Notice of Agency Rule-making Proposal

DETAILED BASIS STATEMENT / SUMMARY:

Maine law requires that any behavior modification, behavior management, or safely device plan for an adult with an intellectual disability or autism be approved by a three-person review team composed of a Department representative, a representative from the advocacy agency designated pursuant to 5 M.R.S.A. §19502, and a representative designated by the Maine Developmental Services Oversight and Advisory Board. *See* 34-B M.R.S.A. §5605(13)(B) and 14-197 C.M.R. Ch. 5, Regulations Governing Emergency Interventions and Behavioral Treatment for People with Intellectual Disabilities and/or Autism. Prior to November 8, 2012, unanimous approval by the review team was required.

The Disability Rights Center (DRC) recently assumed the responsibilities as the advocacy agency designated pursuant to 5 M.R.S.A. §19502. These responsibilities include participation on the three-person review team. Because DRC's role requires it to represent the interests of individuals with intellectual disabilities and autism served by the Department, both informally and in formal legal proceedings, the DRC recently raised a concern that participating in the approval of such plans would create a conflict of interest under the Maine Rules of Professional Conduct. In light of those concerns the DRC notified the Department that its representatives would participate in the three-person review team but would not vote for approval of any plan. Without the DRC's vote, the review team was unable to fulfill its statutory function.

In response to this impasse, the Department adopted Emergency Rule 2012-311, which allowed approval of behavior modification and behavior management plans and safety devices by majority vote of the review team's members. This emergency rule will expire February 6, 2013. The Department proposes to make this change permanent.

The Department also proposes to change language and names when usage has changed or has been deemed inappropriate by the Maine Legislature.



MaineCare Services

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Paul R. LePage

Mary C. Mayhew

DATE: December 19, 2012

TO: Interested Parties

FROM: Ricker Hamilton, Director, Office of Aging and Disability Services

SUBJECT: Proposed Rulemaking:

14-197 C.M.R. Ch. 5, Regulations Governing Emergency Interventions and Behavioral

Treatment for People with Intellectual Disability and/or Autism

This letter gives notice of a proposed rule change to 14-197 C.M.R. Ch. 5, Regulations Governing Emergency Interventions and Behavioral Treatment for People with Intellectual Disability and/or Autism.

This proposed rulemaking follows emergency rulemaking to allow approval of behavior modification and behavior management plans and safety devices by majority vote of the three-person review team created by Maine law. Action by majority vote will allow the review team to fulfill its statutory function to review and approve the use of severally intrusive behavior modification, behavior management, or safely device plans when less intrusive plans, or positive interventions or supports have failed to protect the health, safety and welfare of an adult with an intellectual disability and/or autism.

The proposed rulemaking also makes changes to language and names when usage has changed or has been deemed inappropriate by the Maine Legislature.

The proposed rules may be reviewed and printed from the Office of Aging and Disability Services website at http://www.maine.gov/dhhs/oads/aging/rulemaking/index.shtml or for a fee, interested parties may request a paper copy of rules by calling 207-287-4242. For those who are deaf or hard of hearing please call the Maine Relay number 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rule-making Proposal. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Proposal.

14 DEPARTMENT OF HEALTH AND HUMAN SERVICES

197 OFFICE OF ADULTS WITH COGNITIVE AND PHYSICAL DISABILITIES

Chapter 5: REGULATIONS GOVERNING EMERGENCY INTERVENTIONS AND
BEHAVIORAL TREATMENT FOR PEOPLE WITH MENTAL RETARDATION
INTELLECTUAL DISABILITIES AND/OR AUTISM

SUMMARY: These regulations are designed to implement Maine Law regarding the Rights of Maine Citizens with Mental Retardation Intellectual Disabilities or Autism. At 34-B M.R.S.A. §5601 *et seq.*, these rights are specified, including the governance of emergency interventions and behavioral treatment procedures.

SECTION 1. STATEMENT OF INTENT

- 1. These regulations are intended to govern the use of emergency interventions and behavioral treatment in a manner consistent with maximizing the safety, well-being, independence, and inclusion of Maine citizens with mental retardation intellectual disabilities or autism.
- 2. These regulations acknowledge that the goals of safety, well being, independence and inclusion may sometimes best be achieved by means of systematic behavioral treatment, which
 - A. Assists individuals in decreasing the frequency and severity of specifically identified dangerous or maladaptive behaviors,
 - B. Assists individuals in learning safer, more adaptive behaviors in place of the dangerous or maladaptive behaviors, and
 - C. Assists individuals and their supporters in modifying the home, workplace and recreational environment in order to minimize or eliminate factors that may provoke dangerous or maladaptive behaviors.
- 3. Because of the risks inherent in employing some behavioral treatment interventions, these regulations describe the procedural steps that must be taken prior to the implementation of planned behavioral interventions. These regulations also identify allowable forms of emergency interventions in the community and the specific criteria by which these interventions may be employed.
- 4. These regulations are not intended to regulate the use of therapeutic adaptive equipment or therapeutic interventions in occupational or physical therapy. They are also not intended to regulate medical practice or the use of psychoactive medication. Planning teams are encouraged to work closely with individuals' health service providers.

