**Summary of Public Comments and Department’s Responses**

**14-197 CMR Chapter 5**

**REGULATIONS GOVERNING BEHAVIORAL SUPPORT, MODIFICATION AND MANAGEMENT FOR PEOPLE WITH INTELLECTUAL DISABILITIES OR AUTISM IN MAINE**

(“Chapter 5”)

The Department of Health and Human Services (“Department”), Office of Aging and Disability Services

(“OADS”) held public hearings on October 7, 2105 and December 8, 2015. Written comments were

accepted through December 18, 2015. The following Comments were received.

**FUNDING**

1. **Comment**: Commenters (9, 12 & 13) questioned who will pay for the additional assessments, plans, meetings, and other additional requirements in the proposed regulation.

**Response**: The Department thanks the Commenters for these comments. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.168% of the total number of persons eligible for services (+/- 6000). The requirements for a Functional Assessment and Positive Support Plan is similar to the requirements for the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. (See MBM, Chapter II Sections 21.04-2 & 29.04-2). The documentation under these regulations for the Functional Assessment and Positive Support Plan is appropriate and necessary to ensure least restrictive level of support need. The Department made no changes to the final rule as a result of these comments.

1. An independent psychologist is reimbursed at $100/hour and a physician at approximately $100/service. Not only is the expense not accounted for in the proposed regulations, but psychologists with expertise in intellectual disabilities and mental health issues are in very short supply in Maine, potentially causing a bottleneck in the ability to produce the Level 4 Plans.

**Response**: The Department thanks the Commenter for this comment. The Department shares the concern about availability and access to qualified professionals. The Department continuously seeks to identify and secure these resources throughout the State. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to change based on these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (12) expressed concern that the current service and funding system does not align with or support the collaborative monitoring meetings, collaborative plan writing by various professionals, and clinical consultation required by these regulations

**Response**: The Department thanks the Commenter for this comment. These regulations and the current version do not significantly differ in the area of plans or meeting. Within these regulations there is no requirement that the clinician be present at the Planning Team meetings. This is left to the discretion of the clinician and the Planning Team. The Department made no changes to the final rule as a result of these comments.

1. **Comment**:Commenters (9 & 12) asked if there will be a change in MaineCare regulations to support the process and procedures, and assessments/plans outline in these regulations. Commenter (9) asked when these changes will take place

**Response**: The Department thanks the Commenters for these comments. MaineCare Benefits Manual, Chapter II, Section 21 Waiver Services has an expanded definition of qualified professional that can oversee and monitor Behavior management Plans. Other changes are not necessary. The Department made no changes to the final rule as a result of these comments.

1. **Comment**:Commenter (12) asked, for those with Mental Health outpatient services, how are they going to be compensated for attending Planning Meetings

**Response**: The Department thanks the Commenter for this comment. Within these regulations there is no requirement for Mental Health professional to be present at Planning Team meetings. This is left to the discretion of the clinician and the Planning Team. The Department made no changes to the final rule as a result of these comments.

1. **Comment**:Commenter (12) asked how will the Functional Assessment be funded for some individuals living at home receiving 65 HCT Services

**Response**: The Department thanks the Commenter for this comment. These regulations only applies to a person 18 years of age or older who has an intellectual disabilities or autism and who is receiving services funded under a Department program. The Department does not intend these regulations to conflict with requirements in other MaineCare rules that apply to a diagnosis other than intellectual disability or autism. In cases where a Person is receiving services under another MaineCare program, plans or documents created under the requirements of that program, may be used by the Planning Team to better meet the needs of the Person. The Department made no changes to the final rule as a result of these comments.

1. **Comment**:Commenter (12) asked what if the consultation required with Mental Health Professionals exceeds caps in MaineCare funding

**Response**: The Department thanks the Commenter for this comment. Whenever a service is needed that exceeds available funding the Person’s Case Manager should be contacted in order to assist in seeking alternative resources. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (15) stated that contrary to the published notice, the rule change includes an estimated $2,651,400 of increased services required by the rule that will have to be funded through MaineCare and another estimated $26.5M ($354,000 per provider agency at approximately 75 agencies) that will either have to subsume the fiscal effects of the increased regulations or pass this burden on to MaineCare. The resulting total system impact is approximately $30M.

**Response**: The Department thanks the Commenter for this comment. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.0168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to increase significantly based on these regulations. The requirements for a Functional Assessment and Positive Support Plan is similar to the requirements for the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. (See MBM, Chapter II Sections 21.04-2 & 29.04-2). The documentation under these regulations for the Functional Assessment and Positive Support Plan is appropriate and necessary to ensure least restrictive level of support need. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (15) estimated the average per organization cost of $353,904 for the approximately 75 provider organizations affected. The total estimated year-one impact for providers is in excess of $26.5M.

**Response**: The Department thanks the Commenter for this comment. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.0168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to increase significantly based on these regulations. The requirement for a Positive Support Plan does not significantly differ from the requirements providers must meet in the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenters (14, 15, 22 & 27) believe this change is an unfunded mandate. Commenter (15) stated the change will fundamentally impact the State budget by mandating $2.651M of costly changes to the current rule and will require significant increases in frequency and a broadening of professional services funded by MaineCare. The change will also authorize an unfunded approximately $26.5M requirement for providers to deliver extensive new services that require an increase in documentation, greater administrative oversight, and new training. We estimate that the total financial impact on the service delivery system will be approximately $30M. Commenter (22) is concerned that the increase in required functional assessments will require a significant financial investment by agencies and appears to be an unfunded mandate. Commenter (14) states that this is going to present a significant financial burden for many agencies. Commenter (15) estimated the impact to State budget for all Section 21 members (based on 2500 members served) at $420,000 and the estimated impact to state budget for all Section 21 members for the Transition Plans at $210,000.

**Response**: The Department thanks the Commenters for these comments. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.0168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to increase significantly based on these regulations. The requirements for a Functional Assessment and Positive Support Plan is similar to the requirements for the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. (See MBM, Chapter II Sections 21.04-2 & 29.04-2). The documentation under these regulations for the Functional Assessment and Positive Support Plan is appropriate and necessary to ensure least restrictive level of support need. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (15) stated that given the far-reaching nature of this rule change, many more adults will be identified as needing a Functional Assessment and Positive Support Plan based on behaviors that are currently easily handled, respectfully and safely, every day all over Maine. The assessments and plans will require the expertise of highly paid professionals that are currently being reimbursed by MaineCare at a rate of $84/hour. If the assessment and planning takes two hours per individual per year, just in our organization alone, the increase in a MaineCare Section 65 funded service (Outpatient Services – Comprehensive Assessment) will add $12,264 to the state’s budget for 73 individuals who exhibit behavior at the lowest level or higher.

**Response**: The Department thanks the Commenter for this comment. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.0168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to increase significantly based on these regulations. The requirements for a Functional Assessment and Positive Support Plan is similar to the requirements for the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. (See MBM, Chapter II Sections 21.04-2 & 29.04-2). The documentation under these regulations for the Functional Assessment and Positive Support Plan is appropriate and necessary to ensure least restrictive level of support need. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (17) states that taking money for treatments and/or services that aren’t delivered has the ring of fraudulence. The state appointees’ power to prevent treatment is an issue for further review, elsewhere.

**Response**: The Department thanks the Commenter for this comment. The Department agrees that services being paid for should be delivered. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (15) state that provider agencies are scheduled for a significant rate cut based on the SIS Initiative. This further taxing of limited resources will force organizations to discharge clients with challenging behavioral issues.

**Response**: The Department thanks the Commenter for this comment. This comment is outside the scope of this rulemaking. The Department made no changes to the final rule as a result of these comments

1. **Comment**: Commenter (13) asked the Department whether MaineCare will cover the cost for the following, and if so, what the additional cost will be to MaineCare for:
2. developing the Functional Assessment, Behavior Management Plan, Positive Support Plans, including the additional services required of all members of the Planning Team, the highly detailed Behavior Management Plan, Psychological Assessment (see §5.05-5), the Second Clinical Opinion required for Level 5 Intervention and Physician’s Evaluation (see §5.05-5)
3. monitoring and meeting on a monthly and quarterly basis, including cost for documentation with a clinician for all clients with a Behavior Management Plan
4. for Advocates involvement in each Level 3-5 plan
5. trainer and the time for training the DSPs
6. additional services of Case Managers
7. service providers for the additional time and services that must be provided to ensure the requirements of this rule are met.

**Response**: The Department thanks the Commenter for this comment. Most of these requirements exist in the current regulations. For the few that remain the Department asserts that when Planning Teams work with the Person to identity and document a Functional Assessment and Positive Support Plan the Person’s supporters are better able to assist the Person increase their skill building and pro-Social Behaviors thus mitigating the need to move toward more costly and intrusive interventions. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13) asked whether providers will see a rate increase for clients with Challenging Behaviors.

**Response**: The Department thanks the Commenter for this comment. Within MaineCare Section 21 waiver services, there are mechanisms for Service Providers to request crisis hours as needed. In addition Service Providers currently work on an individual basis with a Person’s Planning Team to make requests for funding that they assert are necessary to meet the Person’s health and safety needs. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13) asked whether the Department has created a plan for the resulting termination of services by service providers to high-need clients when they are not reimbursed for the additional services and training.

**Response**: The Department thanks the Commenter for this comment. Current Service Provider agencies work diligently to ensure the health and safety for the Persons’ they serve. The Department does not believe that these Service Providers will discharge a Person they are serving based on these regulations. The changes to these regulations focus most heavily on enhancing the processes Service Providers, families, Case Managers, and others currently follow. The process enhancements are intended to ensure that all opportunities for less restrictive interventions and increased positive supports are in place. In the event a Service Provider terminates services the Department expects the Service Provider to follow the processes for termination required in the MaineCare Benefits Manual. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (25) is concerned that the qualified people, the Psychiatrists and Psychologists, are not available because of the funding difficulties with Maine Care.

**Response:** The Department thanks the Commenter for this comment. The change in MaineCare rule under Section 21 waiver services expands the definition of “qualified professional” that can oversee and monitor Behavior Management Plans. The Department shares the concern about availability and access to some of these qualified professionals. The Department continuously seeks to identify and secure these resources throughout the State. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (15) estimates the impact to state budget for 33% of Section 21 members: $165,000 for just these two additional services.

**Response**: The Department thanks the Commenter for this comment. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.0168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to increase significantly based on these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (15) states that a Level 5 Plan requires a Functional Assessment, Positive Support Plan, and a Transition Plan, a Behavior Management Plan, and an In-Home Stabilization Plan, as indicated, Psychological Assessment, a Physician’s Evaluation, a second clinical opinion and review by the Statewide Review Panel and the Commissioner of DHHS. Commenter (15) estimates that 13 of its residents will require a Level 5 Plan, which represents approximately 19% of its clients. If 5% of all MaineCare Section 21 members require this level of planning, then 125 people would be affected. Commenter (15) estimates the impact to state budget would be $10,500 for the second clinical opinion.

**Response**: The Department thanks the Commenter for this comment. At this time the Department is unable to confirm whether this Commenter’s cost estimation is accurate. In all of 2015 there were approximately 100 plans that under these regulations will most likely be considered a Level 3 – 5 Plan. The requirements for a Functional Assessment and Positive Support Plan is similar to the requirements for the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. (See MBM, Chapter II Sections 21.04-2 & 29.04-2). The documentation under these regulations for the Functional Assessment and Positive Support Plan is appropriate and necessary to ensure least restrictive level of support need. The Department made no changes to the final rule as a result of these comments.

**PROCESS**

1. **Comment**: Commenters (1, 3, 10, 13, 17, 19, 21 23, 35 & 36) expressed concerns about the process followed to create the proposed regulations. The concerns included: involving more stakeholders in the drafting of proposed regulations; increasing the written comment period; publicizing the rulemaking notice is more newspapers including out-of-state papers as some Persons are served out of state; ensuring that electronic notice is adequate; difficulty of website. Commenter (17) stated that these regulations evidently meet the letter of the law in terms of announcing a public hearing and offering the prescribed period of time for written comments, but frankly those affected by these regulations who don’t subscribe to the Kennebec Journal, and who weren’t contacted regarding the regulations, essentially have been excluded from making timely comments/objections.Commenter (19) urges the Department to reconsider the breadth and bureaucratic response to these important issues and build capacity for relationships with our loved ones to insure their safety and happiness. These Behavior Regulations need work and should involve more stakeholders in the planning/evaluation process. Most parents I am connected to were surprised by these as written and the timeline to give feedback.

**Response**: The Department thanks the Commenters for these comments. Because the Department received many similar comments at the October 7, 2015 hearing, the Department made the decision to restart the rulemaking process. A second newspaper notice was published on November 18, 2015. Electronic notice was sent out through the Office of Maine Care Services list serve as well as the OADS’ GovDelivery system. A second public hearing was held on December 8, 2015 and public comments were accepted until December 18, 2105. The public notice and Interested Parties letter included instructions on how to obtain a hard copy of the proposed rulemaking, free of charge. The purpose of a public hearing is for the public to be given the opportunity to provide feedback to the agency proposing the regulation.  It is not intended to be a question and answer meeting.  Section 8052 of the APA sets forth the requirements for the public hearing process, as well as how the Department is to summarize and respond to any/all comments it receives on a rule. The law does not require an agency to answer questions or engage in a conversation with commenters during the public hearing on a proposed rule, and indeed, doing so may not be proper. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (3) suggests that the scope of the regulations isn’t necessary because there are mechanisms in place through Adult Protective Services, Licensing and Regulatory Entities and advocacy by the individuals and families.

**Response**: The Department thanks the Commenter for this comment. The mechanisms in place through Adult Protective Services, Licensing and Regulatory Services, and advocacy by the individuals and families are not sufficient to meet all the statutory requirements. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (5) fears that instead of protecting her child’s rights, safety and well-being the regulation may compromise these very things.

**Response**: The Department thanks the Commenter for this comment. The Department appreciates the Commenter’s concerns for the health, safety, and wellbeing of her adult child. The Department reaffirms its commitment to the Principles listed in §5.01-1 of these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (23) finds the OADS website to be difficult to navigate at the best of times. Commenter (23) states that not everyone with an intellectual disability has internet access which might limit their ability to fully participate in this rulemaking.

**Response**: The Department thanks the Commenter for this comment. The public notice was published in the newspaper. The Interested Parties letter included instructions on how to obtain a hard copy of the proposed rulemaking, free of charge. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (6, 7 & 10) ask why the regulations being changed and why are they being changed now. Commenter (10) asks the Department to delay implementing these regulations while all the other new implementations are occurring.

**Response**: The Department thanks the Commenters for these comments. The Department and interested stakeholders have been discussing and working on changing Chapter 5 for several years. Further delay is not in the best interest of the persons with intellectual disabilities or autism in need of behavior interventions. The current regulation was created in 1987 and has not been substantively amended since 2010. Laws have changed and clinical practices have evolved. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenters (17, 22, 27, 28, & 29) comment on who participated in the process of developing these proposed regulations and who will be going forward given the forthcoming comments and hearings and the subsequent, hopeful, need for adjustments to the regulations. Commenter (17) stated that essentially, those charged with implementing these regulations, were excluded from their design.

**Response:** The Department thanks the Commenters for these comments. These regulations were developed over a period of years through a collaborative process among different DHHS offices and numerous stakeholders and clinicians. These parties were involved in a consultant role, a drafting role, or both. Parties involved, included but is not limited to Disability Rights Maine, Maine Oversight and Advisory Board (and the former Consumer Advisory Board), the Office of Advocacy, Maine Psychological Association, Division of Licensing and Regulatory Services, OACPDS. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (24) was disappointed in the way which the hearing was conducted and believed there would be interaction with questions and answers.

**Response:** The Department thanks the Commenter for this comment. The purpose of a public hearing is for the public to be given the opportunity to provide feedback to the agency proposing the regulation.  It is not intended to be a question and answer meeting.  Section 8052 of the APA sets forth the requirements for the public hearing process, as well as how the Department is to summarize and respond to any/all comments it receives on a rule. The law does not require an agency to answer questions or engage in a conversation with commenters during the public hearing on a proposed rule, and indeed, doing so may not be proper.

The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (27) questioned whether other models of review teams had been considered prior to putting the rules together.

**Response:** The Department thanks the Commenter for this comment. Other models were considered. Statutory changes would be necessary and the fiscal impact to reimburse for the level of work would be cost prohibited. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (27) requests that the committee who proposed the rules to not only summarize changes between the existing rules and the proposed rules but also to detail the rationale for each and every change in the rules.

