short stays). Even someone under a court order has a right to be given the opportunity to have a plan, to participate in developing it to the fullest extent possible and having a voice in its implementation. R9-10-309 covers discharge yet subsection A 1 & 2 lack a reference to the fact that the plan for discharge must have been developed with the person and any representative. This is crucial to ensuring a solid discharge plan and limiting the possibility of a readmission after discharge. While subsection B addresses requesting participation and opportunity for participation, that seems secondary to subsection A and should actually be addressed in subsection A to show its import. Subsection C 1 & 2 address when a patient must be discharged yet it leaves out the requirement to have a solid and viable discharge plan that meets the person's needs. It also does not mention a circumstance that comes up at times that despite being ready for discharge, the discharge placement is still being developed and will be available soon, so the person can stay a short time as long as still moving toward a prompt discharge (as provided for in federal law). Subsection F addresses discharge to anything other than an HCI, but then there is no mention of what type of coordination must happen when discharged to an HCI – wouldn't the individual still need a copy of the discharge instructions, as well as the receiving HCI? Rights R9-10-312 covers individual rights but it fails to under A 2 make a reference to sharing SMI rights and specifically R9-21-101, et seq with individuals who are identified as SMI. This section also omits a significant number of rights that is contained in the current licensure rules – which should not be omitted. We are shocked to see that subsection B 1 a permits the "intentional infliction of physical, mental or emotional pain" that is