- 5. These regulations are intended to protect the rights of Maine citizens with mental retardation-intellectual disabilities or autism, whenever these citizens are receiving services funded in whole or in part by, licensed by or provided pursuant to a contract or agreement with the Department of Health and Human Services, Office of Adults with Cognitive and Physical Disabilities Aging and Disability Services.
- 6. It is not the Department's policy to promote either intrusive behavioral interventions or any form of emergency restraint, but only to assure that when utilized they are utilized in a fashion that protects the health and safety of participants.

SECTION 2. DEFINITIONS

Adaptive: descriptive of a change in structure, function or form that produces the individual's better adjustment to the environment.

Assessment: an evaluation to determine needs, abilities and limitations.

Autism: as defined at 34-B M.R.S.A. §6002.

Aversive: a stimulus is aversive to a given individual if (a) it would cause harm or damage to any individual, or (b) if it arouses fear or extreme distress in that specific individual, even when the stimulus appears to be pleasant or neutral to others.

Blocking: momentary deflection of an individual's movement, when that movement would otherwise be destructive or harmful. Blocking may occur as an emergency intervention, or a moderate or severely intrusive intervention.

Chemical restraint: the use of a medication, administered involuntarily, for the purpose of immobilizing an individual who is in imminent danger of self-injury or harm to others.

Coercion: the act of causing an individual to do something through the use of force or the threat of force.

Commissioner: the Commissioner of the Department of Health and Human Services (DHHS).

Dangerous behavior: behavior that imperils safety or is likely to cause injury or pain to self or others.

Department: the Department of Health and Human Services (DHHS).

Discipline: interventions that guide or correct.

Emergency: a situation in which there is risk of imminent harm or danger to the individual or others. Risk of criminal detention or arrest may constitute an emergency.

Emergency interventions: physical and/or chemical restraints employed to prevent or interrupt emergency situations.

Environmental alteration: the modification of a site, activity or schedule that appears to be triggering or contributing to a dangerous or maladaptive behavior.

Extinction: withdrawal of attention or planned ignoring of the target behavior that is in response to behavior that is disruptive but not harmful or destructive. This is a mildly intrusive behavioral intervention.

Fining: the forfeiture of an object or participation in an event when an individual engages in a target dangerous or maladaptive behavior. The object or event must have been provided by the service provider and cannot be a personal possession or everyday event. This is a moderately intrusive intervention.

Imminent: descriptive of a situation or event that is about to occur at any moment.

Inclusion: the status of being or becoming a part of the whole of the community.

Individual: a person receiving services by or through Mental Retardation Intellectual Disability Services.

Intervention: the act of being an influencing force, in order to modify, promote or hinder some action.

Maladaptive behavior: behavior that is an inadequate, dangerous, harmful, or socially unacceptable response to circumstances or events, or interferes with the individual's acquisition or performance of appropriate and prosocial behaviors.

Mechanical restraints: an apparatus employed to restrain an individual, or the act of using an apparatus for this purpose. Mechanical restraints can include but are not limited to camisoles, strait jackets or similar garments, enclosed cribs, or tying an individual to a bed or chair. They do not include positioning or adaptive devices when used correctly.

Mildly intrusive: descriptive of interventions in which some form of limitation is imposed upon the individual, but the individual voluntarily complies with the imposition.

Moderately intrusive: descriptive of interventions characterized by a greater degree of limitation than a mildly intrusive intervention, but the individual voluntarily complies with the imposition.

Non-emergency: descriptive of a situation in which no imminent harm or danger to an individual or others is present.

Noxious: distasteful, unpleasant or intolerable to the individual.

Overcorrection: activity done in excess of what would reasonably be required simply to restore a setting or situation to its original state. There are two forms of overcorrection. The first involves activity in excess of what is necessary or desired, such as mopping the entire room when milk is spilled onto the floor, rather than simply cleaning the spill. The second, also called positive practice overcorrection, consists of practicing an alternative more desirable behavior,

such as spending ten minutes putting glasses into the dishwasher. This is a moderately intrusive intervention.

Painful: that which causes strong emotional or physical discomfort to an individual.

Physical holding: an intervention intended to interfere with the voluntary movement of an individual or any part of the individual's body, by grasping, hugging, embracing or similarly using one's body to effect the intervention.

Planning team: the group of people who are responsible for developing an individual's plan for habilitation.

Positive behavioral supports: the broad enterprise of helping people develop and engage in adaptive, socially desirable behaviors and overcome patterns of destructive and stigmatizing responding, but which do not entail any limitations upon the individual's rights. Positive behavioral support incorporates a comprehensive set of procedures and support strategies that are selectively employed based on an individual's needs, characteristics, and preferences.

Positive or neutral interventions: those which are directed toward reducing an individual's maladaptive behavior, but which do not entail any restrictions upon the individual's rights.

Potentially harmful: descriptive of behaviors or activities that might pose a risk to the physical or emotional well being of an individual.

Punishment/punitive: descriptive of retaliatory responses that have no programmatic justification, teaching benefit or purpose to maintain safety.

Redirection: the distraction or diversion of the attention of an individual from a maladaptive or dangerous behavior to a positive or neutral behavior; a suggestion, by word or gesture, that an individual try an alternate activity. No threats or coercion are involved.

Restraint: a mechanism or action that deprives an individual of the use of all or part of the body. This does not include those devices or actions used for positioning when used correctly.

Review Committee: a group of persons, as defined at 34-B M.R.S.A. §5605(13)(B), responsible for reviewing and approving all severely intrusive behavioral programs.