**Response:** The Department thanks the Commenter for this comment. The Department appreciates the Commenter’s request for detailed information. Given the scope of the amendments, including reorganization of the regulation, a detailed crosswalk was not possible. The Department held two public hearings and extended the written comment period to give the public more time to consider these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenters (28 & 29) would like to know the experience and background of those involved in writing these regulations as well as what is their experience and background.

**Response:** The Department thanks the Commenters for these comments. Stakeholders who participated in the drafting of these regulations have a wide variety of backgrounds and experience, including but not limited to: Individuals receiving services, Service Provider agencies, clinical professional, DHHS personnel, Advocates, Developmental Disabilities Council, members of Maine Oversight and Advisory Board. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (15) stated that contrary to the published notice, the rule change is a substantive rule change and should follow legislative process for substantive rule changes. The changes propose a complete overhaul of the current methodologies for assessing, planning, training, tracking, and treatment of behavioral issues for people with intellectual disabilities and autism.

**Response**: The Department thanks the Commenter for this comment. Maine law, 34-B M.R.S. §5605, states that these regulations are routine technical rules. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) states that it will be helpful to know which psychiatrist contributed to the formulation of this §5.04-5, Use of Psychiatric Medications. Commenter (17) states that certainly those whose professional judgment and practice is being called into judgment and accountability to the state appointees were consulted in drafting this section.

**Response**: The Department thanks the Commenter for this comment. During the drafting of these regulations, the Department consulted a psychiatrist in its employ on these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) asked how the Department will manage the volume of plans and the volume of

Review Meetings required for every change in an individualized behavioral plan.

**Response**: The Department thanks the Commenter for this comment. The Department included a process in these regulations for the transition of current plans that allows the Planning Teams and Review Teams to manage any temporary increase in volume. The Department expects the volume to level off as current plans are processed. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) asked how the Department plans to insure clinical integrity and oversight to

the Review Team’s work

**Response**: The Department thanks the Commenter for this comment. Under these regulations the Statewide Review Panel is responsible to monitor for quality and consistency amongst the regional Review Teams. In addition Statewide Review Teams have been meeting on a regular basis and will continue to do so in order to discuss consistent applicability of these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (23) suggested that the Department develop formats through which adults with ID and ASD might have a fighting chance to make thoughtful comments on the laws, policies, and rules that govern their autonomy.

**Response**: The Department thanks the Commenter for this comment. Individuals receiving services were part of the stakeholder process. In addition the Department has regular contact with Speaking Up for Us in order to discuss services and supports as well as policies and rules. The Department made no changes to the final rule as a result of these comments.

**RULE ORGANIZATION / READABILITY**

1. **Comment**: Commenters (1, 3, 6, 9, 10, 11, 12, 17, 19, 20, 22, 31, 33, 35 & 36) suggest that the rule is difficult to follow and the organization is complex and requires one to skip back and for the throughout the documents. Commenters urge the Department to insure the regulation is clear and understandable for family members and other stakeholders. One Commenter stated that having clear, consistent, appropriate guidelines, and appropriate expertise, are components that led to success for individuals with Intellectual Disabilities or Autism. One Commenter experienced difficulty navigating the proposed regulation; including the terminology changes throughout the document which the Commenter felt created an added layer of confusion. Commenter (33) is concerned that there are too many levels of pushing and getting the same forms signed over and over. Commenter (17) stated that these regulations obfuscate rather than efficiently inform in a clear, accessible document that which is purportedly being communicated. Commenter (18) stated that the proposed regulations should be re-written in their entirety. Commenter’s (19) overall assessment is that these regulations create a complicated bureaucratic system for individuals and their families. Commenter (20) finds the format is confusing and difficult to follow (e.g. pages 7 & 8 references Positive Supports and Behavior Management without definitions and refers to other sections) Commenter (22) suggested the Department consider a format that succinctly defines each intervention level, identifies requirements for each level, as well as approval and monitoring for each level in a clear, consistent, user-friendly format to promote understanding and compliance.

**Response**: The Department thanks the Commenters for these comments. The Department has reviewed the proposed regulation to address the comments above. In response to these comments the Department has made numerous amendments to these regulations.

1. **Comment**: Commenter (20) prefers the list of Prohibitions and Emergency Interventions to be nearer the

beginning of the document as in current regulations.

**Response**: The Department thanks the Commenter for this comment. The Department has reorganized these regulations to address other comments but did not move the list of Prohibitions and Emergency Interventions to the beginning of the regulation but did copy the Prohibited Practices grid into Appendix Five to these regulations..

1. **Comment**: Commenter (13) asks the Department to develop a “family friendly” version of the final rule.

**Response**: The Department thanks the Commenter for this comment. Given the complex nature of these regulations, a “family friendly” version is not easily accomplished. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13)states that the proposed Behavior Regulations appear to describe each level of intervention in four separate places with each segment having a slightly different focus. As it reads, §5.03 gives a short description of each intervention level; §5.04 and §5.05 give a more detailed description of each intervention level; §5.06 gives another short description of each intervention level with examples in a table format; and §5.08 restates the documentary requirements for each intervention level. Re-describing each intervention level four separate times without using the exact same language allows for ambiguity and inconsistency. Furthermore, having to look in four separate places to gather information about a single intervention level makes it difficult to be assured that you have met each requirement.

**Response**: The Department thanks the Commenter for this comment. The Department has reviewed and edited the proposed regulation to address the comments above. The table in §5.06 has been broken up into the separate Levels 1-5. Each separate table has been moved into other sections of the proposed regulation that discuss that particular Level. Other sections of the proposed regulation have been made into Appendices.

1. **Comment**: Commenters (3, 6) suggests that the rule is contradictory.

**Response**: The Department thanks the Commenters for these comments. Based on this, and other comments the Department has reviewed and edited the proposed regulation to remove apparent contradictory language.

1. **Comment**: Commenters (7, 10 & 15) request that the current regulations remain in effect. In the alternative, the Commenter asks that the new regulations be made clear, efficient, and less bureaucratically complex. The Commenter also requests that the changes not be made effective while other changes are taking place.

Commenter (15) states that the proposed regulation will create a bureaucratic quagmire of documentation, reviews and assessments that are not funded, tax the service delivery of professionals in short supply, create confusion about implementing the new rules, and severely inhibit our ability to provide services to individuals with intellectual disabilities, autism, and behavioral challenges. Commenter (15) is against the proposed rule change, as written, in favor of a more measured and collaboratively developed approach that would be phased in, with training and education, and funds the expense of the services and addresses the lack of qualified professionals available to perform the proposed additional services.

**Response**: The Department thanks the Commenters for these comments. The Department and interested stakeholders have been discussing and working on changing Chapter 5 for several years. Further delay is not in the best interest of the persons with intellectual disabilities or autism in need of behavior interventions. The current regulation was created in 1987 and has not been substantively amended since 2010. Laws have changed and clinical practices have evolved. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (8) suggests that the document be reviewed for consistency regarding terminology (consistency with usage of words and definitions throughout) and to increase overall readability.

**Response**: The Department thanks the Commenter for this comment. The Department made several changes to the final rule as a result of these comments.

1. **Comment**: Commenters (11& 23) had concerns that the proposed regulation was not thoroughly reviewed and that typing mistakes may have unintended consequences in interpretation. One Commenter was concerned with the use of capitalizing versus not capitalizing specific words can change the dynamic of a sentence and could lead to misunderstandings. This Commenter was also concerned with the creation of capitalized terms that were not defined (i.e. "Positive Behavior Modification Techniques") or were defined by not used elsewhere ("Noxious"). The Commenter was concerned that the typos and grammatical errors within the regulations undermine the gravity of its tone. The Commenter recommends that the Department consider restructuring these regulations to increase readability and review this document to ensure that terminology that is used is the terminology which is intended. One Commenter suggested the Department consider eliminating the capitalization throughout the text of most of these terms (i.e. person, planning team, and guardian) and reserve capitalization to indicate terms that truly need definition.

**Response**: The Department thanks the Commenters for these comments. In response to this and similar comments the Department made numerous technical corrections in this rule, including changes in grammar, capitalization, punctuation and consistency of the format when using numbers in the text of the policy.

1. **Comment**: Commenter (10) pointed out the page numbering on pages 41-44 were inaccurate.

**Response**: The Department thanks the Commenter for this comment. The Department fixed all page numbers in the final regulation.

1. **Comment:** Commenter (8) suggested that someone go through and be very clear that the words being used reflect the words that we use to describe things in practice as well as agree with things in other parts of the document.

**Response:** The Department thanks the Commenter for this comment. In response to this and similar comments the Department made numerous technical corrections in this rule, including changes in grammar, capitalization, punctuation and consistency of the format when using numbers in the text of the policy.

1. **Comment:** Commenters (22 & 23) suggests it is not clear why the State states in §5.01-2 that “it is not the Department’s intention to promote behavior modification” but states in §5.02-6 that “behavior modifications must be included in the positive support plan”. Commenter (23) agrees the positive behavioral supports plan be the first approach we are concerned with the lack of consistency within the proposed regulations.

**Response:** The Department thanks the Commenters for these comments. The Department does not view these statements as contradictory. The Department does not seek to promote behavior modification that impinges on a person’s rights; however the Department recognizes that some persons with intellectual disabilities or autism experience behaviors that necessitate interventions that impinge on these rights. Because of this fact, regulations to guide, protect, and balance the rights, safety, health and welfare of these persons are vital. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (22) feels the entire Section involving Safety Devices appears to be written by a different group of people then the rest of the text. It includes, for example, information about including a mailing address and a fax number to which the approval can be sent and indicates that the review team “shall make a determination of approval or disapproval within 30 calendar days of receipt of the request. Neither of which are included in the previous section of Behavior Management and Plan of Approval with the review team. This lack of consistency leaves the reader confused and with unanswered questions.

**Response:** The Department thanks the Commenter for this comment. The Department recognizes the need for more consistency throughout these regulations. In response to this and similar comments the Department made numerous technical corrections in this rule, including changes in grammar, capitalization, punctuation and consistency of the format and language in these regulations.

1. **Comment:** Commenter (31) talked a lot about the needs of his son and that the overcomplicating of the rules is going to have a negative impact on his son.

**Response**: The Department thanks the Commenter for this comment. The Department appreciates the Commenters interest and concern for his son. These regulations requires Planning Teams ensure that all possible less intrusive options have been explored and that through the use of Functional Assessments and Positive Supports a Person is able to increase his/her skill building and Pro-Social Behavior thus mitigating the need for more intrusive and costly interventions. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) states that there are less restrictive interventions than for example, having a person present to redirect on site. Commenter (19) asks if this is possible if approved by the assigned teams. Commenter (19) asks whether it would make sense to reduce the caseload/work of case managers and allow them to have more of a relationship and oversight role in individual client’s life, with the expectation of oversight of the medication use, day to day planning/lives of our loved ones as opposed to requiring more meetings and plans. Commenter (19) states this these regulations is creating an entire system of plan writing, oversight, monitoring when we already have critical people in place to evaluate outcomes of services, which will likely not improve the care of and outcome for my loved one.

**Response**: The Department thanks the Commenter for this comment. When Case Managers are more involved with the Person they serve the outcome of services improves. Case Managers’ responsibility to ensure appropriate level of services and supports exists in the current regulations. State law limits caseloads to an average not to exceed 35-1. Qualified adult community case management agencies have the responsibility to assign lower caseloads to ensure appropriate level of service. The Department strives to maintain and overall ratio of 25-1. The Department made no changes to the final rule as a result of these comments.

**Applicability**

1. **Comment**: Commenter (5) suggests that 14-197 CMR Ch. 5 does not apply and has never been applied to acute care hospitals licensed in the State of Maine

**Response**: The Department thanks the Commenter for this comment. The Department agrees that this rule does not apply to acute care hospitals licensed in the State of Maine. The Department amended the regulation to clarify this point. The word “hospitals” was added to the 2nd paragraph of the Applicability section of these regulations. The amended sentence now reads:

“These regulations do not apply within hospitals, schools or correctional settings …”

1. **Comment**: Commenter (19) asked why hospitals and correctional institutions are excluded when the more institutional settings in Maine have historically created a higher risk for misuse of behavioral strategies.

**Response**: The Department thanks the Commenter for this comment. In response to another comment, the Department has amended these regulations to specifically exclude acute hospitals as stated in 34-B M.R.S. §5605(13). Hospitals and correctional institutions are excluded from these regulations because they are regulated under other state and federal laws. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (3) asks how the Department plans to insure that the rule is applied consistently across the State.

**Response**: The Department thanks the Commenter for this comment. The Department will provide trainings for staff, Service Providers, and other stakeholder on the proposed regulations. The involvement of the Person, his/her Guardian, Service Providers, the Case Manager, members of the Planning Team and the Review Team in the development and implementation of interventions provides strong oversight of how the rule is applied. The Reportable Events and adult protective services systems provide an added level of oversight on how the rule is applied throughout the state. The Statewide Review Team will also provide a feedback mechanism to ensure consistency in application. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (14) asked how the regulations are going to be enforced.

**Response**: The Department thanks the Commenter for this comment. The Department will provide trainings for staff, Service Providers, and other stakeholder on the proposed regulations. The involvement of the Person, his/her Guardian, Service Providers, the Case Manager, members of the Planning Team and the Review Team in the development and implementation of interventions provides strong oversight of how the rule is applied and a mechanism to ensure the regulation is enforced. The Reportable Events and adult protective services systems provide an added level of oversight on how the rule is applied throughout the state. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (14) is concerned about what happens when agencies do not file reportable events and

suggests that there are many rights restrictions and violations likely occur than DHHS and/or the Protection and Advocacy Agency are no aware of.

**Response**: The Department thanks the Commenter for this comment. The Department agrees that failure to file a Reportable Event is a serious concern. The Department encourages anyone who is aware that a Reportable Event is required but has not been filed to contact Adult Protective Services. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (3, 9, 13 & 19) asked about the scope of applicability of the regulation. Commenter (3) asked whether plans are expected for individuals residing with family members, and those individuals receiving non-institutional service (i.e. Section 65, Section 29). Commenter (9) asked whether everyone on the Section 21 Waiver would require a plan of some sort, whether a positive support plan or a behavior management plan. Commenter (13) asked whether Level 1 and 2 plans are expected for all persons served. Commenter (19) asked whether it is the intention of the Department to implement them across all services that receive DHHS funds---for example, outpatient, intermittent staffing, SLO, private practitioners.

**Response**: The Department thanks the Commenters for these comments. When individuals with intellectual disabilities or autism are receiving services through the Department, such as under MaineCare Benefits Manual Sections 21, 29, and 65, and the individual is experiencing Challenging Behaviors, then the regulation applies. When the regulation applies, it applies to Service Providers who are funded under these programs. When the person is experiencing Challenging Behaviors they will need a Positive Support Plan and Functional Assessment and may require a Behavior Management Plan. Family members or others who care for Persons but are not paid, do not need to meet the requirements of these regulations. That does not mean unpaid care givers are allowed to restrict a Person’s rights given to them by Maine and federal law. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13) asked if the rule becomes effective the first time a restraint is used regardless of the circumstances or when there are three restraints in a two week period

**Response**: The Department thanks the Commenter for this comment. Restraints are allowed pursuant to a Behavior Management Plan or in emergency situations. All Emergency restraints must be reported as a reportable event. More than three (3) Emergency restraints within a 2 week period is a Reoccurring Pattern under these regulations and results in the need for an IST. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13)asked how the Department will identify clients in need of Functional Assessments and Positive Support Plans when the vast majority of clients currently receiving services will fall into this category.

**Response**: The Department thanks the Commenter for this comment. Service Providers, Case Managers, clinicians, the individual, and others may identify individuals who require these types of assessment or plans. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13)asked why clients with Challenging Behaviors receive a Functional Assessment and Positive Support Plan and not all clients receiving Section 21 and 29 services receive these when the goals delineated should apply to all clients served irrespective of behavioral issues.

**Response**: The Department thanks the Commenter for this comment. Nothing in these regulations prevents caregivers or others from developing Functional Assessments or Positive Support Plans for individuals with intellectual disabilities and autism who are not experiencing Challenging Behaviors. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13) states that every Community Support and Residential Support program in Maine includes “Communication Support”, “Teaching Skills”, and “Physical & mental health assessments and treatment” even if the client does not face challenging behaviors. Commenter (13) asks if this means that clients with challenging behaviors are subject to a greater level of services and assessments than their peers that do not exhibit “Challenging Behaviors” or, does that mean that any client receiving Section 21 and 29 supports who receives the “restrictions” below must now have a Functional Assessment and Positive Support Plan.

**Response**: The Department thanks the Commenter for this comment. The Commenter is correct that Persons experiencing Challenging Behaviors do require a greater level of assessment. It is the intent of these regulations that the greater level of assessment will result in Positive Supports being utilized that increase the Person’s skill building ability and Pro Social Behavior while mitigating the need to move toward more intrusive interventions. The Department made several changes to the final rule to clarify the Department’s intent.