related to the "patient's condition" How can this be? We strongly support removal of the qualifier about relation to the individual's condition. We also strongly suggest that a section noting the word "abuse" is also inserted – as that would cover instances of negligence that would not fall under "intentional" In the same subsection under f & g, we note concern that the term "sexual abuse" is used and then two references to Arizona criminal law are made – is this sufficient to cover such, as not all acts may fall under a criminal definition yet still should be prohibited. With respect to seclusion or restraint in subsection h, the standard noted is not the same as other parts of the draft rules indicate, so we suggest removing that and staying with the original language that refers to coercion, convenience, retaliation, etc. Additionally, subsection 2 a is missing a reference to receiving telephone calls. Subsection C addresses when a person's activity (rights in B 2) can be limited under certain circumstances. This could be clarified and more individual rights-focused by adding a subsection 3 that notes that individual must be informed about what needs to occur to have the restriction lifted, a subsection 4 that specifies that a timeframe for review of the restriction must be set and changing the existing #3 to #5. Records Subsection C of R9-10-313 should note a requirement that when a resident has a representative, proof of the legal authority of the representative must also be stored in the records. This makes it clear who holds the power to give consent and also supports appropriate communication with the representative. Behavioral Health Services R9-10-315 covers behavioral health services and it contains a reference in subsection A 3 to "may present a threat to the patient" which is quite vague and broad. In practice, particularly on a psychiatric unit where acuity is high, this could be impossible to meet and it could subject certain individuals who are viewed as a possible "threat" to others to restrictions that are unnecessary. We strongly support including some language about imminence of harm or being an actual threat as documented by actions in place of the "may present a threat" language. We were alarmed and discouraged to see in subsection F that a person entering the facility under COE is not required to undergo any of the admission, patient, treatment plan or discharge requirements. While the COE admission may result in a very short stay (less than 24 hours), at a minimum, discharge planning requirements should remain in place as the facility has a clinical, ethical and legal obligation to ensure that the person is not simply discharged "to the streets." We strongly support putting some minimum discharge requirements in place for individuals admitted under COE. We also strongly support including that once a person admitted under COE's status changes – such as goes voluntary or goes under COT, then all of those requirements (admission, assessment, treatment plan, discharge) apply. Subsection H 2 a notes that the facility must ensure another individual at the facility does not subject others receiving treatment to "threats, ridicule, verbal harassment, punishment or abuse." It seems more practical language would emphasize that others receiving treatment should be free from and the facility should protect them from such negative interactions from other patients. What is a possible result of leaving the draft language as is – perhaps that the individuals with the most difficult behaviors and issues will be discharged suddenly (or perhaps worse, subjected to inappropriate law enforcement involvement) because the facility cannot always meet this standard? It seems there must be a balance between the facility's obligation to treat individuals (no matter how acute or how difficult the behavior) in an inpatient setting while also keeping others safe in that setting. Seclusion/Restraint. Please note that OHR has extensive experience with seclusion/restraint issues as we regularly review all reports involving seclusion/restraint for individuals with a SMI and address issues often directly with the facilities using seclusion/restraint. The use of seclusion and restraint is covered in R9-10-316 and we strongly believe subsection 1 should make some reference to the requirement that policies and procedures developed must be consistent with/comply with existing laws on seclusion and restraint. This will ensure that other state law and regulations that apply are considered as well as any federal laws or regulations that apply. Subsection 3 a (& 4) delineates when seclusion or restraint can be used and unfortunately, has broadened the circumstances per the current rules. The current rules require in an "emergency safety situation" which is also clearly defined currently. However the draft rules note two instances in which seclusion or restraint can be used: 1) in an emergency situation, 2) for management of patient's violent or self-destructive behavior – when less restrictive alternatives have been determined ineffective and for the purpose of ensuring the "immediate physical safety of the patient or to stop physical harm to another individual." Unfortunately, "emergency situation" is not defined anywhere in the rules so it is unclear what this entails. The general section definitions subsection defines an "emergency" but not an "emergency situation." The use of the term "patient's violent" behavior is problematic as it is also undefined and open to varying interpretations. We strongly support continuing the use of the term and definition of "emergency safety situation" and its definition; or in the alternative, that the term "in an emergency" be used only to limit confusion and differing interpretations. Additionally, the purpose (subsection 3 b iv) should also include "preventing imminent harm to another individual" to cover instances where the person who is engaged in an action, such as rushing toward another individual on the unit with a chair ready to strike the person, the staff can intervene with physical restraint action (assuming all lesser interventions fail) before physical harm actually starts. As it stands now, the staff would have to allow the individual to strike the other person first before using a physical restraint. If in subsection 3 c the seclusion or restraint must be discontinued at the earliest possible time, then what other criteria would be needed to be specified as subsection 5.e requires. The release criteria are simply that when the emergency has passed, the person should be released! We suggest either removing this subsection or re-emphasizing within it that the specific criteria are meant to help staff determine when the emergency has subsided. Similarly, subsection 9 a v mentions "clinical identification of specific behavioral changes that indicate seclusion or restraint is no longer necessary" should be tied to when the emergency has passed – that is when seclusion/restraint must be discontinued. Subsection 9 b would also be clearer if include that according to policies

and procedures and "existing laws" related to seclusion or restraint. Similarly, subsection 10.d should contain a reference to "existing laws" as there are significant state and federal requirements with respect to monitoring. Additionally, 15 minute checks including documentation of what the individual is doing at the time should be specifically required for any seclusion or restraint lasting 15 minutes or longer as is currently required – otherwise there is no way to ensure the individual's safety as the time in seclusion/restraint gets longer (often increasing chance for safety and/or medical issues to arise) or to review whether a seclusion or restraint was still justified as time passes. Subsection 10.f makes another reference to discontinuing "at the earliest possible time" – again we suggest making this more consistent with previous language and tying it to the emergency being over or subsiding to make it consistent/clearer. Similarly, subsection 13.a. makes another reference to "specific criteria for release" – this should be tied to the emergency subsiding/being over. Subsection 14's reference to a person being "evaluated" after the restraint or seclusion is over is very vague – it should consist of at least a look at whether the person was injured, whether the person was traumatized in any way and otherwise determine any need for debriefing of individual, staff, others involved or witnessing the event.