Routine use: the regular use of an emergency intervention as a result of nonexistent, inadequate or improper planning for behavioral interventions. Restraints used three or more times in a two week period or any other regular pattern of use constitutes routine use.

Seclusion: placement in any room from which exit is prohibited or prevented, without constant monitoring. Rooms that fit this description include those that are locked or whose door is blocked or held shut by any means.

Service providers: any person or agency that provides services to an individual with mental retardation intellectual disabilities or autism, whether funded by or through the Department, under contract, subcontract or agreement with the Department, or licensed by the Department. This includes employees of the State of Maine, and volunteers and students under the supervision and control of the service provider.

Severely intrusive: descriptive of interventions that involve some degree of coercion. They must be planned behavioral interventions except during an emergency.

Timeout, exclusionary: the withdrawal of an individual from a reinforcing environment when the individual engages in targeted undesirable behavior. This is a voluntary response by the individual following a request by a service provider. This is a moderately intrusive behavioral intervention.

Timeout, nonexclusionary: the voluntary withdrawal of an individual from a reinforcing activity or setting while remaining in the reinforcing environment. Coercion may not be used. This is a mildly intrusive behavioral intervention.

Verbal reprimand: a matter-of-fact message, delivered against a background of a generally positive and supportive environment, to express disapproval of an individual's behavior. It must be conveyed without humiliating or threatening language. This is a mildly intrusive behavioral intervention.

Voluntary compliance: circumstances under which the individual does not resist or object to the intervention or request, or agrees to follow the strategy.

SECTION 3. PRINCIPLES

Individuals served by the Department are entitled to the same rights as every other Maine citizen, except as limited by reason of guardianship. Any emergency or behavioral intervention that limits the exercise of any of an individual's rights must adhere to the following principles.

- 1. The individual's behavior must be more destructive to himself or to others than is the imposed limitation.
- 2. A limitation may only be imposed:
 - A. During an emergency, and for the duration of the emergency. Emergency interventions may not be employed as a punishment, for staff convenience or as a substitute for planned behavioral interventions; or
 - B. As part of a behavioral plan developed and approved by the planning team. Additional review and approval may be required in some instances.

SECTION 4. EMERGENCY INTERVENTIONS

1. General Requirements

A. Emergency interventions may never be employed as a punishment, for staff convenience or as a substitute for planned behavioral interventions.

- В. Emergency interventions must impose the least possible restriction consistent with the purpose for which they are used.
- C. Emergency interventions may be employed only if alternative techniques have been tried and failed, unless it would be unreasonable under the circumstances to implement less restrictive techniques. When the use of an emergency intervention is predicated upon the failure of alternative techniques or a planned behavioral intervention, the individual's record shall reflect which alternative techniques were attempted and/or the planned behavioral intervention employed, and with what result. When no alternative techniques were attempted, the individual's record shall document why it would have been unreasonable to attempt to implement them.

2. **Prohibitions**

The following are not permitted as emergency interventions:

- A. Routine use of emergency interventions,
- B. Mechanical restraints, or
- C. Seclusion.

3. Permissible Emergency Interventions and Requirements for Their Use

- A. Physical holding
 - (1) Physical holding must be stopped when the emergency ends. It may be employed for no longer than one *continuous* hour per application.
 - (2) Assessments must be utilized to establish the length of time the physical holding may be employed, up to the maximum allowed. Such assessment must be included as part of the planning process and must be discussed with the planning team as soon as is practicable after an episode. The assessment must specifically address issues of trauma (i.e., whether the physical holding of a person with a history of trauma would be more harmful than not doing so).
 - Records must document the length of time that physical holding was (3) employed and must describe every holding technique used.
 - (4) Individuals employed to serve individuals upon whom physical holding may be imposed shall receive training in appropriate intervention techniques, as soon as possible after their hiring dates or once it is known that an individual may require such intervention. Individuals who have not received such training may not employ physical holding.

B. Chemical restraints

- (1) Chemical restraints may only be administered by properly trained staff, as a last resort, in order to prevent imminent harm to self or others.
- (2) Orders for the use of chemical restraints must be approved by the guardian if one has been appointed unless a physician determines that any delay in administration of the restraint increases the danger to the individual or others. In such a case, the guardian must be informed as soon as possible that the restraint has been used. Approval may include written approval of a plan of which the use of chemical restraints is a part, written blanket approval for treatment and intervention in emergency situations, written specific approval for the use of a particular chemical restraint in particular circumstances, or a monitored telephone call.
- (3) Every use of a chemical restraint must be authorized by a physician prior to the administration of the medication. Each authorization shall remain in effect for a maximum of twelve hours. Physician orders for chemical restraint shall be confirmed in writing within 48 hours and the use of the chemical restraint shall be reviewed by the physician as soon as possible.
- (4) Chemical restraints may not be used until a physician determines and documents that the harmful effect of the behavior clearly outweighs the potential harmful effects of the medication.