1. **Comment**: Commenters (3 &10) ask how the SIS system and policy relate to these regulations

**Response**: The Department thanks the Commenters for these comments. The SIS system and policy is not related to these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (3 &10) ask how the SIS Levels correspond to the Levels in these regulations.

**Response**: The Department thanks the Commenters for these comments. There is no relationship between the Levels in these regulations and SIS levels. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (6) states that parents, guardians and family members are currently struggling to understand the SIS and how it will impact their loved ones, without another level of bureaucracy to navigate and comprehend

**Response**: The Department thanks the Commenter for this comment. The Department appreciates that changes are stressful. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13) asked whether the functional assessment is the SIS.

**Response**: The Department thanks the Commenter for this comment. The functional assessment is not the SIS. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (3) suggests that “Challenging Behaviors”, as currently written, is defined very broadly so would seem to include any person with IDD who is on psychotropic medication or any treatment intended to modify behaviors. Commenter (3) asks whether it is the intention of the Department to manage all psychotropic medications for “behaviors” and all mental health treatment intended to modify.

**Response**: The Department thanks the Commenter for this comment. It is not the Department intention to manage the use of psychotropic medications for the treatment of behaviors that are caused by mental health diagnosis. It is the Department’s intent to monitor psychotropic medications when used to modify or manage Challenging Behaviors. In response to this comment, the Department amended §5.04-3 and added language to §5.01-2 of these regulations.

1. **Comment**: Commenter (12) had a question regarding an apparent discrepancy with the proposed regulations and lack of alignment with the Statute 34-B M.R.S. §5605. Commenter (12) argued that the levels were in direct conflict with §5605. Commenter (12) reads §5605 to indicate that ANY behavior modification or behavior management program to eliminate dangerous or maladaptive behavior must be approved by the Review Team. Commenter (12) points out that Levels 1 and 2, under the proposed regulations out do not require Review Team approval. Commenter (12) asserts that because statute legally supersedes regulations then all plans would need Review Team approval if a client with intellectual disabilities and/or autism were receiving DHHS funded services. Commenter (12) wondered if that isn’t the intent of the Department and the level system was a way to ensure best practice and outline a process to assure the least restrictive and harmful interventions were being implemented as a first response. Commenter (12) asked, if this is in fact the intent, wouldn’t the Department first have to pursue modifying the 34-B M.R.S. §5605 and then move forward with passing the Behavioral Regulations as written.

**Response**: The Department thanks the Commenter for this comment. In these regulations, Levels 1 & 2 are limited to non-coercive interventions with the voluntary participation of the Person. Under these conditions Review Team approval is not required under the statute. The Department made no changes to the final rule as a result of these comments.

1. **Comment**:Commenter (12) asked about the collaboration between OADS and OCFS regarding persons with Intellectual Disabilities or Autism who are 18-21 years of age and receiving services under an OCFS program in children’s residential PNMI funded programs. Commenter (12) reads the proposed regulation to apply to those adults. Commenter (12) asks whether there has there been an analysis of how many young adults this would include. Commenter (12) asks whether the Review Teams would include representation from OCFS and OADS. Commenter (12) asked whether the Protection and Advocacy Agency has resources and funding to sit on teams for these children’s programs not funded by OADS. Commenter (12) also asked about 18-21 year olds who residential PNMIs for children out-of-state that are funded by OCFS. Commenter (12) reads the regulations as applying to these adults. Commenter (12) asked if there are resources for Review Teams for these individuals to travel out-of-state. Commenter (12) asks how OADS and OCFS will collaborate on these clients. Commenter (12) also asked how providers are supposed to comply with these regulations. Commenter (12) asks how OADS and OCFS will collaborate on these clients.

**Response**: The Department thanks the Commenter for this comment. The Commenter is correct that these regulations apply to all persons with intellectual disabilities or autism 18 years of age or older regardless of which MaineCare program funds the services they receive. OADS and OCFS staff will work together and with the Service Provider communities to ensure appropriate level of training is available. These regulations do not apply to out-of-state placements as these are beyond the scope of the State’s legal authority. The Department made no changes to the final rule as a result of these comments.

1. **Comment**:Commenter (12) asks whether there has been an analysis of the impact of the level of review on the 65 HCT clients. Commenter (12) assumes that these clients fall under the proposed regulations. Commenter (12) also asked whether the Protection and Advocacy Agency has resources and funding to serve on Review Teams for these additional clients.

**Response**: The Department thanks the Commenter for this comment. The Department has not done an analysis on the impact on adults with intellectual disabilities or autism who are receiving service under the MaineCare Benefits Manual, Chapter II, Section 65. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (8) suggests that OADS coordinate these regulations with children’s services or education services around behavioral support and intervention particularly for those in the transition years.

**Response**: The Department thanks the Commenter for this comment. OADS and OCFS are coordinating on the implementation of these regulations for adults with intellectual disabilities or autism 18 years of age or older. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (14) was confused with two portions of the regulation. Commenter (14) states that §5.06 Levels of Intervention, a Level 2 intervention includes "restriction on food or liquid with doctor's health or safety recommendations", but in the Applicability (title page) section the regulation it states that these regulations do not apply to "medical practice for the treatment of a medical condition". Commenter (14) included an example to show the confusion: a Person has an order for a diabetic and cardiac diet, has had two heart attacks in the past year and has sugar levels over 400 if medications or diet aren’t followed. In this example food would need to be secured, meals would be portioned by staff and the person would be expected to take the medications. Commenter (14) states that in this example this would be deemed a severely intrusive plan under the current regulation but would fall under Level 2 in the proposed regulation. Commenter (14) asked for clarity.

**Response**: The Department thanks the Commenter for this comment. The Department acknowledges the complexity of the example given. So long as a restriction of food or liquid is necessary to address a medical condition, is pursuant to a doctor’s orders, and the limitation does not restrict a Person’s right to “nutritious food in adequate quantities”, these regulations do not apply. When a restriction of food or liquid is to address a Challenging Behavior, and the Person voluntarily participates it is a Level 2 Intervention. If the Person does not voluntarily participate with the restriction to address a Challenging Behavior, this would be a Level 3 intervention. In response to this comment, the Department amended the Level 3 grid in §5.03-2 and Appendix Three.

1. **Comment**: Commenter (17) finds it interesting in that in the “Applicability” preamble it says these regulations do not apply to medication, when the use of medication “is not intended primarily for Behavior Modification or Management”. What then is the medication intended for? It’s common knowledge that psychiatric medications address symptoms (read, “behavior”) symptomatically. When the regulations get into medical practice they contradict themselves.

**Response**: The Department thanks the Commenter for this comment. The Department does not agree there is a contradiction as described in this comment. Persons with medical or mental health conditions that require psychiatric medication may be prescribed to address the Challenging Behavior. The difference is that a medical or mental health professional has determined that the Challenging Behavior is the result of a medical or mental health condition. The Department made no changes to the final rule as a result of these comments

**qualifications / TRAINING**

1. **Comment**: Commenters (2, 3, 9, 10, 27 & 31) question whether the Review Team members and others involved in the process have the right credentials to review and assess medications, assessments, or behavior management. Commenter (9) questions if the expertise outlined to oversee the plans makes sense and is appropriate in certain situations. Commenter (10) asked that the expertise of the voting members of the Review Team be spelled out.

**Response**: The Department thanks the Commenters for these comments. The purpose of the Review Team and the Statewide Review Panel is not to provide clinical oversight of plans written by licensed professionals. The Review Team’s purpose is to ensure that the appropriate assessments have been completed by the appropriate professionals; plans have been written that address the needs of the Person; and the plans with behavior management interventions comply with these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (3, 12 & 27) asked how the Department plans to insure that people with clinical expertise are providing the review of plans that are written by licensed professionals. Commenter (12) asked that the Review Team and Statewide Review Panel membership be expanded to include a qualified credentialed or licensed professional

**Response**: The Department thanks the Commenter for this comment. The purpose of the Review Team and the Statewide Review Panel is not to provide clinical oversight of plans written by licensed professionals. The Review Team’s purpose is to ensure that the appropriate assessments have been completed by the appropriate professionals; plans have been written that address the needs of the Person; and the plans with behavior management interventions comply with these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (2) asks whether a person with a BCBA will be on the Review Team.

**Response**: The Department thanks the Commenter for this comment. There is no requirement for a person with a BCBA to be a member of the Review Team The purpose of the Review Team is not to provide clinical oversight of plans written by licensed professionals. The Review Team’s purpose is to ensure that the appropriate assessments have been completed by the appropriate professionals; plans have been written that address the needs of the Person; and the plans with behavior management interventions comply with these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (21) hopes that there will be extensive and comprehensive training available on these behavior regulations, once approved, for all stakeholders by person(s) who are well versed in the changes.

**Response**: The Department thanks the Commenter for this comment. The Department will be providing comprehensive training to all stakeholders immediately following the effective date of these regulations.The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (10) wonders if there is enough qualified workforce to carry out the necessary requirements spelled out in the new rule.

**Response**: The Department thanks the Commenter for this comment. The Department does not have the expertise to determine whether there is adequate workforce of the numerous professionals and persons that provide services to the persons with intellectual disabilities or autism. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (12) asked how the Planning Team will receive training to write Positive Behavioral Support Plans.

**Response**: The Department thanks the Commenter for this comment. The Department will be providing comprehensive training regarding these regulations to all stakeholders immediately following the effective date of these regulations. Service Providers are responsible to ensure their staff are appropriately trained. The Department will continue to assess training needs surrounding these regulations and will work to enhance the trainings offered. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) asks how the Department will insure all settings expected to adhere to these receive the adequate training/support on an annual basis to insure consistency across the state.

**Response**: The Department thanks the Commenter for this comment. The Department will be providing comprehensive training regarding these regulations to all stakeholders immediately following the effective date of these regulations. Service Providers are responsible to assure their staff are appropriately trained. In addition, the Planning Team and Review Team will be able to identify when training is necessary. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (13) asked if the Department has identified the appropriate training for Case Managers to successfully accomplish the requirements involved in requesting plans, ensuring they are followed, reviewing plans as required and coordinating plans among separate service providers

**Response**: The Department thanks the Commenter for this comment. The Department has developed trainings for Case Managers and Service Providers. The trainings will be provided across the State once these regulations become effective. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13) asked who will provide the training requirement that Direct Support Professional (DSP) be trained in accordance with the Behavior Management Plan.

**Response**: The Department thanks the Commenter for this comment. The professional who writes the Behavior Management Plan will identify the appropriate trainer. The Department made no changes to the final rule as a result of these comments.

**GENERAL COMMENTS**

1. **Comment**: Commenters (2, 9, 10 & 12) questioned whether the Department and/or its staff of case managers have the capability to oversee all the plans. Commenters felt the burden was significant in terms of time and administration, and they questioned the capacity of case managers to take this on, particularly in light of increased administrative tasks regarding the SIS, new coding, new waiver proposal, and new transition plan. Commenter (12) asked if additional resources have been allocated to Case Management for lower caseloads if they are now going to be the lead in creating plans, as opposed to Service Provider agencies. Commenter (12) asked if the Department has done an analysis on the impact on resource needs.

**Response**: The Department thanks the Commenters for these comments. The Department anticipates a temporary increase in work load while current plans are brought into compliance with the new requirements of these regulations. The Transition of Existing Plans section of these regulations is designed to minimize this temporary effect. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (12) asked if changes are needed and the Case Manager isn’t responding to phone calls, how does the Department expect the agency to proceed.

**Response**: The Department thanks the Commenter for this comment. Case Managers are required to be responsive to the needs of the Person they serve. Any agencies who experience difficulties with the Case Manager assigned to their clients should contact the Department for assistance in resolving this issue. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (2, 3, 12 & 19) question the interplay between these regulations and the rights and responsibilities of guardians under Maine’s Probate Code. Commenter (19) questioned whether the Department intends to interfere with private situations in which teams, Service Providers and the Probate Court are monitoring/overseeing programming and supports. The Commenters ask how the Probate Court will be included in this process so that is clear to family and Service Providers; and what safeguards will ensure that decisions are in the best interest of the client and family, with regard to programming, limits and reinforcement plans

**Response**: The Department thanks the Commenters for these comments. These regulations do not apply to all persons under Guardianship. Only Persons who “receive services [other than case management services] that are provided, licensed, or funded in whole or in part, directly or through a contractor, by the Department.” These regulations are not intended to interfere with the authority of the Maine Probate Court. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (3 & 19) asked how the Probate Court will be included in this process so that is clear to family and Service Providers.

**Response**: The Department thanks the Commenters for these comments. The Department does not intend these regulations to interfere with the authority of the Probate Court. At this time the Department is not aware of any Probate Court finding a conflict between its authority and the statutes governing these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) states that Review Teams are needed but these regulations continue a policy of state and federal appointees, whose authority supersedes guardians. The review team members are answerable to no one, have unlimited terms, and do not have to have any credentials around treatment or diagnosis.

**Response**: The Department thanks the Commenter for this comment. The existing regulation, 14-197 CMR Chapter 8, Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism, provides a process by which individuals with intellectual disabilities or autism who receives services from the Department may enforce their rights or grieve any action or inaction of the Department. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (3) asks what will be the safeguards so that decisions are in the best interest of the client and family, with regard to programming, limits and reinforcement plans. The Commenter asked how the Department plans to insure that decisions are made on an individual basis and if they are the least restrictive options, the plan to make them available to the individual and family.

**Response**: The Department thanks the Commenter for this comment. The Planning and Review Team process is designed to insure that decisions are made on an individual basis. Both teams include the Person, his/her guardian. Other members include the Protection and Advocacy Agency, providers, and correspondents. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (15) states that the role of the guardian is undermined in favor of elevating self-

determinism among individuals who have been deemed incompetent by the courts.

**Response**: The Department thanks the Commenter for this comment. The Department does not intend these regulations to undermine the role of the guardian. These regulations are based on the rights and restrictions created in Maine statute regarding persons with intellectual disabilities or autism. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (3) asks how the Department intends to resolve disagreements between the Review Team and the private guardian, or person’s team.

**Response**: The Department thanks the Commenter for this comment. The Department understands there may be times when a guardian disagrees with the Review Teams decisions or vice versa. The Department relies on the professionalism of the Review Team members to successfully resolve disagreements. Reference to these regulations when questions arise is suggested. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) states that some of these regulations will come into conflict with individual/family practices and beliefs. Commenter (19) asked what mechanism will be in place to resolve such disagreements so the individual is best served.

**Response**: The Department thanks the Commenter for this comment. These regulations are based on the rights and restrictions created in Maine statute regarding persons with intellectual disabilities or autism. The intent of these regulations is to ensure that Service Providers provide supports and interventions in the least restrictive manner possible to protect the rights, health and safety of persons with intellectual disabilities or autism. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (3) states that in the proposed regulations there is more focus on rights and avoiding past historical mistakes, often occurring in institutional settings, than on evidenced-based interventions and supports that could offer hope and opportunity to our individuals and families.

**Response**: The Department thanks the Commenter for this comment. Without more specific information from this commenter the Department is not able to provide a meaningful response. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (22) is concerned with the State’s plan to replace the current regulations in their entirety. Commenter (22) agrees the current regulations may require updating but does not think it is clear why a sweeping change is being proposed. Commenter (22) states that the justification for a complete re-write is unclear, the purpose of a complete re-write is unclear, and those who were invited to participate in this substantive rule change are unclear. Commenter (22) states while several points for consideration have been described above, in summary we are very concerned with the unclear justification for why the State is proposing a complete repeal of the current behavior regulations. Given the inconsistencies and confusing format, it is unclear what the expectations are for implementing these regulations. Finally, we would like to ask who was invited to participate in the process of developing these proposed regulations and who will do so going forward given the forthcoming comments and hearings and the subsequent need for adjustments to these regulations.

**Response**: The Department thanks the Commenter for this comment. The Department and interested stakeholders have been discussing and working on changing Chapter 5 for several years. The current regulation was created in 1987 and has not been substantively amended since 2010. Laws have changed and clinical practices have evolved. Stakeholders who participated in the drafting of these regulations have a wide variety of backgrounds and experience, including but not limited to: individuals receiving services, Service Provider agencies, clinical professional, DHHS staff, advocates, representatives of the Developmental Disabilities Council, members of Maine Oversight and Advisory Board, the Department of Corrections, Speak Up For Us, Muskie, parents, guardians and family members. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (9, 13 & 14) ask whether the EIS has the capacity for the increase in documentation required under this proposed regulation. Commenter (13) asked whether the documentation would be available for “anyone who might need to understand the plan for the Person. Commenter (14) states that in EIS home providers are limited to 4000 characters so all we can do is make reference to behavior and safety plans being on file in the homes. If they store plans in EIS we, as well as other providers, do not see them. OHI has maintained our annual Person Centered Plan which already contains approximately 90% of what the new regulations require. I suspect agencies that rely only on EIS are going to have a lot of work to gain compliance with the new regulations.