3. Has anything been left out that should be in the rules?

The rules are missing a reference to the SMI regulations – R9-21-101 et seq. The current rules contain such a reference which is essential to ensure facilities are reminded of and abide by the additional requirements in the SMI rules. Section R9-10-319 covers medication services but no reference is made to the inpatient facility coordinating medication/knowledge of current medication prescribed with any outpatient service provider already in place and/or primary care provider or other provider who has prescribed medication to the individual. This addition would be beneficial to individuals who go inpatient to ensure stronger coordination of prescribed medications.

Browse Responses

[Filter Responses](#)[Download Responses](#)[View Summary](#)

Displaying 6 of 6 respondents

[« Prev](#)[Next »](#)

Jump To: 6

[Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 12 23 250 195**Response Started:** Monday, April 29, 2013 12:49:25 PM**Response Modified:** Monday, April 29, 2013 12:54:25 PM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

Request consideration that level 1 sub acute substance abuse facilities not be required to include seclusion and restraint Calvary Center has a policy that we do not do seclusion and restraint We do utilize CPI and verbal de-escalation techniques Personally I have worked at Calvary Center for 14 years During those years we have had two incidents where we were required to implement a brief safety hold All other incidents have been de-escalated verbally Thank you Larry Solomon, Clinical Director, Calvary Center

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

[Filter Responses](#)[Download Responses](#)[View Summary](#)

Displaying 5 of 6 respondents

[« Prev](#)[Next »](#)

Jump To: 5

[Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 12 23 250 195**Response Started:** Monday, April 29, 2013 11:20:37 AM**Response Modified:** Monday, April 29, 2013 11:42:11 AM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

It is a step backward to require level 1 sub acute facilities to have policies allowing and perform training on seclusion and restraint. The industry is working hard to reduce seclusion and restraint and this will serve to increase the possibility. Our facility, Calvary is as a matter of policy a seclusion and restraint free facility. Certainly if a facility is going to do seclusion and restraint they should have appropriate policy, training and capabilities. People can get hurt during the process and it should be done correctly if done. I would request that a sub acute with a policy that does Crisis Prevention and Intervention and de-escalation but prohibits seclusion and restraint should not be forced to include it. Jim Kreitler CEO Calvary Addiction Center.

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)Displaying 4 of 4 respondents [« Prev](#) [Next »](#) Jump To: 4 [Go »](#)**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** *empty***IP Address:** 68.71.101.188**Response Started:** Monday, April 22, 2013 9:57:42 AM**Response Modified:** Monday, April 22, 2013 10:08:54 AM**1 What parts of the draft rules do you believe are effective?**No Response

2 How can the draft rules be improved?

R9-10-322.C and R9-10-323 D. should be consistent with residential and residential should be consistent with inpatient... Pool regulations, testing, requirements/cleanliness, fence etc should be the same for both Please change

3. Has anything been left out that should be in the rules?

Preliminary Treatment Plan - R9-20-209."I" is not in the new rules; preliminary tx plan is a necessity for behavioral health inpatient treatment and residential. The idea that a final treatment plan can be formulated before the patient or resident can receive tx is unrealistic due to the time it takes to gather all the pertinent assessment data; having a preliminary treatment is in the best interest of the patient/resident

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)Displaying 3 of 3 respondents [« Prev](#) [Next »](#) Jump To: 3 [Go »](#)

Respondent Type: Normal Response

Collector: Web Link (Web Link)

Custom Value: *empty*

IP Address: 12 23 250 195

Response Started: Wednesday April 17 2013 4:14:20 PM

Response Modified: Wednesday April 17, 2013 4:43:12 PM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

After reviewing the draft rules for BH Inpatient Facilities, our Level I Subacute facility has made it a practice not to perform seclusion restraints. The new rules reflect a requirement for seclusion restraint, requiring a formal policy, forms, and training. We do however have a policy and training that addresses de-escalation. For those facilities that make it a practice not to initiate seclusion restraint, could the seclusion restraint requirements be updated in the new rules to reflect a policy for de-escalation and training only. We would like to continue our business practices without the implementation of provisions for seclusion restraint?

3. Has anything been left out that should be in the rules?

No Response