C. Review and Reporting

- (1) Three uses of any chemical restraint or physical holding within a two week period or other patterns of use requires the individual's planning team to convene to review the adequacy of the individual's behavioral intervention plan and services.
- (2) Use of an emergency intervention must be reported promptly to the individual's physician by the professional ordering or overseeing such use.
- (3) Each use of an emergency intervention shall be reported daily to the manager of each program. Each use of an emergency intervention without a planned behavioral intervention procedure shall be reported daily to the appropriate DHHS regional office.
- **(4)** Other reports as may be required by the Department or other regulatory agencies shall be completed on time.
- Other Circumstances. On rare occasions, emergency measures not specified in D. these regulations may be required. In such instances, the following procedures shall be followed.
 - (1) A telephone report of the use of an emergency intervention other than those named as permissible shall be made by the service provider within

- one business day to the appropriate DHHS regional office. A written report must follow by mail or fax within two business days.
- (2) The written report must describe the intervention used, the circumstances leading up to the use of the intervention, the effectiveness of the intervention, any injuries suffered by the individual as a result of the intervention, and any follow-up to the incident.
- (3) Within two weeks of the use of such an intervention, the individual's planning team shall convene to review the use of the intervention. Such review shall be documented in the individual's record.

4. **Other Regulations**

These rules do not supplant any requirements governing the use of restraints that may be included in other Maine or Federal regulations, including but not necessarily limited to Licensing and Functioning of Intermediate Care Facilities for the Mentally Retarded Intellectually Disabled (10-144 CMR Ch. 118) and Regulations Governing the Licensing and Functioning of Assisted Living Facilities (10-144 CMR Ch 113).

SECTION 5. BEHAVIORAL INTERVENTIONS

1. **Principles**

Individuals served by the Department are entitled to the same rights as every other Maine citizen, except as limited by reason of guardianship. Any behavioral intervention that limits the exercise of any of an individual's rights must adhere to the following principles.

- A. The limiting intervention must be reviewed at least quarterly and approved by the planning team.
- B. The intervention must be approved, in writing, by the individual or by the guardian when one has been appointed. Withdrawal of approval requires immediate termination of the intervention.
- C. The use of an intervention must always be preceded by a behavioral assessment and documented efforts to address the dangerous or maladaptive behavior by the use of less intrusive or more positive techniques, which have been tried systematically and determined to be ineffective.
- D. Moderately intrusive interventions must be part of the written plan and approved by the planning team. The Review Committee, following review and approval by the planning team, must approve severely intrusive interventions.
- E. Individuals with mental retardation intellectual disabilities and autism have a right to receive effective intervention. While there are risks inherent in employing some behavioral interventions, it should also be noted that in some cases there are risks in not employing behavioral interventions.

F. Interventions must be limited to the individual in question. The imposition of group interventions is prohibited.

2. Positive Environment.

As stated above, every individual is entitled to the same rights afforded every citizen of Maine, except as limited by guardianship. The Department is obligated to ensure that all individuals have the opportunity to live in a safe, supportive environment. All service providers share this obligation. Any interventions that restrict an individual's rights, even if a guardian approves, will not be approved, unless the individual has been provided with necessary positive supports and appropriate services.

3. Prohibited Interventions

- A. The following procedures and interventions are expressly forbidden in all circumstances:
 - (1) Intentional infliction of pain or injury,
 - (2) The intentional instilling of fear of pain or injury,
 - (3) Actions or language intended to humiliate, dehumanize or degrade an individual.
 - (4) Denial of basic rights including, but not limited to meals, sleep, adequate clothing, medications, medical treatment, and therapy, and
 - (5) The use of experimental interventions or those without scientific basis or merit.
- B. A service provider's use of any such procedures will be cause for investigation and action by the Department, including, when appropriate, referral to a law enforcement agency, licensing authority or other similar oversight bodies.
- C. Any limitation, whether actual or implied, upon an individual's freedom of movement or exercise of a right (see 34-B M.R.S.A. §5605) is expressly forbidden unless it is either in response to an emergency, or a formal and approved portion of an individual's treatment plan.
- D. There exists the possibility that unusual circumstances may cause a planning team, attempting to assure the health and safety of an individual who is engaging in extremely dangerous behaviors, to propose an unusual or noxious intervention. In cases where such a plan is proposed, it is required that the designer of that intervention show to the Review Committee, by a preponderance of the evidence, why that program should be allowed. See Section 5, subsection 9 for information about the Review Committee.

4. Meetings of the Planning Team to Develop or Review Behavioral Interventions

- When it is proposed that a particular intervention be systematically used to A. change or eliminate a specific behavior of an individual, written documentation of the proposed use of the intervention must be included in the individual's planning process. A planning team must approve this process.
- B. The planning team must always include the individual and the guardian when one has been appointed. It must also include a caseworker or other Departmental representative, who must coordinate the inclusion of any other relevant planning team members. The planning team must include representatives of every site at which the behavioral treatment procedure is to be implemented.
- C. Pursuant to 34-B M.R.S.A. §5605(13), the planning team must evaluate factors that may be contributing to the occurrence of the behavior. Such factors may include but are not limited to
 - (1) Illness.
 - (2) Psychiatric conditions, and
 - (3) Significant life events.

In the event that factors such as those listed above exist, the planning team may still determine that a behavioral plan is indicated, but the planning team shall include, as part of the plan, its rationale for so deciding.