**Response**: The Department thanks the Commenters for these comments. There is no current requirement to enter the Behavior Management plan directly into EIS. Therefore the Department does not anticipate problems with the EIS system. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (9) fears the level of complexity, confusion, and potentially inappropriate uses of authority will lead to gaps, lapses, inconsistencies and ineffective behavioral supports for this population.

**Response**: The Department thanks the Commenter for this comment. As with the current regulations, the involvement of the Planning Team, the Review Team, and when necessary, Commissioner level review and approval, minimizes the occurrences this commenter’s fears. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (4) wrote that overall, there is an obvious need for further personnel to carry out these regulations without delays in making plans and reports timely and appropriate. That includes both in the area of oversight and implementation. Communication and interpretation is vital, and each case will vary as each Plan should reflect, or be suspect. Consistency of interpretation is important for clarity, but flexibility in planning options is a necessity. Clear documentation of timelines and flow in the review and approval process is necessary as well as open minds for unusual ideas. And finding a way to eliminate it if found unhealthy should only be done through communication between those who know him, experts in the field and the Person him/herself. The one thing we need to avoid is ingraining negative behaviors or situations because of doubting the reporters without analyzing the problem or simply delaying action until the behavior or situation becomes thoroughly entrenched goes into remission for some reason. In many situations it will not have gone away and may be more serious when it reappears and more difficult to treat.

**Response**: The Department thanks the Commenter for this comment. The Department will be providing comprehensive training regarding these regulations to all stakeholders immediately following the effective date of these regulations. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.0168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to increase significantly based on these regulations. The requirements for a Functional Assessment and Positive Support Plan is similar to the requirements for the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. (See MBM, Chapter II Sections 21.04-2 & 29.04-2). The documentation under these regulations for the Functional Assessment and Positive Support Plan is appropriate and necessary to ensure least restrictive level of support need. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (13, 17 & 19) noted that the regulation does not contain a section describing the right of appeal or grievance for the individuals whose currently approved plans become non-approved. Commenter (13) asked where these individuals might file a grievance.

**Response**: The Department thanks the Commenter for this comment. The existing regulation, 14-197 CMR Chapter 8, Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism, provides a process by which individuals with intellectual disabilities or autism who receives services from the Department may enforce their rights or grieve any action or inaction of the Department. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (12) asks the Department to take a step back and consider the unintended impact created by these regulations.

**Response**: The Department thanks the Commenter for this comment. The Department and interested stakeholders have been discussing and working on changing Chapter 5 for several years. The current regulation was created in 1987 and has not been substantively amended since 2010. Laws have changed and clinical practices have evolved. Stakeholders who participated in the drafting of these regulations have a wide variety of backgrounds and experience, including but not limited to: individuals receiving services, Service Provider agencies, clinical professional, DHHS staff, advocates, representatives of the Developmental Disabilities Council, members of Maine Oversight and Advisory Board, the Department of Corrections, Speak Up For Us, Muskie, parents, guardians and family members. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (13, 17 & 22) state that this proposal greatly increases the administrative burden for agencies to achieve the necessary assessments and provide the required documentation. Commenters (17 & 22) views this as an unfunded mandate

**Response**: The Department thanks the Commenters for these comments. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.0168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to increase significantly based on these regulations. The requirements for a Functional Assessment and Positive Support Plan is similar to the requirements for the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. (See MBM, Chapter II Sections 21.04-2 & 29.04-2). The documentation under these regulations for the Functional Assessment and Positive Support Plan is appropriate and necessary to ensure least restrictive level of support need. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (32) is concerned for his son and the impact the members of the Review Committee have on deciding what is best for his son. The current intervention used to protect the health and safety of Commenter’s son will be a prohibited practice leaving the son exposed to severe physical harm.

**Response**: The Department thanks the Commenter for this comment. In response to these and similar comments the Department moved “binding of wrists to waist or wrist to bed” out of Prohibited Practices and into Level 5.

1. **Comment:** Commenter (27) believes these rules are way out of balance in protecting and defending the rights and interfering with appropriate treatment.

**Response**: The Department thanks the Commenter for this comment. These regulations are based on the rights and restrictions created in Maine statute regarding persons with intellectual disabilities or autism. The intent of these regulations is to ensure that Service Providers provide supports and interventions in the least restrictive manner possible to protect the rights, health and safety of persons with intellectual disabilities or autism. The Department made no changes to the final rule in response to these comments.

1. **Comment**: Commenter (15) states that the rule places excessive burden on a system dependent on the scarce resources of clinicians qualified in the behavioral health of individuals with intellectual disabilities and autism.

**Response**: The Department thanks the Commenter for this comment. The Department shares this commenter’s concerns about the availability and access to qualified professionals. The Department continuously seeks to identify and secure these resources throughout the State. The Department does not view these regulations as significantly increasing the responsibilities required under current regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (15) stated that under these regulations many current approved systems of restraint, in

particular most MANDT physical restraints, will be prohibited, endangering the individual, other clients and the supporting care giver.

**Response**: The Department thanks the Commenter for this comment. The Department disagrees with the commenter’s assessment that these regulations prohibit most MANDT physical restraints. In response to this and similar public comments the Department

1. **Comment**: Commenter (15) expressed grave concerns about the impact of the replacement of current rule with these regulations. Commenter (15) states that the changes are sweeping and costly and will have severe unintended consequences to the Commenter.

**Response**: The Department thanks the Commenter for this comment. The Department does not agree with this Commenter’s statement that these regulations contain sweeping and costly changes. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.0168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to increase significantly based on these regulations. The requirements for a Functional Assessment and Positive Support Plan is similar to the requirements for the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. (See MBM, Chapter II Sections 21.04-2 & 29.04-2). The documentation under these regulations for the Functional Assessment and Positive Support Plan is appropriate and necessary to ensure least restrictive level of support need. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (15) believes these regulations will greatly increase the number of clients for whom additional services would be required, which is in contrast to the relatively small numbers under the current regulations.

**Response**: The Department thanks the Commenter for this comment. When individuals are experiencing challenging behaviors Planning Team must work to create least restrictive strategies and do so through ensuring clear documentation. Positive supports are required in the current regulations and functional assessments will ensure a better understanding of the issues related to the Person and their challenging behaviors that will create the appropriate level of supports to meet the needs of the individual. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.0168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to increase significantly based on these regulations. The requirements for a Functional Assessment and Positive Support Plan is similar to the requirements for the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. (See MBM, Chapter II Sections 21.04-2 & 29.04-2). The documentation under these regulations for the Functional Assessment and Positive Support Plan is appropriate and necessary to ensure least restrictive level of support need. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) commented that one of the greatest, among great, flaws of these regulations is that they continue and expand governmental control of the lives of handicapped Maine citizens. The “review team” is composed solely of state and federal appointees with no published criteria for familiarity with the ID/Autistic population, nor for any formal training in mental health, or with “behavior modification or management”. Commenter (17) stated that the authors are unknown, and the document is uncredited so it’s not possible to really know who the “committee” was which obviously took years to fabricate these rules. Commenter (17) stated that an informal survey of organizations this consultant has worked with for years, involved in the process of behavior interventions, were not included, nor even contacted with regard to making contributions to the process. Nearly all were unaware, coincidentally, that the regulations were being promulgated. The very people involved in the implementation were excluded from having any input.

**Response**: The Department thanks the Commenter for this comment. The Department and interested stakeholders have been discussing and working on changing Chapter 5 for several years. The current regulation was created in 1987 and has not been substantively amended since 2010. Laws have changed and clinical practices have evolved. Stakeholders who participated in the drafting of these regulations have a wide variety of backgrounds and experience, including but not limited to: individuals receiving services, Service Provider agencies, clinical professional, DHHS staff, advocates, representatives of the Developmental Disabilities Council, members of Maine Oversight and Advisory Board, the Department of Corrections, Speak Up For Us, Muskie, parents, guardians and family members. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) stated it is unclear who exactly will read and decide on comments. Commenter (17) states that it very likely will be the authors of the document. If so, this represents an autocratic self-serving process which will complete the goal of excluding dissenting input. Commenter (17) asked if this is coincidental.

**Response**: The Department thanks the Commenter for this comment. The Maine Administrative Procedures Act requires the agency proposing the rulemaking to prepare written responses to all written comments and public hearing testimony. The Department takes the public comment process seriously and has modified parts of these regulations based on this process. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) states it is especially noteworthy the inclusion of rules for psychiatrists and any physician or prescribing agent for behavior-influencing medications.

**Response**: The Department thanks the Commenter for this comment. During the drafting of these regulations, the Department consulted a psychiatrist in its employ. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) asked which, if any, psychiatrist was consulted in writing the rules affecting their practice.

**Response**: The Department thanks the Commenter for this comment. During the drafting of these regulations, the Department consulted a psychiatrist in its employ on these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) states that this set of rules which governs psychological interventions, remarkably excludes psychologists from having any input in the review of plans. Commenter (17) asked if any formal input has been solicited from the Maine Psychological Association or have they endorsed this document. Commenter (17) asks if any psychologist were a member of the group writing these regulations, did this person or person have any concerns/objections, or was this token inclusion designed for “window dressing”.Commenter (17) asked if any psychologists were consulted in the development of these regulations, is there any endorsement or approval.

**Response**: The Department thanks the Commenter for this comment. A psychologist was part of the drafting committee for these regulations who was a member of the Maine Psychological Association. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) states that in §5.03-2 the Planning Team is ordered to do the psychiatrist’s job, including confronting and quizzing the psychiatrist, and then running to the review teams for their “imprimatur”.

**Response**: The Department thanks the Commenter for this comment. The Planning Team’s role is not clinical in nature. The Planning Team should rely on those members with the expertise in the particular areas addressed in the Positive Behavioral Support Plan or Behavior Management Plans. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) states that this rule strikes as gratuitous bullying. Commenter (17) asks who is going to pay for it. Commenter (17) states that making a requirement of twice a year viewing is largely a meaningless requirement. Commenter (17) states that MaineCare does not pay for travel. Commenter (17) states it would be easy for him/her as clinician to simply dictate to the managers to bring the Person to me. Commenter (17) states that this that would put me in the same position of review teams, simply making onerous demands on others.

**Response**: The Department thanks the Commenter for this comment. The Department assumes clinician’s providing care to Persons experiencing Challenging Behaviors monitor the progress of their patients/clients. This is a minimum requirement to ensure direct contact / consult with the individual is occurring. There is no requirement for the clinician to always meet the team at the agency providing services. The Department will continue to monitor and analyze the level of service required to meet these requirements. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) agrees that there should be an initial observation as this is often crucial to be able to observe during crises, when things have changed. Commenter (17) states that at such times a clinician needs to be there and observe, but is bound in by the DHHS Waiver payment scheme. Commenter (17) suggests building in at least 4 hours, but could be upwards, for the clinician to go and view the person “as needed”, per the clinician’s judgment as to when.

**Response**: The Department thanks the Commenter for this comment. The Department will continue to review the number of hours available under the Section 21 Waiver program for this service. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) states that it is a glaring, telling hypocrisy that the “qualified professional” must meet twice yearly while no member of the Review Team is required to “meet and observe” the Person ever. Commenter (17) suggests that all review team members see every person whose plan comes to them, before they make any judgment.

**Response**: The Department thanks the Commenter for this comment. Although not required, Review Team members have met with many Persons who have approved Behavior Management Plans. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (18) is very concerned about several changes to clinical practice that the regulations will impose upon consumers. The draft proposes to prohibit several clinical treatment procedures that are permissible under the current regulations and are currently in use on behalf of several persons. The judicious and well-supervised use of these procedures can reduce the frequency of much more coercive and dangerous procedures, such as physical restraint, hospitalization and incarceration. To deny individuals access to these clinical procedures denies them their rights to effective, less restrictive treatment. The specific treatments Commenter (18) thinks should be retained under the new regulations are: Overcorrection. Commenter (18) goes on to say that the term refers to a wide variety of techniques, several of which are inappropriate and should not be used such forms that are effortful, require physical guidance, or require coercion. Other forms of overcorrection, however, are commonly used to teach appropriate skills or are part of self-control procedures (habit reversal procedures, for example) and should be allowed. These types of overcorrection are not corporal punishment. Such procedures should be classified as Level 4 procedures to ensure adequate oversight.

**Response**: The Department thanks the Commenter for this comment. These regulations specifically prohibits overcorrection as that term is narrowly defined in §5.02-25. Other practices that do not fall within this specific definition will need to be evaluated to determine whether the practice falls within Levels 1-5. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) states that the change to allow Behavior Management Plans to be developed by licensed and knowledgeable practitioners is an improvement over current regulations and should make necessary plans better. Commenter (19) states that it is not clear who owns the plan or how issues of disagreement between needs in different settings will be resolved.

**Response**: The Department thanks the Commenter for this comment. In response to this and similar comments the Department has amended these regulations to clarify the role of the Planning Team in relation to the clinicians.

1. **Comment**: Commenter (31) made several comments on the particular problems faced by his son cause by long term medical problems.

**Response**: The Department thanks the Commenter for this comment. The Department appreciates the difficulties experienced by parents of persons with intellectual disabilities or autism who also experience chronic long term medical problems. The Department appreciates the Commenter’s interest and concern for his son. These regulations requires Planning Teams ensure that all possible less intrusive options have been explored and that through the use of Functional Assessments and Positive Supports a Person is able to increase his/her skill building and Pro-Social Behavior thus mitigating the need for more intrusive and costly interventions. The Department made no changes to the final rule as a result of these comments.

**5.01 STATEMENT OF PRINCIPLES AND INTENT**

***5.01-1 Principles***

1. **Comment**: Commenter (8) appreciates the stated commitment to principles of Social Role Valorization and encourages the Department to support that commitment through staff development.

**Response**: The Department thanks the Commenter for this comment. The Department will consider this suggestion. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (23) stated that this this section names three principles that are very similar in content, but does not elaborate on any of them. The Commenter suggests that, rather than naming these concepts (and relying on the reader to seek out external sources, read about, analyze, and apply each); the Department instead refers back to the first five bulleted points on page 4 of its 2013 Biennial Plan for Services to Adults with Intellectual Disability and Autism, Vision and Values. The Commenter felt that doing so would demonstrate an important connection between what the Department values, and the application of these values in practice, as well as eliminate any question in the reader's mind about the Department's intent.

**Response**: The Department thanks the Commenter for this comment. Because the Biennial Plan is designed to address the needs and create a vision and strategic plan for a broader population than those covered by these regulations, the Department prefers to keep the language and concepts of this section as proposed. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) states that the Principles as drafted adhere to the principle of Social Role Valorization, normalization and full inclusion (would be better defined as community inclusion) Commenter (20) suggest it is better stated with greater clarity and respect in the current regulations - "Individuals serviced by the Department are entitled to the same rights as every other Maine citizen, except as limited by reason of guardianship."

**Response**: The Department thanks the Commenter for this comment. The Department prefers to keep the language and concepts of this section as proposed. The Department made no changes to the final rule as a result of these comments.

***5.01-2 Intent***

1. **Comment**: Commenter (12) stated that one thing that doesn’t appear to be taken into consideration in the current or proposed regulations is addressing that persons’ being protected under these regulations can receive varying service levels. The level of need for checks and balances systems for outpatient therapy verses MaineCare Benefits Manual §21 agency home support should look differently. It appears these regulations have the same set of process and procedures for each level of care, yet the common themes seem to be addressing concerns around institutionalized settings.

**Response**: The Department thanks the Commenter for this comment. The Department is not entirely sure what the Commenter means by this comment so we are unable to provide a meaningful response. The

Department made no changes to the final rule as a result of these comments.

**5.02 DEFINITIONS**

1. **Comment:** Commenter (11) recommends including a definition of Supported Decision Making in the Behavior Regulations and including consideration of Supported Decision-Making as a Positive Support by adding the following new subsection:

§5.02-49-A Supported Decision-Making means a process of supporting and accommodating a Person to enable the Person to make life decisions without impeding self-determination.

**Response**: The Department thanks the Commenter for this comment. The Department believes amending these regulations to include reference to the still evolving concept of Supported Decision Making is premature. The Department made no changes to the final rule as a result of these comments.

***5.02-7 Blocking***

1. **Comment:** Commenter (17) states that Blocking, as defined in §5.02-7 is considered a restraint, an intrusive, abusive intervention, even if the “person” is assaulting staff and they are trying to ward off a blow. While protecting “persons” is purportedly the goal, this makes common sense endeavors by staff to protect themselves a restricted activity.

**Response**: The Department thanks the Commenter for this comment. It is not the Department’s intent to prevent the use of blocking. Under these regulations blocking is allowed as an emergency intervention if it is the least restrictive technique necessary to make the situation safe. However, planned use of blocking requires review and approval of a Behavior Management Plan. The Department made no changes to the final rule as a result of these comments.

***5.02-9 Challenging Behavior***

1. **Comment**: Commenter (12) states that §5.02-9 (C) is very general with the effect that anyone requiring a Department funded services would be exhibiting a “Challenging Behavior” and therefore, everyone would fall under the regulations.

**Response**: The Department thanks the Commenter for this comment. Not all persons with intellectual disabilities or autism experience Challenging Behaviors. In response to this and similar comments the Department added a new paragraph to the Intent section of these regulations.

1. **Comment:** Commenter (19) states that the definition of “Challenging Behaviors” in §5.02-09 is so broad that it encompasses nearly all behaviors, thereby requiring several layers of plans for most people. Commenter (19) stated that this “seriously interferes with a Person’s ability to have a positive life experiences and maintain relationships.”

**Response**: The Department thanks the Commenter for this comment. The intent of including subsection (C) is to ensure that support a planned, least restrictive response to behaviors that seriously interfere. The Department considers this best patriciate. In response to this and similar comments the Department added a new paragraph to the Intent section of these regulations.

1. **Comment:** Commenter (17) states that §5.02-10, “Challenging Behaviors” as with all of the attempts to usurp medical practice, is loosely defined and arbitrary so as to be confusing and unenforceable.

**Response**: The Department thanks the Commenter for this comment. In response to this and similar comments the Department added a new paragraph to the Intent section of these regulations.

***5.02-10 Chemical Restraint***

1. **Comment:** Commenter (14) states that the definition of “Chemical Restraint” in §5.02-10 is very subjective. Commenter (14) asked who determines whether a person is overmedicated or "chemically restrained"

**Response**: The Department thanks the Commenter for this comment. Under these regulations the determination of whether a person is overmedicated or “chemically restrained” will be made by professionals and those familiar with the person. One of the criterions used to make this determination is how the person performs on the medication in comparison to his/her usual performance when not on the medication. The Department made no changes to the final rule as a result of these comments.

***5.02-11 Coercion***

1. **Comment:** Commenter (17) stated that by including the “threat of diminishment of any right or privilege” in §5.02-11 definition of “Coercion” is a platform for misconstruing any statement, even in a planned intervention, by those motivated to find such.

**Response**: The Department thanks the Commenter for this comment. The Department is confident that process required by these regulations and the inclusion of professionals and others familiar with the Person will ensure the best result for the Person. The Department made no changes to the final rule as a result of these comments

***5.02-17 Functional Assessment***

1. **Comment**: Commenter (21) stated that the term “Functional Assessment”, defined in §5.02-17, is used throughout the document in a confusing manner. The definition states, “means an analysis of what may be contributing to a Person’s Challenging Behavior. Section 5.03-1(A) and §5.04-2(A) state that positive supports are the first approach to be used to assist someone with Challenging Behavior and the ‘planning team must conduct a functional assessment..” This statement indicates the team conducts the assessment. However, §5.04-2(D) adds that the functional assessment must be completed by or under the supervision of a person who has been designated by the Planning Team and who has training and experience in behavior analysis and Positive Supports. This statement leaves room for broad interpretation. Further confusion to what a functional assessment is, and who can complete it, is on page 14, §5.05 -1(B), second paragraph, that states the Updated Functional Assessment must be developed or updated under the supervision of a Psychiatrist, a Psychologist or Psychological Examiner, a Licensed Clinical Social Worker a , Licensed Clinical Professional Counselor, or a Board Certified Behavior Analyst.

**Response**: The Department thanks the Commenter for this comment. In response to this comment the Department amended §5.03-1(A) to clarify that the Planning Team ensures the Functional Assessment is developed. Functional Assessments for Levels 1 and 2 must be completed by a person identified by the Planning Team who has the training and experience in behavior analysis and Positive Supports. For Levels 3 – 5 the initial or updated Functional Assessments must be completed by or under the supervision of a qualified professional as identified in these regulations.

1. **Comment**: Commenter (23) would like to see the definition in §5.02-17 Functional Assessment be more robust in order to separate a functional assessment from a best guess. The Commenter suggests the following language

“Functional Assessment: means a systematic analysis of factors, both internal and external to the person, which may be contributing to his or her challenging behavior.”

**Response**: The Department thanks the Commenter for this comment. The Department has amended the definition of Functional Assessment to incorporate this suggestions.

***5.02-20 In-Home Stabilization***

1. **Comment**: Commenter (11) recommends the following change to §5.02-20

“In-Home Stabilization means a limited period of time for which a Person whose Challenging Behavior has placed that Person or others in Imminent Risk of physical harm may be denied access to the community ~~for safety and assessment~~.”

**Response**: The Department thanks the Commenter for this comment. The Department does not agree that amending this definition as suggested is in the best interest of the Person’s served. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (23) recommends change “who’s” to “whose” in §5.02-20, In-Home Stabilization

**Response**: The Department thanks the Commenter for this comment. The Department amended §5.02-20 as suggested.

***5.02-22 IST***

1. **Comment**: Commenter (11) recommends the following changes to §5.02-22

“IST: means an Individual Support Team consisting of the Person, other members Planning Team, and other professionals, family, or friends that the Planning Team determines would be supportive to the Person in a time of crisis …”.

**Response**: The Department thanks the Commenter for this comment. The Department does not believe this amendment is necessary. 34-B M.R.S. §5451 §8-C defines the Planning Team. Under this definition, the Planning team" means those persons, including at a minimum the client, the client's guardian and the client's individual support coordinator and others selected by the client or guardian to participate, who develop a personal plan or service plan. The planning team may include family, friends, Service Providers, correspondents, advocates and others.” The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (14) stated that there is no specific criterion for when an IST is to be convened (e.g., 3 restraints in a 2 week period).

**Response**: The Department thanks the Commenter for this comment. The Department refers the Commenter to §5.09-4, Recurring Patterns, which sets out specific criteria for when an IST must be convened and the OADS Developmental Services Case Management Manual, 3/18/14, which may be found at <http://www.maine.gov/dhhs/oads/provider/developmental-services/training-info.html>. The Department made no changes to the final rule as a result of these comments

***5.02-23 Mechanical Restraint***

1. **Comment**: Commenter (23) recommends removing “bed rails” from the definition in §5.02-23 Mechanical

Restraint because bed rails does not fit the definition of “a device worn by or placed upon the individual to limit movement.”

**Response**: The Department thanks the Commenter for this comment. In response to this comment the Department has made the suggested amendment. With this amendment the Department intends bed rails when used as a Restraint to require an approved Level 4 Behavior Management Plan.

1. **Comment**: Commenter (12) asks whether voluntary use of a device included in the definition of Mechanical Restraint in §5.02-23 requires the same level of plan and oversight as non-voluntary use.

**Response**: The Department thanks the Commenter for this comment. By definition a Mechanical Restraint is something a person can’t get out of so it can’t be voluntary. The Department made no changes to the final rule as a result of these comments.

***5.02-24 Noxious and 5.02-25 Overcorrection***

1. **Comment**: Commenter (23) asks the Department to identify both Noxious and Overcorrection as prohibited practice in the definitions for each, §5.02-24 and §5.02-25, respectively. The Commenter points out that it is not until 21 pages later that one learns that these practices are prohibited.

**Response**: The Department thanks the Commenter for this comment. In response to this comment the Department amended these regulations by adding “noxious intervention” as a Level 5 Intervention.

***5.02-29 A Personal Plan***

1. **Comment:** Commenter (11 & 20) asks for the meaning of Personal Plan in §5.08-4(A). Commenter (20) states that the definition gives several options: PCP Service Plan, Positive Support Plan and Behavior Management Plan, or other plans. Commenter (11) states that the proposed Behavior Regulations, as written, has created “A Personal Plan" which is different from that of the Person Centered Plan ("PCP"). This appears to be an oversight. Commenter (11) recommends making clear that the current rules regarding the PCP apply, including the person's right to participate in the development of the PCP, and make the following changes in §5.02-29:

“~~A Personal~~ Person Centered Plan: means a plan, as required by 34-B M.R.S. §5470-B ("Personal planning") that articulates and identifies the needs and desires of the Person and describes services which will be offered to achieve them. The ~~Personal~~ Person Centered Plan may include a ~~Person Centered Plan (PCP), an individual service plan, a~~ Positive Support Plan, a Behavior Management Plan, or other plans that describe how services will be delivered.

**Response**: The Department thanks the Commenters for these comments. The term “Personal Plan” and “Person Centered Plan” are often used interchangeably. The Department made no changes to the final rule as a result of these comments. The definition in the proposed regulations states that the “Personal Plan” may include a “Person Centered Plan”. The Department prefers “Personal Plan” as this term is used in Section 21 of the MaineCare Benefits Manual, Chapter II and in the sections of Title 34-B of Maine law that govern this regulation. A PCP is a type of Personal Plan for Case Management under Waiver programs. The Person has a choice whether they want a PCP of a Personal Plan. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (10) asked who makes up the planning team mentioned in §5.02-29 and whether the planning team is the Person Centered Planning Team or is that an additional team.

**Response**: The Department thanks the Commenter for this comment. The Planning Team is composed of the following people per 34-B M.R.S. §5470-B: the Person; the guardian, if applicable; any correspondent; the Person’s Case Manager; and “people whom the person choses to participate.” Personal Plan” and “Person Centered Plan” are often used interchangeably. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) states that the Personal Plan definition does not indicate who actually owns the plan. While you can have multiple contributors to a plan, you do need a person(s)/agency/provider responsible for its development and maintenance.

**Response**: The Department thanks the Commenter for this comment. The Commenter is correct that the Personal Plan may have a variety of components developed by a variety of clinicians. Department intends that the Planning Team share responsibilities for the various aspects in the planning process as appropriate. In response to this and other similar comments the Department amended these regulations to clarify the Planning Team responsibilities.

***5.02-31 Planning Team***

1. **Comment**: Commenter (19) asks the Department to clarify whether the Planning Team is the Person Centered Planning Team. The changing use of jargon is confusing to figure out who has to do what.

**Response**: The Department thanks the Commenter for this comment. In response to this comment the Department replaced all references to the “person centered planning team” with “Planning Team”.

***5.02-32 Positive Support and 5.02-33 Positive Support Plan***

1. **Comment:** Commenter (22) does not feel that there is a need for two definitions; positive supports and positive support plan.

**Response:** The Department thanks the Commenter for this comment. Both terms are used throughout these regulations. The definitions provide clarity. The Department made no changes to the final rule as a result of these comments.

***5.02-34 Prosocial Behavior***

1. **Comment:** Commenter (17) asked how the phrase “concern and empathy” §5.02-34 can be measured, be assessed, or verified, and by whom.

**Response**: The Department thanks the Commenter for this comment. The Department agrees these words are subjective but does not think they need to be measured, assessed or verified for these regulations to be effective. The Department made no changes to the final rule as a result of these comments

***5.02-36 Psychiatric Medications***

1. **Comment**: Commenters (12 & 19) state that the proposed definition of psychiatric medication in §5.02-36 indicates any substance “prescribed to modify behavior.” By definition, most behavioral health symptoms/indicators are observable behaviors. This would essentially require a plan for anyone on psychotropic medication.

**Response**: The Department thanks the Commenters for these comments. These regulations apply to psychotropic medications prescribed to address identified Challenging Behaviors. The Department made no changes to the final rule as a result of these comments.

***5.02-45 Safety Device***

1. **Comment**: Commenter (23) states that under the §5.02-45 Safety Device one could argue that locking a device is broad. Commenter recommends a standard that considers the purpose of the device as limiting unintentional movement by the person.

**Response**: The Department thanks the Commenter for this comment. Not all behaviors that require a Safety Device are the result of unintentional movement. Examples of intentional movement necessitating a Safety Device can be found in §5.10-2. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (11) states that in their experience as a member of the 3-Person Committee and a resource for the community on Developmental Services, they have discovered state-wide inconsistencies in how each committee and agency interprets Safety Devices. Commenter (11) believes this is due to the ambiguity in the current definition of Safety Device. These regulations use the same definition and the Commenter (11) recommends that the State consider changes that would make the term clearer to the organizations attempting to implement them. Commenter (11) states that it is their understanding that the State's intent with Safety Devices is to regulate the use of devices which assist an individual with unintended movement. For example: Using a seatbelt in a wheelchair to assist a person from falling out of the wheelchair during a seizure would be reviewed as a Safety Device. Using a seatbelt in a wheelchair to keep a person from standing up and eloping would be a Mechanical Restraint and reviewed as a Behavior Management Plan. The key difference being the use of the same device to stop unintended movement in the former and intended movement in the latter. Commenter (11) recommends that the State adopt changes to the definition of Safety Device which would make this distinction clearer in §5.02-45 Safety Device by making the following change:

“means a~~n implement, garment, gate, barrier, lock or locking apparatus, video monitoring or video alarm device, helmet, mask, glove, strap, belt or protective glove~~ device, limited to the person in question, whose effect is to reduce or inhibit the person's unintended movement in any way.”

**Response**: The Department thanks the Commenter for this comment. Not all behaviors that require a Safety Device are the result of unintentional movement. Examples of intentional movement necessitating a Safety Device can be found in §5.10-2. The Department made no changes to the final rule as a result of these comments.

***5.02-46 Seclusion***

1. **Comment**: Commenter (23) suggests the definition in § 5.02-46 Seclusion include a note that this is a prohibited practice.

**Response**: The Department thanks the Commenter for this comment. In response to this comment, the Department has included a note in the definitions of “Seclusion” and all other prohibited practices.

***5.02-48 Social Role Valorization (SRV)***

1. **Comment**: Commenter (23) suggest that §5.02-48 Social Role Valorization and its reference in the regulation be eliminated if the Department articulates its values as suggested previously by this Commenter. The Commenter states that since neither normalization nor inclusion are similarly defined, this appears to privilege one concept over the other two.

**Response**: The Department thanks the Commenter for this comment. The Department does not intent to privilege one concept over another. The definition of this term includes concepts of inclusion and normalization. The Department made no changes to the final rule as a result of these comments.

* + 1. ***Therapeutic devices or interventions***

1. **Comment**: Commenters (11 & 23) ask the Department to clarify the definition in §5.02-51, Therapeutic Devices Commenter(23) states under this definition, devices used for safety are included. The Commenter asked how therapeutic devices differ from safety devices and whether a mechanical lift mechanism (like Hoyer lift, or a ceiling track) fit as a Therapeutic or Safety Device. Commenter (11) stated that in its experience the current regulations regarding Therapeutic Devices are clearer than that being proposed in the new Behavior Regulations. The current regulations state: "These regulations are not intended to regulate the use of therapeutic adaptive equipment or therapeutic interventions in occupational or physical therapy". (14-197 C.M.R. Ch. 5 §1(4)) The proposed regulations echo the same sentiment in the Applicability segment, however, then the regulations go further to expand the definition of Therapeutic Devices to include devices which are outside of that used in occupational or physical therapy. This distinction is critical in categorizing Therapeutic Devices and Safety Devices. Commenter (11) recommends making the following changes to §5.02-51 to make this distinction clearer:

“Therapeutic ~~d~~evices or interventions: means devices or interventions used in occupational or physical therapy which are designed to assist the Person in daily functioning as written in the ~~Personal~~ Person Centered Plan. Therapeutic Devices or Interventions include, but are not limited to: . . .”

**Response**: The Department thanks the Commenter for this comment. In response to these comments the Department amended the definition of Therapeutic Devices to read:

**“**Therapeutic Devices**:** means devices used for body positioning or alignmentunder the supervision of a medical doctor, occupational therapist or physical therapist.”

**5.03 SUPPORTING A PERSON WHO IS ENGAGING IN CHALLENGING BEHAVIOR**

1. **Comment**: Commenters (1, 9 & 12) suggest that it is not clear who is ultimately responsible for initiating and implementing of the different the plans. Commenters (9, 12) questioned who is person responsible for initiating and implementing of the different the plans changes depending on whether the Person resides in a Waiver Home or PNMI.

**Response**: The Department thanks the Commenters for these comments. In response to this and similar comments, the Department amended these regulations to clarify who is responsible to initiate the planning process and develop the required plans.