- D. The behavioral intervention procedure must include all of the following:
 - (1) Consent by the individual or the guardian if one has been appointed;
 - A concise and accurate identification and description of the specific (2) behavior(s) to be addressed and the behavioral goal;
 - (3) A description of the baseline measurements of the frequency, duration, intensity and/or severity of the behavior(s);
 - (4) A concise and precise description of the methodology for consistently implementing the plan;
 - (5) A description of the means of recording and measuring of the frequency, duration, intensity and/or severity of episodes of the specific behavior(s) and the use of interventions:
 - (6)A schedule for periodic review of the plan, which shall be at least quarterly;
 - Criteria for the discontinuation of the plan, whether because it has been (7) successful, its continued implementation is unlikely to be successful, or it is causing the individual more harm than benefit. There may be behavioral plans which show slow progress. These plans may require implementation and monitoring over an extended period of time.

5. Positive Behavioral Supports

- A. Positive behavioral supports are those which are directed toward reducing an individual's maladaptive behavior, but which do not entail any limitations upon the individual's rights. The planning team should approve all behavioral interventions.
- B. Examples of such interventions include but are not limited to:
 - (1) Rewarding positive behavior,
 - (2) Rewarding the absence of dangerous behavior,
 - (3) Modeling of appropriate behavior,
 - (4) Environmental alteration,
 - (5) Teaching of skills, and
 - (6) Redirection.
- C. Positive or neutral interventions may be used on an informal basis for individual safety or to promote a harmonious, supportive environment. The planning team must approve systematic use of an intervention.

6. Mildly Intrusive Interventions

- A. Mildly intrusive interventions are characterized as those in which some form of limitation is imposed upon the individual, but the individual voluntarily complies with this imposition. Examples of mildly intrusive interventions include but are not limited to:
 - (1) Nonexclusionary timeout,
 - (2) Verbal reprimand, and
 - (3) Extinction.
- B. An individual's voluntary compliance in a mildly intrusive plan is essential.

 Coercion is not permitted. Even in cases where a guardian has approved a plan, implementation is predicated upon the individual's voluntary compliance.
- C. Whenever a mildly intrusive plan is being considered, a member of the Office of Advocacy advocacy agency designated pursuant to Title 5, section 19502 must be informed that such a plan is under consideration.

7. Moderately Intrusive Interventions

- A. Moderately intrusive interventions are characterized by a greater degree of limitation being imposed upon the individual, but the individual voluntarily complies with this imposition. Examples of moderately intrusive interventions include, but are not limited to:
 - (1) Exclusionary timeout,
 - (2) Overcorrection, and
 - (3) Fining.
- B. An individual's voluntary compliance in a moderately intrusive plan is essential. Coercion is not permitted, but planning teams must be mindful of the possibility of more extreme behavior if compliance is not achieved. Even in cases where a guardian has suggested a procedure, implementation is predicated upon the individual's voluntary compliance.
- C. Whenever a moderately intrusive plan is being considered, a member of the Office of Advocacy advocacy agency designated pursuant to Title 5, section 19502 must be included in the planning team.
- D. Blocking, depending upon how and when it is used, may be an emergency or a programmatic intrusive intervention.
 - (1) Blocking used by a staff person to deflect a potentially dangerous movement (e.g., a blow) and this response is not part of a behavioral plan, then blocking must be reported as an emergency restraint.
 - (2) Blocking may be used as part of a plan to replace stereotypical, potentially harmful behaviors with preferable substitutes. A planning team may determine that the plan is either moderately or severely intrusive, subject to the necessary levels of planning team approval and review.

8. Severely Intrusive Interventions

- A. Severely intrusive interventions are those that involve some degree of coercion.

 They are distinct from emergency interventions, which are described in Section 4 of these rules.
- B. Severely intrusive behavioral plans may never be implemented on an informal basis. They may only be instituted following
 - (1) The consent of the individual or guardian if one has been appointed,
 - (2) Planning team approval. A member of the Office of Advocacy advocacy agency designated pursuant to Title 5, section 19502 must be present as a member of the planning team,

- (3) Approval by the Review Committee as described at Section 5, subsection 9, and
- (4) The consideration of trauma issues by both the planning team and the Review Committee.
- C. The usually permissible forms of severely intrusive interventions are personal (i.e., physical) restraint and the temporary removal of personal property when that property is being used in a threatening or dangerous way. It is impermissible for any staff person to participate in a severely intrusive plan unless the staff person has received training in the specific plan and in physical restraint techniques approved by the Department.
- D. Plans for severely intrusive interventions that include the temporary removal of personal belongings must comply with 34-B M.R.S.A. §5605(6), and less intrusive efforts must have been tried and failed.
- E. The maximum permissible time for continuous physical restraint is one hour. The planning team or the Review Committee may mandate a shorter duration for any given intervention. A severely intrusive behavioral intervention plan must include strategies to respond when the behavior continues beyond one hour.
- F. A physician, or physician extender (as described at 02-373 CMR Ch 1 and 2) shall evaluate the individual no more than three weeks prior to the implementation of an intrusive plan, in order to determine that the proposed plan is safe, given an individual's physical and emotional condition. The physician or physician extender must also determine whether the behavior would be better treated medically.
- G. Prior to approving a plan for a severely intrusive intervention, the planning team must identify a Licensed Psychologist or Psychiatrist who will recommend the intervention and
 - (1) Meet the individual and the individual's support staff,
 - (2) Confer with the individual's family if involved and guardian if one has been appointed,
 - (3) Develop, recommend or approve the written plan and the monitoring system, and
 - (4) Agree to monitor the implementation and the effectiveness of the plan no less frequently than twice a month in the first month and once monthly thereafter.
- H. Plans for severely intrusive interventions must include the agreement of the service provider to ensure that all individual staff members who work with the individual are trained as described at 8.C, above. This training must be developed and approved or conducted by the Psychologist or Psychiatrist.