1. **Comment**: Commenter (12) noted that under these regulations the Planning Team is led by the Person and the Person directs who attends. Commenter (12) envisioned a problem coordinating among the various agencies that serve the Person, problems is the Person does not want a particular provider on the team. Commenter (12) expressed concerns about difficulty in implementation of plans created by The Planning Team and not by an agency. Commenter (12) asked how the plan will account for differences between programs or the Person’s challenging behaviors between settings. Commenter (12) also asked what will happen if a provider does not agree with how the plan should be implemented in another setting. Commenter (12) asked who will be responsible for a singular plan; it makes one agency reliant on other agencies/providers to comply with regulations. Commenter (12) went on to state that agencies are not supposed to bill for PCP approved services without the signed face sheet from the PCP meeting. It has proved very difficult and required many resources to pursue Case Managers to get these face sheets after the meetings. These regulations, as written, would only exacerbate the difficulties of having various agencies reliant on Case Management to disperse required signed documentation. Commenter (12) finds this confusing and states that this needs clarification for implementation

**Response**: The Department thanks the Commenter for this comment. The Person retains the authority to determine who attends the Planning Team meetings unless otherwise identified by a Guardian. The Department expects all other members participate to the fullest extend required to meet the needs of the Person. In response to other comments the Department has clarified that the Planning Team is responsible to ensure the development of Positive Support or Behavior Management Plans and that the entity or person responsible to initiative a Plan is the member of the Planning Team responsible to initiate the Planning Team process and ensure all documentation, assessments, plans and reviews are completed as required.

1. **Comment**: Commenter (23) asks how § 5.03 Supporting a Person with Challenging Behaviors differs conceptually from § 5.06 Levels of Intervention. The Commenter suggests that the Department consider revising the charts in §5.06 into one chart that begins with safety devices, include references to relevant sections under each level, and include it after the introductory paragraphs in §5.03. The Commenter believes this will give the reader a quick visual representation of the differences, and interconnectedness, of the levels of support before asking him or her to delve into the details. This would eliminate the need for the remainder of §5.03.

**Response**: The Department thanks the Commenter for this comment. The Department has reorganized these regulations in response to this comment and other similar comments received.

1. **Comment**: Commenters (9, 12 & 13) expressed concern about the wide variety of plans (behavior management, positive support, mental health, medical, personal) and who would be required to have which plans, as well as if they are all separate plans with their own pre-specified format. Commenter (13) stated that it was unclear when, and how these plans are developed; if these plans intended to be separate documents; and how the teams were going to figure out who needs what and why.

**Response**: The Department thanks the Commenters for these comments. The types of plans required is dependent on the needs of the Person receiving services. All Service Providers responsible for carrying out a Plan or components of a Plan will be involved in the review and approval process to same degree. The Planning Team is expected to work together to ensure the required documentation is prepared for review and approval. Although these regulations indicate some required components of the plans, the exact format for individual plans is not prescribed by the Department. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (11) states that one of the critical differences between a Behavior Management Plan and a Positive Supports Plan is the person's consent to the intervention. Language describing this consent is again, slightly different each time it is restated. As previously stated, these slight differences could lead to misinterpretation. Commenter (11) recommends making the following changes to keep the language consistent across the document:

In §5.05-3(E) “Therapeutic Devices or Interventions, or approved .Safety Devices to which the Person ~~does not object~~ consents and which are not intended as an intervention . . .”

In §5.05-3(F) “Monitoring Devices intended to enhance independence, to which the Person ~~does not communicate an objection~~ consents and which are not intended as an intervention . . .”

In §5.06 (Level 2) “Securing of incendiary material, clothes, shoes or sharps with documented safety issues or problematic misuse, ~~when the Person does not communicate a specific~~ objection to which the Person consents”.

In §5.06(Level 3) “An intervention to which the Person ~~objects~~ does not consent to.”

In §5.06(Level 3) “Buzzers/alarms /sensors or locks the Person is able to unlock on doors/windows, etc., if the Person or a member of the Planning Team ~~communicates a specific objection~~ does not consent or if a response to a Challenging Behavior.

In §5.06(Level 3) “Electronic monitoring devices (video, ankle bracelet, etc.), when the Person or a member of the Planning Team ~~communicates a specific objection~~ does not consent or if a response to a Challenging Behavior.

In §5.07 “Swaddling from which the Person can remove him or herself but to which the Person or

other member of the Planning Team does not consent.

**Response**: The Department thanks the Commenter for this comment. In response to this comment the Department amended these regulations to make the language regarding objections and consent consistent throughout.

1. **Comment**: Commenter (13) states that time frames are not included for several items including assessments, plans, and evaluations. Commenter (13) asks the following with respect to time frames:
2. what are the time frames for notifying the Planning Team to convene when Challenging Behaviors have been documented. Commenter (13) recommended 10 days between
3. What is the time frame from the time of convening to the time when a plan must be in place?
4. What is that entire time frame, including the need for involving clinicians, who are currently in short supply in Maine.

**Response**: The Department thanks the Commenter for this comment. The Department agrees that Planning Teams should perform their responsibilities in a timely manner to ensure the health and safety of the Persons. The Department does not have a mechanism to enforce time frames on Planning Team members. Any Planning Team member has the ability to request a meeting and should do so when they believe the Team is not fulfilling its obligation in a timely manner. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13) was concerned about the time frame between an occurrence of a Challenging

Behavior and the implementation of a plan and what actions can the service provider take with the client

during the interim

**Response**: The Department thanks the Commenter for this comment. The Department agrees that the Planning and Review Teams should perform their responsibilities in a timely manner to ensure the health and safety of the Person. The Department does not have a mechanism to enforce time frames on members of these Teams. Any Team member has the ability to request a meeting and should do so when they believe the Team is not fulfilling its obligation in a timely manner. The Department made no changes to the final rule as a result of these comments.

***5.03-1 Positive Support (Levels 1-2)***

1. **Comment**: Commenter (15) states that Level 1 interventions include “Teaching Skills,” “Physical prompts for teaching or personal support without Coercions,” “Voluntary Timeout,” and “Communication Support” – all actions which are currently positively used in programs. In fact, agencies promote their use of these actions in programs to assist clients in self-monitoring their behaviors and learning additional skills that could lead to greater independence. Commenter (15) believes that just this broadening of the definition will require that most people with Intellectual Disabilities or Autism have a behavior plan. Commenter (15) suggests that any individual that requires agency residential support and community supports has “challenging behaviors” that “interfere with their ability to have positive life experiences” and are routinely taught skills, given communication support, environmental modifications, and personal support without coercion – all actions that require expensive assessments and plans. Commenter (15) provided the following examples (1) A high functioning person with an intellectual disability or autism goes to a day program that teaches cooking skills or employment skills, which is a current practice built in to the daily activities of most day programs. “Teaching skills” is a listed “intervention”; (2) a Person chooses to use a “Voluntary Timeout” to self-moderate their behavior, this would also require a Functional Assessment and Positive Support Plan; Commenter (15) states that these intervention types are widespread and currently don’t warrant behavioral plans, but with the new rule, a Functional Assessment (“conducted by a professional with training in behavior analysis and Positive Supports”) and a Positive Support Plan must be written. The Positive Support Plan includes an extensive list of requirements that could only be written by a clinician as it includes the “identification of events and environmental factors that are likely to provoke the Challenging Behavior and steps to reduce them” and “strategies and training for staff”, among a list of other requirements. Commenter (15) states that a Level 2 Plan is required for a “Non-exclusionary Timeout” and will require a Functional Assessment, a Positive Support Plan, and a Transition Plan. Commenter (15) gives an example as a verbal suggestion to take a timeout, in the same room as others, when the Individual is exhibiting behaviors that may lead to more extensive challenging behaviors.

**Response**: The Department thanks the Commenter for this comment. The interventions listed above, such as Teaching Skills and environmental modifications, do not always fall within these regulations. Only when these interventions are implemented to address a Challenging Behavior does the requirements of these regulations apply. It is the intent of the Department to continue to change the culture of providing support. Functions Assessments and Positive Support Plans are being put in place to decrease the possibility of Challenging Behaviors that would require interventions that would be more restrictive. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (16) asked what would differentiate someone needing a Level 1 Positive Support Plan from an individual who would need to have prompting and cuing for reminders such as taking a shower, fixing their lunch for the day, taking medications, etc. In other words, things that staff do throughout the day to enhance quality of life and promote individual independence.

**Response**: The Department thanks the Commenter for this comment. The primary distinction to keep in mind when reading the examples in Level 1 is that the intervention listed is used to address a Challenging Behavior verses reminders to complete day-to-day activities. The Department made no changes to the final rule as a result of these comments.

***5.03-2 Behavior Management (Levels 3-5)***

1. **Comment**: Commenter (15) states that if a client objects to locked sharps or incendiary devices, a Level 3 Behavior Plan in needed. It’s important to remember that most clients with intellectual disabilities that receive agency residential supports have, by nature of their diagnosis, limitations on their ability to make decisions about their safety and the safety of others. Locking sharps and matches are generally viewed as a best practice, not a limiting intervention. If the clients object to this practice, we will now be obligated to all the previous plans, but also a Behavior Management plan. Commenter (15) states that if a client objects to any intervention (as stated in the rule change: “An intervention to which the Person objects”), a Level 3 plan is required. Examples could include a client that is a known risk wants to carry a lighter or a knife, a client who perseverates with his cell phone and repeatedly calls people, hundreds of times each day, or a client who wants to get into a dumpster to look for junk (all actual examples from our clients).

**Response**: The Department thanks the Commenter for this comment. These regulations are based on the rights and restrictions created in Maine statute regarding persons with intellectual disabilities or autism. The intent of these regulations is to ensure that Service Providers provide supports and interventions in the least restrictive manner possible to protect the rights, health and safety of persons with intellectual disabilities or autism. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (14) stated that in the past, some of the restrictions in Level 3 were considered moderately intrusive, which did not require monitoring by the "qualified professional". It was the expectation that the Advocate be invited to the planning meeting if a moderately intrusive plan is considered. Is the expectation now that all Level 3 - 5 plans require the “qualified professional"?

**Response**: The Department thanks the Commenter for this comment. This Commenter is correct that all Level 3-5 plans require monitoring by a “qualified professional” The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (15) states that to create, implement, and monitor these additional plans, the services of more professionals is needed, including the Case Management Supervisor and the Review Team (composed of a representative from the Department, a representative from the designated advocacy agency and a representative designated by the Maine Developmental Services Oversight and Advisory Board.) Current law requires a Review Team review Highly Intrusive Plans. Commenter (15) believes the Review Team will now be responsible for a massive increase in Plans to review, possibly overtaxing the members of this committee. Commenter (15) expressed concerned about the vastly increased amount of oversight that the Review Team, which consists of three members, only two of whom vote, will have on the daily operations of programs all over the state. In addition, the Case Management Supervisor must sign off on this plan, necessitating more billable hours in addition to the case manager.

**Response**: The Department thanks the commenter for these comments. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.0168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to increase significantly based on these regulations. The requirements for a Functional Assessment and Positive Support Plan is similar to the requirements for the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. (See MBM, Chapter II Sections 21.04-2 & 29.04-2). The documentation under these regulations for the Functional Assessment and Positive Support Plan is appropriate and necessary to ensure least restrictive level of support need. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (15) states that a Plan is required when “blocking” is used, or when “any physical force …is used in response to a Challenging Behavior to cause a person to move”, or when the “Temporary removal of staff” occurs. Blocking, as defined in the current Chapter 5 regulations, is a “momentary deflection of an individual’s movement, when that movement would otherwise be destructive or harmful.” Commenter (15) uses blocking as a safe, effective technique for preventing harm, both to the individual and to others. For example, if an individual was about to burn themselves on the stove, around a fire or radiator, and the support professional blocked their hand a Level 4 Plan would be required. If the support person actually held the individual’s arm to keep them from burning, or had to physically hold someone to keep them in the building, a Level 4 plan would be required. In another example, if a person is exhibiting “Challenging Behavior” in their room and the staff leave the room (but remain in the home) for their safety and to de-escalate the situation, a Level 4 plan is required.

**Response**: The Department thanks the Commenter for this comment. It is not the Department’s intent to prevent the use of blocking. Under these regulations blocking is allowed as an emergency intervention if it is the least restrictive technique necessary to make the situation safe. However, planned use of blocking requires review and approval of a Behavior Management Plan. The commenter is correct that staff leaving someone who may be at risk of harming themselves or others needs to be reviewed and approved to ensure this is a safe and effective intervention. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (15) states that a Level 5 Plan requires a Functional Assessment, Positive Support Plan, and a Transition Plan, a Behavior Management Plan, and an In-Home Stabilization Plan, as indicated, Psychological Assessment, a Physician’s Evaluation, a second clinical opinion and review by the Statewide Review Panel and the Commissioner of DHHS. Commenter (15) questions how the State will resolve the need for additional DHHS employee resources for the Review Team, the Statewide Review Panel, and the Commissioner of DHHS, along with the issue of a critically low supply of qualified clinicians.

**Response**: The Department thanks the Commenter for this comment. The Department shares the concern about availability and access to qualified professionals. The Department continuously seeks to identify and secure these resources throughout the State. As of March 2016 the Department has a total of 101approved behavioral plans that will most likely require Level 3-5 review and approval. Under the current regulation, these are considered “severely intrusive plans. The requirements for these 101 plans have not changed significantly under these regulations. This represents approximately 0.0168% of the total number of persons eligible for services (+/- 6000). The Department does not expect this percentage to increase significantly based on these regulations. The requirements for a Functional Assessment and Positive Support Plan is similar to the requirements for the Personal Planning Process set out in the MaineCare Waiver programs serving the same population as these regulations. (See MBM, Chapter II Sections 21.04-2 & 29.04-2). The documentation under these regulations for the Functional Assessment and Positive Support Plan is appropriate and necessary to ensure least restrictive level of support need. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) recommend that the timeframe for an In-Home Stabilization be directly related to the average length of time that documentation indicates it takes the individual to return to baseline behavior or safe behavior

**Response**: The Department thanks the Commenter for this comment. The requirement in Level 2 applies for up to one hour and beyond one-hour In-Home Stabilization needs to be approved at Level Four. In response to this and similar comments the Department made amendments to clarify the intent.

1. **Comment:** Commenter (11) states that currently, the act of systematically depriving an individual access to the community must have 3-Person Committee approval before implementation. Commenter (11) stated that these types of plans should be rare and only to prevent serious physical harm due to the extreme nature of the restriction. The proposed regulations would allow for systematic deprivation of community access for up to an hour even when there is no longer imminent risk of physical injury without any such review. Commenter (11) clarified that encouraging and promoting community integration is, in many ways, the purpose of Developmental Services. For decades, individuals were segregated from the community in institutions, creating a stigma which the Supreme Court identified as discrimination in the famous Olmstead v. LC ruling. Home and Community Based Waiver Homes were created to allow individuals the opportunities to live and thrive in their own communities. Cultivating community access is arguably the central focus of service delivery. Commenter (11) attached a copy of the fundamentals of service delivery for reference. Commenter (11) went on to say it is no small thing to deprive someone access to the community for any length of time. Further, it cannot be said to be comparable to the Positive Support Plans implicit in Level 2 interventions. It is unnecessary to create this loophole which exists nowhere else in the regulations that allows a systematic rights violation without appropriate systematic review. The serious nature of In-Home Stabilization Plans should be reflected in the review process. As with all other interventions, in emergency circumstances, In-Home Stabilization may be utilized to protect the person or others from imminent risk of physical harm. If it becomes necessary then to develop a plan for the systematic deprivation of community access, it should be reviewed as a Behavior Management Plan at Level 3-5 with all other rights restrictions. Based on this Commenter (11) recommends that the State identify all In-Home Stabilization Plans as Level 3-5 interventions and make the following changes to clarify that In-Home Stabilization may be an emergency intervention:

In §5.05-3(D)(3) The proposed use of In-Home Stabilization for any planned length of time is a Level 3-5 intervention and must be derived from the Functional Assessment and incorporated into the Positive Support Plan.”

In §5.05-3(D) (4) The proposed use of In-Home Stabilization for a period less than 24 hours, is a Level 3 intervention . . .”

In §5.05-3(D) (5) In-Home Stabilization at Level 3 must not be applied cumulatively . . .”

~~In §5.06(Level 2 Examples): ln Home Stabilization for a maximum of one hour for safety and assessments~~.”

In §5.06(Level 2 Required Documentation): Functional Assessment, Positive Support Plan, Transition Plan toward more naturally occurring reinforcers ~~or ln Home Stabilization Plan as indicated.~~”

In §5.06(Level 3 Examples): In-Home Stabilization for more than one hour for safety and assessment not to exceed 24 hours.”

**Response**: The Department thanks the Commenter for this comment. In response to these regulations the Department amended Appendix Four, In-Home Stabilization to clarify that reoccurring use of Level 2 In-Home Stabilization triggers the need for Level 3 review and approval. With respect to the comment that these regulations will allow deprivation of community access for up to one hour even if there is no longer an imminent risk of harm. The Department does not agree that this is the result. As Level 2, In-Home Stabilization requires the voluntary participation of the Person.

1. **Comment**: Commenter (19) asked how the Department arrived at the 1 hour restriction for In-Home

Stabilization.

**Response**: The Department thanks the Commenter for this comment. The 1-hour restriction was developed based on knowledge and experience. The Department intent is to allow enough time for de-escalation, use self-regulation/coping skills and returning to baseline. The Department made no changes to the final rule as a result of these comments

1. **Comment**: Commenter (19) asked how the Department will monitor the 1 hour in-Home Stabilization restriction across settings.

**Response**: The Department thanks the Commenter for this comment. The Planning Team is responsible to monitor the voluntary participation of In-Home Stabilization that last less than or up to one hour. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (15) expressed concerned that these new limitations and restrictions would stand to elevate the client’s self-determination over common sense and negate the role of the guardian in making decisions for a person who has been deemed incompetent by the court. Commenter (15) stated it believes all individuals should have the highest and safest level of access to a normal environment, including decision making. Commenter (15) believes the service provider, with the guardian’s support, can be entrusted to make appropriate decisions regarding client care without the interference of these new regulations.

**Response**: The Department thanks the Commenter for this comment. The Department has an obligation under state and federal to ensure the delivery of services that are provided, licensed or funded by or through the Department is done in a manner that protects the rights of Persons with intellectual disabilities or autism. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (14) states that there is no mention in Level 4 (Restraint Component): of escorting or body positioning (just blocking). There also is no reference to extinction (i.e., ignoring behaviors that can be tolerated). The temporary removal of staff may be an example of extinction but it is a common and effective technique used in a variety of ways to de-escalate behavior. According to the previous regulations, extinction was considered mildly intrusive.

**Response**: By definition “Escort” is only the physical assistance to support a Person to stand or walk when the person who is providing the support follows the lead of the Person. The Department believes the current definition of “Blocking” adequately describes actions that are considered a restraint. The Department did not include extinction as an example in the Levels because extinction that is ignoring behavior but not the person is not a restriction of rights that requires review and approval. These regulations do address Temporary Removal of Staff. This is considered a Level 4 intervention. Temporary removal of staff when the Person still has access to the staff does not fall within the definition in these regulations. The examples in these regulations are not exclusive. The Department made no changes to the final rule as a result of these comments.

***5.03-4 Requirements for Plans and Assessments***

1. **Comment**: Commenter (20) states that it is not clear why the Functional Assessment in §5.04-2(D)(4) needs to be updated every three years if the challenging behavior is eliminated due to success of the plan

**Response**: The Department thanks the Commenter for this comment. If the Person is not experiencing a

Challenging Behavior these regulations does not apply. The Department made no changes to the final rule as a result of these comments.

**5.04 POSITIVE SUPPORT (Levels 1-2)**

* + 1. ***Positive Supports Must Be the First Approach***

1. **Comment:** Commenters (4, 10 & 20) discussed ruling out medical conditions. Comment (10) was glad that the regulations mention addressing potential medical conditions before implementing behavioral intervention but was disappointed that the concept is one short phrase lost in a larger section that is confusing. Commenter (20) would like to see more emphasis on the need to always rule out a medical condition and or pain prior to any level of treatment plan, increase in behavior or new behavior. Commenter (4) states that dental issues may be the cause of behaviors.

**Response**: The Department thanks the Commenters for these comments. In addition to language in these regulations specifying that medical conditions must be ruled out as the cause of behaviors, trainings provided by the Department will stress the need to conduct this assessment prior to implementing any behavior modification or management plan. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (11) recommends the following changes be made to §5.04-l (B)(1):

“learn how to make choices, exercise personal autonomy, and develop decision-making skills using Supported Decision-Making.”

**Response**: The Department thanks the Commenter for this comment. The Department believes amending these regulations to include reference to the still evolving concept of Supported Decision Making is premature. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13) asked the Department to explain the rationale for the proposed Functional Assessment and Positive Support Plan approach?

**Response**: The Department thanks the Commenter for this comment. The Positive Support Plan approach is not new to these regulations. It is part of the current regulation. The rationale for these regulations is to increase communication, assessment, documentation and review when a Person experiences Challenging Behaviors. These changes are intended to increase the use of positive supports and decrease the use of more restrictive interventions. The Department made no changes to the final rule as a result of these comments.

***5.04-2 Requirements for the Functional Assessment***

1. **Comment**: Commenters (11 & 23) suggest that Functional Assessment be updated at least annually Commenter (23) states that this assessment serves as a meaningful evaluation of any plan developed to address challenging behaviors.Commenter (11) states that the updating the plan less frequently seems to undervalue the Functional Assessment as key to identifying environmental stressors and opportunities to promote independence in the person. Commenter (11) states that over the course of a year, people can change dramatically, especially after receiving targeted support for Challenging Behaviors. Commenter (11) believes it's important that the Functional Assessment be updated annually to reflect changes and potential improvement in the person's behavior by making the following changes to §5.04-2(D) (4):

“updated annually, or more often as needed.

**Response**: The Department thanks the Commenters for these comments. Nothing in these regulations prohibits more frequent Functional Assessments. The Planning Team must review and approve documentation that includes the Functional Assessment, on an annual basis. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (10) asked that the annual functional assessment not be required if the Person does not need one. The Commenter suggested using it only when there are reoccurring behaviors that need to be addressed.

**Response**: The Department thanks the Commenter for this comment. These regulations does not require the Functional Assessment be updated on an annual basis. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenters (8, 11 & 23) made suggestions on who is qualified to conduct a Functional Assessment. Commenters (8, 11 &23) suggest that those qualified to conduct updated functional assessments as specified in §5.05-1(B) and those identified in the initial paragraph about functional assessment on §5.04-2(D) be the same individuals. Commenter (11) suggests the following change to §5.04-2(D).

“The Functional Assessment must be 1. Completed by or under the supervision of a ~~person who has been designated by the Planning Team and who has training and experience in behavior analysis and Positive Supports~~ psychiatrist, a licensed psychiatrist, licensed psychologist or psychological examiner, a Licensed Clinical Social Worker, Licensed Clinical Professional Counselor, or a Board Certified Behavior Analyst;”

**Response**: The Department thanks the Commenters for these comments. The Department thanks the Commenter for this comment. The Department does not agree that the specified qualified professionals are necessary for all Functional Assessments, particularly Functional Assessment for Level 1 or Level 2 plans. The Department amended these regulations in response to this comments.

1. **Comment**: Commenter (12) reads the proposed regulation as requiring Functional Assessments for all plans. Commenter (12) finds this unrealistic given the definition of Challenging Behavior. Commenter (12) reads the proposed definition of “Challenging Behavior” to include when a person gets distracted walking in the city who could easily walk off the sidewalk into traffic as falling under “dangerous behavior with imminent risk”.

**Response**: The Department thanks the Commenter for this comment. This commenter is correct that a Functional Assessment must be completed when a Challenging Behavior exists. The Department does not interpret these regulations as always leading to the result described by this commenter. The process in these regulations allows for thoughtful discussion regarding individual situations and appropriate interventions. This process is intended to increase the use of positive supports and decrease the use of more restrictive interventions The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (22) is concerned that a functional assessment is required prior to implementing even a Positive Support Plan.

**Response**: The Department thanks the Commenter for this comment. The Commenter is correct that a Functional Assessment is required. The assessment is necessary to inform the development of an appropriate plan. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (14) asked is a specific tool is going to be provided for §5.04·2: Requirements for the Functional Assessment.

**Response**: The Department thanks the Commenter for this comment. The Department has not developed a specific tool or format for the Functional Assessment. Each Assessment will be unique to the Person. The Department made no changes to the final rule as a result of these comments.

***5.04-3 Requirements for the Positive Support Plan***

1. **Comment**: Commenter (21) points out that this section of the regulation mentions “Positive Behavior Modification Techniques” which is not defined. The Commenter suggests clarifying this term

**Response**: The Department thanks the Commenter for this comment. The Department acknowledges the use of an undefined term and has amended these regulations by adding a definition for the term “Positive Behavior Modification Techniques”.

1. **Comment**: Commenter (20) stated that in §5.04-3 there was excellent detail and clarity on requirements for a

Positive Support Plan.

**Response**: The Department thanks the Commenter for this comment. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) asked who is judging what is meant by §5.04-3(A)(2) “more meaningful activities”.

**Response**: The Department thanks the Commenter for this comment. The Planning Team, and others familiar with the Person, at the Person’s invitation, will assess for the needs listed in §5.04-3(A). The Department made no changes to the final rule as a result of these comments.

***5.04-4 Medical and Mental Health Assessment and Treatment***

1. **Comment**: Commenter (12) asked if the plans are written and monitored by the Planning Team, without physician involvement who are professionals with the highest level of school and licensure and licensing regulations that should provide the protections sought by the proposed regulation.

**Response**: The Department thanks the Commenter for this comment. There must be physician involvement as stated in §5.05-4 (C): “When a Behavior Management Plan includes restraint, the Planning Team must ensure completion of a Physician’s Evaluation, in which a physician (as described in 02-373 CMR Ch. 1) or a physician assistant (as described in 02-373 CMR Ch. 2) evaluates the Person no more than thirty (30) days prior to the implementation of the Behavior Management Plan and yearly thereafter. Whenever a significant change in physical or medical condition occurs, a new evaluation must be conducted. In order for a Behavior Management Plan including restraint to be implemented, the Physician’s Evaluation must state in writing that:

1. The proposed Plan is safe, given the Person’s physical and emotional condition; and

2. The behavior cannot be better treated medically. “

The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (11) discussed that people with developmental disabilities experience sexual assault at a rate much higher than people without disabilities. Putting hands on a person with a history of trauma has the potential to escalate the situation. When restraint is identified as a potential intervention, it is critical to assess the least intrusive way to implement it. Commenter (11) recommends that the State maintain the current special assessment requirements when restraints have been identified as a potential intervention and incorporate that language into the requirements of Medical and Mental Health Assessment and Treatment in §5.04-4(B) as follows:

“The Positive Support Plan must document how it incorporates factors related to trauma. Consideration must be given to the emotional and physical impact of the use of Restraint or other interventions. Assessments must be utilized to establish the length of time the physical holding may be employed up to a maximum of one hour. 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).”

**Response**: The Department thanks the Commenter for this comment. The previous rule allowed on hour of restraint prior to release. These regulations reduces that to a maximum of fifteen (15) minutes prior to release. With respect to the comment regarding trauma, the Department believes the language as proposed is sufficient to ensure appropriate levels of consideration and documentation to address any factors related to trauma. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) stated that the question that "consideration must be given to the emotional and physical impact of the use of Restraints" for use in a Positive Support Plan vs a more restrictive plan level is an excellent statement. Commenter (20) is concerned about lack of resources for MH professionals trained to support individuals with IDD

**Response**: The Department thanks the Commenter for this comment. The Department is also concerned with lack of clinical professionals with ID/DD experience however it is best practice to ensure that mental health professionals become involved to ensure appropriate level of care. The Department made no changes to the final rule as a result of these comments.

* + 1. ***Use of Psychiatric Medications***

1. **Comment**: Commenter (31) states that the new regulations do not take into consideration comorbid diagnostic problems leading to behavioral changes. The problem exists because medical experts do not confer or intrude in the areas of expertise of other physicians.

**Response**: The Department thanks the Commenter for this comment. The Planning Team should ensure that all professionals, including medical professionals, communicate to provide appropriate care that meets all the needs of the individual. State law does not give the Department the authority to regulate medical professionals. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (8) suggests rewording this subsection §5.04-5 to require that the professional developing the more restrictive plan utilize an Updated Functional Assessment (within the past 3 years). Commenter (8)’s rationale is that the requirements for Updated Functional Assessment include the need it to be completed by or under the supervision of certain licensed professionals whose level of skill is not indicated in the §5.04-2. Modifying the language clarifies the intent that the individuals team approach the Functional Assessment in a person centered manner.

**Response**: The Department thanks the Commenter for this comment. The Department does not agree that the specified qualified professionals are necessary for all Functional Assessments, particularly Functional Assessment for Level 1 or Level 2 plans.

1. **Comment**: Commenters (12 & 19) state that the requirement for a Psychiatric Medication Plan, Functional Assessment and a Positive Support Plan is overreaching and interferes with the established relationship between the physician, the individual and family/guardian in some instances. Some families/individuals do not discuss psychiatric medications in Person Centered Planning meetings and in fact, the expectation as outlined by HIPPA and related Privacy Practices is that this is not a discussion at a planning team, particularly a planning team with no clinical training/expertise documented and insured. Commenter (12) stated that involvement of the Planning Team violates doctor/patient privacy.

**Response**: The Department thanks the Commenters for these comments. Membership on the Planning Team is dictated by Maine law, 34-B M.R.S. §5470-B. Under this statute the Planning Team includes the person, their guardian if any, the correspondent, if any, the Case Manager, and “people whom the person chooses to participate”. This allows the Person to control who has access to his/her private information. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (12) questioned how the Planning Team would keep a thorough up to date and accurate plan given the rate and immediacy of medication change needs.

**Response**: The Department thanks the Commenter for this comment. Under these regulations the Planning Team will develop a procedure for documentation and review. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (12) points out that psychiatrist and psychiatric nurse practitioners are not currently funded to create the types of plans required by this proposed regulation. Commenter (12) reads the proposed regulation as indicating that the Planning Teams will create plans for use of psychiatric mediation.

Commenter (12) questions whether the teams have the expertise to create and monitor these plans.

**Response**: The Department thanks the Commenter for this comment. The Planning Team is responsible to monitor, not prescribe or administer psychiatric medications. Medications are administered by a qualified professional who will report and document any problems. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (12 & 19) express concerns about the frequency with which psychiatric medications are changed. Commenter (12) points out that medication changes can happen often and questions what will happen if the team cannot get together on a day’s notice prior to a Psychiatrist and guardian wanting a medication change. Commenter (12) stated that that the requirement to notify the prescribing physician within 24 hours of administering a PRN medication may be overly taxing for physicians who must already manage a higher administrative burden when working with our population. This may deter physicians from accepting new clients or limiting how many new clients they take on. It is often difficult to reach physicians after hours and on weekends. Commenter (12) asked what would be considered appropriate notification. Commenter (12) asked whether a messages left on voicemail or with answering services suffice. Commenter (19) states that this is outside of the doctor/patient/guardian relationship and discussion. Commenter (19) states that this must be updated when medications change which for some can be frequent and asks how this will be managed at the Department level.

**Response**: The Department thanks the Commenters for these comments. These regulations only applies to psychiatric medications prescribed for behavior management purposes. Changes in medications do not require prior approval by the Planning Team or Review Team. Rather, the changes must be documented for and the Plan updated. Section 5.04-3(D)(3) of the adopted regulation includes a provision for the prescribing physician to instruct a different notification schedule. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (12) points out that after each administration of a Psychiatric PRN medication, the prescribing physician must be notified within twenty-four (24) hours of the administration of the medication, unless otherwise instructed in writing by the physician.

**Response**: The Department thanks the Commenter for this comment. The 24 hour notice requirement may be waived by the prescribing physician under §5.04-3(D)(3). The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (12)stated thatcurrent CRMA requirements are inconsistent with this proposed regulation and would need to be updated.

**Response**: The Department thanks the Commenter for this comment. The Department is unaware of any areas of inconsistency. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (22) asks who will take the lead in to ensure monitoring of the effectiveness of such medications on health and mental functioning.

**Response**: The Department thanks the Commenter for this comment. Both the prescribing clinician and the Person’s support staff will monitor the effectiveness of medications. The support staff providing protective oversight and supervision of the Person have both the necessary training and the responsibility to inform the prescribing clinician on the effectiveness of any medications. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (22) is concerned that the regulations are silent regarding psychotropic medications which are used for medical diagnosis rather than behavior and mood.

**Response**: The Department thanks the Commenter for this comment. Psychotropic medication used for medical diagnosis is outside the scope of these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment:**  Commenter (22) is concerned that this requirement drastically increases the administrative burden for agency and includes points best assessed and monitored directly by the prescribing physician him or herself.

**Response**: The Department thanks the Commenter for this comment. These regulations does not negate the prescribing physician authority and responsibility to monitor the effectiveness and effects of all medications his/she prescribes. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (28) is concerned that under these regulations psychotropic medications will have to be adjusted downward each year which will lead to sabotaging their stability.