- I. The Review Committee, prior to considering approval, must receive and review a documentary record of prior attempts and their relative effectiveness to address the behavior via less intrusive measures. A knowledgeable member of the planning team must meet with the Review Committee to present the plan. The Review Committee will make and announce its decision at the meeting and will provide a written notice to the planning team within ten working days following the meeting. The decision shall be one of the following:
 - (1) Approval;
 - Approval with modifications. Modifications are limited to the duration (2) of the intervention, as described at 8.E., above; or
 - (3) Disapproval. Committee requests or recommendations for modifications other than duration shall constitute disapproval.

In any instance in which the Committee is considering approval of an unusual or noxious intervention, the Committee is required to seek a second opinion from another clinician who is a licensed Psychologist or Psychiatrist. That clinician shall meet with the individual and the individual's support staff, and confer with the individual's family if they are involved and the individual's guardian if one has been appointed. The clinician will then provide an opinion of the potential risks and benefits of the proposed program. If the clinician providing the second opinion concurs in the need for the program and the Committee agrees that the program is necessary, the Committee must submit the program to the Commissioner for final approval.

J. A knowledgeable planning team representative must meet with the Review Committee at least quarterly to review the plan. At each of these meetings, the Committee will decide whether or not to continue approval. The limitations of the Committee's decision are as described at 8.I., above. The Review Committee will make and announce its decision at the meeting and will provide a written notice to the planning team within ten working days following the meeting.

9. The Review Committee

- A Review Committee is designated for each of the regional district offices of the A. state. Each committee shall include persons identified in 34-B M.R.S.A. §5605(13)(B).
- B. This committee is responsible, as outlined above, for reviewing and approving all severely intrusive programs on a case-by-case basis, at least quarterly. The committee may elect to conduct reviews more frequently.
- C. Any committee approval and approval with modifications must be unanimous may be made on the affirmative vote of a majority of committee members.
- D. The Review Committee has two distinct categories of review obligation, and the minutes of its deliberations on each case must reflect that it has covered both:

- (1) That a proposed severely intrusive plan takes all possible steps to protect the health, safety, and rights of the individual, and
- (2) That the plan is clear and comprehensible to all its users.

SECTION 6. REGULATION GOVERNING THE USE AND REVIEW OF SAFETY DEVICES

1. Policy Statement

This regulation establishes a hierarchy of review for the use of safety devices for persons with developmental disabilities as those devices are defined by 34-B M.R.S.A. §5605(14-C) and distinguishes safety devices under that law from mechanical supports as that term is used in 34-B M.R.S.A. §5605(14-B). The regulation also prescribes the frequency of review of the use of safety devices and the procedure for requesting approval for the use of safety devices.

2. Application

These regulations apply to any adult served by the Office of Adults with Cognitive and Physical Aging and Disability Services who receives any services that are provided, licensed, or funded in whole or in part, directly or through a contractor, by the Department of Health and Human Services.

3. Guiding Principles

Use of each safety device must be reviewed individually according to the process set out in this regulation. The purpose of the safety device, the impact its use has upon the person for whom it is prescribed or recommended, and the degree of intrusiveness the device imposes must be determined on an individual basis. Safety devices that impose a greater degree of intrusiveness upon the person and have a greater impact upon the mobility of the person or the comfort of the person warrant a higher degree of scrutiny and oversight. Any safety device must impose the least possible restriction consistent with the purpose of insuring safety. Safety devices may never be used as punishment, for staff convenience, or as a substitute for teaching the person new skills or abilities that would eliminate the underlying risk that gives rise to the request for the use of the device.

4. Definitions

- A. "Adult" means any individual who has attained the age of 18 or who is a legally emancipated minor.
- B. "Adult served by Developmental Services" means any person under 34-B M.R.S.A. 5001(3-B).
- C. "Adult with autism" means an adult who has received a diagnosis that falls within the category of Pervasive Developmental Disorders, as defined by the

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

- D. "Advocate" means an employee of the Office of Advocacy of the Department of Health and Human Services, State of Maine advocacy agency designated pursuant to Title 5, section 19502.
- E. "Mechanical support" means a device or mechanism that is used to help a person achieve proper body position or balance. A mechanical support is not a "mechanical restraint". (See 14-197 Chapter 5(2), definition of mechanical restraint.)
- F. "**Person**" means a person as defined by 34-B M.R.S.A. 5001(3-B).
- G. "**Personal planning**" means the process established by 34-B §5470-B or defined by §5001(3-B).
- H. "**Personal planning team**" means the group defined by 34-B M.R.S.A. §5001(3-D) or §5461(8-C).
- I. "Qualified professional":

For safety devices a "qualified professional" means a medical doctor or psychologist licensed to practice in the state of Maine.

For mechanical supports a "qualified professional" means a medical doctor, and occupational therapist, or a physical therapist licensed to practice in the state of Maine.

- J. "**Review team**" means the three persons identified in 34-B M.R.S.A. 5605(13)(B), commonly known as "the three person committee."
- K. "Safety device" means an implement, garment, gate, barrier, lock or locking apparatus, video monitoring or video alarm device, helmet, mask, glove, strap, belt, or protective glove whose effect is to reduce or inhibit a person's movement in any way and whose purpose is to maintain the safety of the person. Except as provided in §9 below, a safety device may not have as its purpose in whole or in part the provision of behavioral treatment under 14-197 Chapter 5, Section 5. Except as provided in §9 below any device whose intent is to modify the behavior of the person must be reviewed and approved according to the process set out in Regulations Governing Emergency Interventions and Behavioral Treatment for People with Mental Retardation Intellectual Disabilities and Autism, 14-197 Chapter 5.

Specific Examples of Devices Usually Considered to be Safety Devices:

The following is a list of devices or protective garb that normally would be considered to be safety devices:

- (1) A one piece suit to prevent the person from pulling out an ostomy bag or interfering with similar medically necessary procedures, equipment, or apparel;
- (2) A locked cupboard or locked refrigerator when the locking is implemented for the purpose of keeping a person safe;
- (3) Hand splints or gloves when used as a safety device, for instance to prevent pica behavior;
- (4) A seat belt on a wheelchair to prevent the person from falling out of the wheelchair:
- (5) A seat belt on a wheelchair to prevent the person from getting out of the wheelchair because the person has a history of falling or being unsteady;
- (6) A seat belt on a toilet to prevent the person from getting off the toilet due the person having a history of having fallen off the toilet or having a history of getting off the toilet and being unsteady or falling;
- (7) Foot straps on a wheelchair that prevent the person's feet from dragging or getting stuck or caught; (*See* §6(F) below for foot straps on wheelchairs whose only purpose is to insure proper positioning of the person's limb(s)).
- (8) A diver's belt in a bathtub to prevent the person from floating while being bathed;
- (9) A chest strap while on the toilet to prevent the person from falling off the toilet;
- (10) A belt on a chair to keep the person from falling or slipping out of the chair:
- (11) Any bed rail that substantially inhibits the person from rising off of or getting out of the bed;
- (12) A gait belt for a person who has a history of unsteadiness or falls in order to assist the person with walking or with transfers;
- (13) A video monitoring device or a video alarm;
- (14) A helmet used solely for safety purposes, for instance to protect a person who has a history of falling because of seizures. See also §9 below.

Non-exclusivity of the Lists of Devices Above: The devices listed above are not intended to describe every safety device that might be used or devised. Personal planning teams and qualified professionals may suggest other safety devices and those safety devices may be utilized if they meet the definition of a

safety device under state law and this regulation. Any such safety device must be approved according to the process set out in this regulation. Review Teams may use the lists above as guidance in judging by analogy whether the purpose and use of any proposed device qualifies the device as a safety device as defined above.

5. **Review Process**

Preliminary Requirements Prior to Review A.

- (1) Any use of a safety device must be pursuant to a written recommendation from a qualified professional.
- (2) Any use of a safety device must be approved by the person's personal planning team, and that approval must be recorded in a document that is part of the person's personal planning record.
- (3) If the person has a guardian, or if the person is under limited medical guardianship, the guardian must approve the use of the safety device. If the person does not have a guardian, the person must consent to the use of the safety device.

B. **Frequency of Review**

Any use of a safety device must be reviewed at least once per year by the review team. Any preliminary requirements for review (as set out in paragraph 5(A) above) must be renewed each year prior to review. Any member of the review team may require that use of a safety device be reviewed more frequently. If review takes place more frequently than annually, any consent, approval, or recommendation that is a preliminary requirement for review must be current at the time of the review.

C. **Standard Forms**

All initial and renewal requests for permission to use a safety device must be submitted on a standard form made available by the Department. Each request for permission must be accompanied by the written recommendation of a qualified professional, and any required consents for the use of the safety device. The request form must clearly identify the safety device and must describe the conditions of use of the device and the anticipated frequency of its use. The request form must include a place for the review team to indicate approval or disapproval of the safety device and must include a mailing address and fax number to which the approval can be sent.

D. Requests for Multiple Safety Devices for the same person

Each request for permission to use a safety device must have its own professional authorization that refers specifically to that safety device. Any consent and any person centered planning team approval required to use a safety device must refer specifically to the safety device for which the consent or approval is being given. Safety devices that are normally used in pairs, such as gloves or foot straps, do not need separate requests.

E. **Review Team Approval**

All three members of the review team-A safety device may be approved on the affirmative vote of a majority of review team members. If the device is approved, the review team members who voted for approval must sign a document authorizing the device's use.

F. **Time for Decision**

The review team shall make a determination of approval or disapproval within thirty calendar days of its receipt of the request for approval and all completed supporting or accompanying documentation necessary to conduct the review.

G. **Notifications after Review**

The person or entity requesting approval to use a safety device is responsible for notifying the person's personal planning team of the decision made by the review team. The personal planning team may designate a member of the team to receive this notification.

H. Consents Required for a Video Monitoring Device or Video Alarm

Prior to using a video monitoring device or a video alarm in any setting in which more than one person may appear, the consent of each person (or the consent of the person's guardian, if the person has a guardian) must be obtained, if there is a reasonable likelihood that the person's image will be displayed on the monitor or alarm.

6. Safety Related Devices or Practices that Do Not Need Approval of the Review Team

The following devices or practices do not need the approval of the review team prior to implementation, but where noted below they do need to be approved by the person's personal planning team and consent needs to be obtained from the person or if the person has a guardian, from the guardian:

- A. The routine use of seat belts in a vehicle;
- B. Tie downs in a van to prevent a person in a wheelchair from flipping over;
- C. A foot or arm strap on a wheelchair whose only purpose is to insure the proper positioning of the person's limb;
- D. The practice of having car doors locked, when applied by written agency policy to all persons transported in a vehicle;

- E. The use of a car lock or "child safety" lock when used for one person (as opposed to being applied to everyone served by an agency by agency policy) must be approved by the person's personal planning team and consent for the use of such a lock must be obtained from the person's guardian if the person is under guardianship or from the person if the person is not under guardianship.
- F. Motion detectors and sound monitoring devices that are used to alert staff to a person's movement within a limited area, but which by themselves do not limit the person's movement. These devices include an ankle bracelet, a door alarm or light, including an infrared light, that alert staff that the person is moving within or leaving a particular area; a window alarm that is intended to alert staff that a person is using the window as a means of escape; a sound monitor (often also referred to as a "baby" monitor) that picks up sounds in the vicinity of the person and transmits those sounds to staff; a motion detector; a chair alarm that alerts staff to the person trying to rise out of a chair; and a bed alarm that alerts staff to the person falling out of bed or rising up out of bed. The use of these devices must be approved by the person's personal planning team and consent for their use must be obtained from the person's guardian if the person is under guardianship or from the person if the person is not under guardianship.
- G. A search, such as a pat down or with a wand, implemented as a proactive measure intended to minimize the person's potential involvement in criminal behavior if the search has been ordered by a court of competent jurisdiction or the search is a condition of probation or release.
- H. A court order or a condition of probation that requires a person to remain in a particular place, such as a residence, or to be involved in a particular program, is not subject to review under this regulation.
- I. A device such as an ankle bracelet that incorporates a GPS (global positioning system) locator or a similar device that a court of competent jurisdiction has ordered the person to wear, or that the person wears as a condition of probation or as a condition of release;
- J. The monitoring of TV, movies, or computer games for possible violence or sexual content. The person's personal planning team must approve any such monitoring and the person or the person's guardian, if the person is under guardianship, must consent to the monitoring.
- K. A doctor's order that a person be held temporarily or that a device such as a strap be used temporarily so that a medical procedure (such as the drawing of blood from the person) can occur. A written doctor's order for the physical holding or for the device is necessary as part of or as an adjunct to the order for the medical procedure that is being performed.
- L. A doctor's order for the temporary holding of a person or the temporary use of a device that restrains a person's movement in order to feed the person, or for the routine administration of medication, or for aiding the person's performance of activities of daily living skills. Any such order may be applied only in the circumstances prescribed in the written order by the doctor. Any such order must

- have the consent of the guardian if the person is under guardianship, or the consent of the person if the person is not under guardianship.
- M. A doctor's standing order for the holding of a person or the use of a device that restrains a person's movement in order to feed the person, or for the routine administration of medication, or for aiding the person's performance of activities of daily living skills. Any such standing doctor's order must be approved by the person's personal planning team, and must have the consent of the guardian if the person is under guardianship, or the consent of the person if the person is not under guardianship.
- N. Any device that is a mechanical support.

7. Requirements for the Use of a Mechanical Support

- A. Any mechanical support may only be applied under the supervision of a qualified professional. The qualified professional may delegate responsibility for the day-to-day application of the use or application of the support to others, as long as any other persons applying the support have been trained in the proper use of the support and the qualified professional retains professional responsibility for the application of the support.
- B. The use and design of any mechanical support must be individualized to the specific need of the person who is using the support, so as to meet the need and maximize the comfort of the person.
- C. Any mechanical support must make allowance for the person to change body position.
- D. The impact upon the person's body alignment and blood circulation must be considered in the use of any mechanical support.

8. Distinctions Between Safety Devices, Devices that are Utilized for Behavioral **Treatment, and Mechanical Supports**

When the same device or apparatus meets the definition of a mechanical support, or a behavioral treatment, or a safety device the person's personal planning team should initially classify the device. Notwithstanding this initial classification, the review team may exercise its own discretion in classifying any device, intervention, or practice.

9. Helmets Used to Protect or Diminish the Degree of Injury to a Person Engaging in **Self Injurious Behavior**

A helmet whose primary purpose is to protect a person from self-injurious behavior or to diminish the degree of injury of a person engaged in self-injurious behavior, or whose purpose is to prevent a person from biting others, is presumed to be part of a severely intrusive behavioral intervention plan for the first year of its use. The use of the helmet during that year is subject to the requirements for review under 14-197 Chapter 5, Section 2. A review team may exercise its discretion to classify the use of a helmet for the purposes enumerated in this paragraph as a safety device if after the expiration of the first year of the device's use it concludes that the primary purpose of the use of the helmet is as a safety device and that review of the use of the helmet as behavior intervention is no longer necessary.

STATUTORY AUTHORITY: 34-B M.R.S.A. §§ 1203(3), 5601 et seq.

EFFECTIVE DATE - as "Regulations for the Use of Behavioral Procedures, Including Restraints":

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