**Response:** The Department thanks the Commenter for this comment. The Department sees nothing in these regulations that leads to the result described in this comment. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (14) asks if the Review Team is going to have a more active role in monitoring psychiatric medications and chemical restraints, is there a member of the Review Team with expertise in this area.

**Response**: The Department thanks the Commenter for this comment. The documentation requirements for psychiatric medications and chemical restraints are intended to ensure that when medications are utilized to address challenging behavior all teams, including the Review Team, are informed. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (14) asked how the Review Team will monitor psychiatric medications and chemical restraints if they don't know the Person's baseline

**Response**: The Department thanks the Commenter for this comment. The Review Team relies on the Person’s Planning Team and prescribing clinicians to inform them of the Person’s baseline. Information on the Person’s baseline should be included in a medication plan. Members of the Planning Team should ensure this is discussed with the prescribing clinician and documented appropriately. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) states that no staff from community organizations are qualified to make these demands from physicians found in this section, nor do they have the training to interpret what they may be given. Commenter (17) states that no member of the Review teams as constituted are trained to oversee psychiatric practice. The regulations charge uneducated paraprofessionals with confronting doctors, so that the “review” teams may sit in judgment of all psychiatric interventions. And to be frank, the existing review teams have repeatedly questioned medical practices before, and have had no hesitation in criticizing prescriptions, suggesting medication changes, and even suggesting changes in medical professionals. Commenter (17) states that this is one area where the Appointed review teams, consisting of state and federal appointees, with no credentialing requirements, have usurped the role of the guardian. Commenter (17) states that this section needs to be removed in its entirety, absent qualified medical personnel on the review team.

**Response**: The Department thanks the Commenter for this comment. The Department does not intend nor interpret these regulations to operate in the manner described in this comment. The Review Teams ensure the development of a comprehensive Plan that meets the needs of the Person being served. The Review Team relies on professionals familiar with the Person to prescribe appropriate medications. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) asked what would happen if the Planning Team all agrees on a Medication Plan, except the legal guardian. Commenter (19) states that the Planning Team does not have the right to implement medication s or a change without guardian approval, so it appears to be a regulation that couldn’t therefore be implemented.

**Response**: The Department thanks the Commenter for this comment. The commenter is correct that a legal guardian must authorize the use of medications. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) states that the Psychiatric Medication Support Plan lists out items already required in DLRS on said medications—side effects, parameters, adverse reactions, risks/benefits. Commenter (19) asked why this rule is duplicative.

**Response**: The Department thanks the Commenter for this comment. Not all Persons live in licensed settings. For those settings that also must comply with licensing rules the Service Provider may develop tools which meets the documentation needs of both systems. The Department made no changes to the final rule as a result of these

1. **Comment**: Commenter (19) asked if this requirement suggests private psychiatrists are going to be responsible for this administrative process. Commenter (19) asked how this will impact private practitioners (i.e. doctors, psychiatrists) who are not affiliated with Section 21 or 29 services.

**Response**: The Department thanks the Commenter for this comment. The Department does not intend to make private psychiatrists responsible for the administrative process required by these regulations. The Department intends Planning Team and Review Team members to work cooperatively. For Service Providers who do not accept the funding mechanism of a waiver service or State plan service the entity hiring the clinician is responsible to secure alternative funding. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) states that the entire §5.04-5 Psychiatric Medications and Psychiatric Medication Support Plan, is not clear as to whether a plan is needed for any time a psych med is ordered or just prn’s (support the need for a plan when there is a prn prescribed for behavior). Commenter (20) states that the language alternates between "when psych meds are prescribed" to "when psych med is used as a Chemical Restraint". If a plan is intended for all prescribed psych meds then there should be a corresponding MH diagnosis and not prescribed for behavior as these regulations indicate; support the need for close monitoring of psychiatric meds with a psychiatric evaluation assessment tool for documentation.

**Response**: The Department thanks the Commenter for this comment. The Department intends for the Psychiatric Medication Support Plan to include a list of all psychiatric medications prescribed. The Department intended to include additional requirements when a psychiatric medication is used as a Chemical Restraint, or as a PRN medications. In response to this comment the Department amended §5.04-3of these regulations.

1. **Comment**: Commenter (22) asked who takes the lead on the requirement that “when Psychiatric Medications are prescribed, the Planning Team must adhere to special procedures to ensure monitoring of the effects of such medication on health and mental functioning”.

**Response**: The Department thanks the Commenter for this comment. The Department expects the members of the Planning Team to work cooperatively. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (22) states that the regulation is silent on the cases where a psychotropic medication is used to treat seizures rather than behavior or mood. Commenter (22) asks whether a Psychiatric Medication Support Plan must be developed in this situation as the regulation states that it must be developed for any member prescribed psychiatric medication.

**Response**: The Department thanks the Commenter for this comment. These regulation’s requirement of a Psychiatric Medication Support Plan applies when psychiatric medications are prescribed for behavior management purposes, not when the medications are prescribed for medical or mental health purposes. The Department made no changes to the final rule as a result of these comments.

**5.05 BEHAVIOR MANAGEMENT (Levels 3-5)**

***5.05-1 Behavior Management Planning***

1. **Comment**: Commenter (12) states that §5.05-1 of the regulations seems contradictory.

**Response**: The Department thanks the Commenter for this comment. The Department has reviewed the regulation and other comments to identify any areas of contradiction and to clarify where appropriate. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) states that whenever the person or a member of the Review Team objects this becomes a restriction and will therefore need the approval of the state and federal appointees. Commenter (17) states that enabling anyone to sabotage what the rest of the team approves will be impractical, and makes it imperative to achieve consensus and unanimity. Commenter (17) states that this needs to be eliminated.

**Response**: The Department thanks the Commenter for this comment. The Department made no changes to the final rule as a result of these comments.

***A. Requirements for Planning Team to Act***

1. **Comment**: Commenter (23) asks for clarification on whether the Department intends to direct support teams to implement rights restrictions not otherwise permissible under the proposed regulations when a court order outlines terms for probation that call for prohibited interventions.

**Response**: The Department thanks the Commenter for this comment. Section 5.05-A requires the Planning Team to develop a Behavior Management Plan consistent with any court order or condition of probation when the intervention falls within these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**:Commenter (12) asked if there will be an increase in number of state Review Teams, as well as an increase in review meetings being held.

**Response**: The Department thanks the Commenter for this comment. The Department does not anticipate an increase in the number of requests for approval of Behavior Management Plans based on these changes. It is anticipated that through the requirements of enhanced focus with regard to preventative strategies and Positive Supports, the need for restraints and restrictions will decrease. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (12) feels agencies are put in an awkward positon when they are not responsible for actually creating and writing a plan, but for simply implementing it. Again, good behavior management planning involves baseline data, assessment, re-evaluation and modifications. For this to help individuals, one cannot wait for weeks or months for a team meeting to be scheduled. Commenter (12) believes the regulation allows an ineffective plan to continue to be implemented, which may cause harm to the individual.

**Response**: The Department thanks the Commenter for this comment. There is nothing in these regulations that prohibits Service Provider staff from creating a plan. Best practice would be to work collaboratively with the identified clinician that will oversee and monitor the Plan. The Department agrees that it may take time to secure the appropriate professionals to meet. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (12) states that the regulations start by saying the Planning Team is in charge of creating the plan, and then it appears to switch to giving the directions regarding the qualifications necessary to create the plan. Commenter (12) asks the Department to explain that discrepancy.

**Response**: The Department thanks the Commenter for this comment. In response to this comment the Department added language to §5.03-1 and §5.03-3.

1. **Comment**: Commenter (13) states that throughout the rule, reference is made to the Planning Team as the catalyst for action and review of plans when the client exhibits Challenging Behavior. Commenter (13) asked who on the Planning Team is the point of contact for all aspects of the plan, including psychological assessments, physicians’ evaluations, residential service plans, community support plans, and employment plans.

**Response**: The Department thanks the Commenter for this comment. In response to this comment, and other similar comments about who is responsible for the work of the Planning Team, the Department has amended these regulations by adding language to §5.03-1 and §5.03-3.

1. **Comment**: Commenter (20) states that the requirement in §5.05-5(A) that the professional must meet and observe the individual at least twice annually is an excellent requirement.

**Response**: The Department thanks the Commenter for this comment. The Department made no changes to the final rule as a result of these comments.

***B. Requirements for Updated Functional Assessment***

1. **Comment**: Commenter (20) states that it is an excellent addition of qualified professionals to supervise the plans (e.g. LCSW, LCPC, BCBA) however the continued use of a Psychiatrist to oversee plans is a concern to this Commenter (20) due to their lack of experience in behavior management

**Response**: The Department thanks the Commenter for this comment. Because Planning Teams may have difficulty accessing clinical resources it is prudent to retain this requirement. The Department made no changes to the final rule as a result of these comments.

***C. Requirements for a Behavior Management Plan***

1. **Comment**: Commenter (23) points out that there are identical statements in §5.05-1 (C)(9) and §5.05-2 (H) about plan training being offered to anyone supporting the person, including parents, guardians, and correspondents. The Commenter agrees that this training is necessary but does not believe it needs to appear twice.

**Response**: The Department thanks the Commenter for this comment. The Department acknowledges this is repetitive but not contradictory. The Department does not believe there is harm in repeating this language. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) states that the baseline measurement in §5.05-1(C)(3) is good practice except when taking baseline data would put staff in the position of simply observing and counting dangerous acts (SIB, aggression, destructiveness). Commenter (17) asks that some statement about this be added as some on the Review Teams view these regulations without regarding such realities.

**Response**: The Department thanks the Commenter for this comment. The Department intends these regulations to allow the number of “attempts” to be counted as baseline data. This allows staff to intervene appropriately. The Teams should consult a professional when necessary. The Department made no changes to the final rule as a result of these comments.

* + 1. ***Behavior Management Practices***

1. **Comment**: Commenter (23) asks the Department to clarify whether it is the intent that any planned use of law enforcement pursuant to §5.05-3(A) is subject to appropriate review by the Review Team.

**Response**: The Department thanks the Commenter for this comment. The intent is that any planned use of law enforcement pursuant to §5.05-3(A) is subject to review. In response to this comment the Department added language to the Level 3 grid in §5.03-2 and Appendix Three to address this comment.

1. **Comment**: Commenters (11, 17, 23 & 20) comment on the length of time allowed for In-Home Stabilization. Commenter (23) suggests the Department clarify in §5.05-3 (D)(3), In Home Stabilization that the cessation of In-Home Stabilization is to be to the person's readiness to continue with his or her day (including clear descriptions of how this person appears when ready) rather than a pre-determined amount of time. Commenter (23) feels that otherwise the intervention is a punishment rather than a therapeutic intervention. For example, when the person gives clear signs that he or she is ready to continue after 15 minutes, the In-Home Stabilization period should end, not be prolonged for 45 additional minutes. This is made clear in §5.05-3 (D)(5) but should be criteria for any use of In-Home Stabilization. Commenter (17) asked what is the basis for the 15 minute limitation in §5.05-3. Commenter (17) states that the point is that many dangerous persons continue to fight to assault staff for longer than 15 minutes. Some restraints have had to go on for hours – even as staff release-regain-release-regain. This arbitrary rule just puts everyone in danger. The old rule was bad enough. Commenter (20) recommends that the timeframe for an In-Home Stabilization, §5.05.-3(D), be directly related to the average length of time that documentation indicates it takes the individual to return to baseline behavior or safe behavior. Commenter (20) recommends that a continuous restraint be limited to 60 minutes as required under the current regulation. Commenter (20) views the 15 minute criteria as arbitrary. Commenter (20) states that approval of a longer restraint as a special circumstance based upon data from the prior 12 months is not appropriate. Once a plan is implemented one often sees the behavior escalate prior to reducing so the previous data may be irrelevant or not the criteria needed at the time. Commenter (11) agrees with and appreciates the State's decision to reduce the time for release during a restraint to fifteen minutes. Commenter (11) writes separately only to request that the State also maintain the current maximum of no longer than one continuous hour with 3-Person Committee approval by the following changes in §5.05-3 (C):

“The use of Restraint without an attempt to release must not continue for longer than fifteen minutes, unless approved as a special circumstance by the Review Team up to a maximum of one hour . . .”

**Response**: The Department thanks the Commenters for these comments. In response to the comments regarding the length of time before discontinuation of In-Home Stabilization, the Department added a criterion to Appendix Four (A). In response to the comments regarding the 15-minute limitation on restraints and In-Home Stabilizations, these requirement promotes the constant use by staff of other de-escalation techniques including using release from the physical hold. Physical holds are the most intrusive interventions and other traumatic to all involved. Section 5.05-3(A) for further clarification.

1. **Comment**: Commenter (20) recommends that in §5.05.-3(D), In-Home Stabilization, that phrase “Person or others” be changed to “Persons or community”. Commenter (2) makes this recommendation because this section is restricting access to the community.

**Response**: The Department thanks the Commenter for this comment. The Department incorporated this suggestion.

1. **Comment**: Commenters (11 & 23) suggest that the Department clarify the ramifications of using a prohibited intervention. Commenter (23) strongly suggests that use of a prohibited intervention as outlined in §5.05-3(H) result in some sort of sanction from the Department. Commenter (23) too often finds that prohibited practices continue, with the assumption that reporting the event absolves the reporter from responsibility. In effect, the report is seen as a "free pass" to continue violation of the person's rights without permission or oversight. Commenter (11) stated that there is currently a widely held misconception that prohibited elements of behavior management plans may be utilized as long as the use is reported to the State. Often, when plans do not receive approval from the 3-Person Committee, service providers will continue to use them and report their usage to the Enterprise Information System (EIS). Commenter (11) feels this misunderstanding is commonly attributed to mandated reporting requirements which require such a use to be reported. However, much like the mandated reporting of abuse, the abuser reporting the abuse does not absolve them of the act. Commenter (11) urges the State to rectify this misconception in the proposed regulations and add the following to the end of §5.05-3(H)

“Reporting does not absolve the reporter of liability for this type of violation of law and regulation.”

**Response**: The Department thanks the Commenters for these comments. State law, 34-B M.R.S. §5604-A and Department regulations, 14-197 CMR , Ch. 12, Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation hearings Regarding Persons with Intellectual Disabilities or Autism, require reports to be filed when Prohibited Practices are used. The filing of a Reportable Event does not negate responsibility for the use of a prohibited practice. All reportable events are reviewed and responded to appropriately. In response to this and similar comments the Department made several changes to these regulations.

1. **Comment**: Commenter (20) states that §5.05-3(F) is confusing. It states that the use of video and ankle bracelets are not considered a Rights Restriction and yet in §5.06 they are listed as a level 3 "Restrictions of Rights".

**Response**: The Department thanks the Commenter for this comment. Videos and ankle bracelets used when the Person does not object and they are being used for therapeutic or safety reasons are not restraints. If used for other purposes, or if the Person objects, they are considered a Level 3 Intervention. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) states that §5.05-3(H) Prohibited Interventions is confusing as to whether the use is prohibited or may be used and then file a Reportable Event.

**Response**: The Department thanks the Commenter for this comment. Prohibited Interventions are not allowed and a Reportable Event must be filed whenever a Prohibited Intervention is used. The filing of a Reportable Event does not negate responsibility for the use of a prohibited practice. All reportable events are reviewed and responded to appropriately. The Planning Team is also required to review all Reportable Events on an annual basis. The Department made no changes to the final rule as a result of these comments.

* + 1. ***Additional Requirements when Restraint is part of a Behavior Management Plan***

1. **Comment**: Commenters (11 & 23) suggest that psychological evaluations associated with restraints pursuant to §5.05-4 (B) be required annually. Commenter (23) states that an evaluation of the effectiveness of the intervention is preferable. The Psychological Assessment should also include observation of the individual; otherwise, the assessment hinges upon, at best, secondary information from those who may be much less objective than the clinical psychologist. Commenter (11) recommends that the Psychological Assessment be updated annually as opposed to the proposed three years for the same reasons. As the State has opened up the licensure of overseeing professionals, it corresponds that having some support from a Psychologist at least annually would provide for some psychological oversight and opportunity for consideration of interventions not yet explored. Commenter (11) recommends the following changes to §5.05-4(B)

“If Restraint or systematic restriction of Rights continues to be recommended in the Behavior Management Plan, the Psychological Assessment must be updated at least ~~every three years~~ annually.

**Response**: The Department thanks the Commenters for these comments. In addition to the psychological assessment, the identified qualified professional is required to monitor the plan on a monthly basis, and must see the Person at least twice a year. Nothing in these regulations prohibits a Planning Team from requesting more frequent psychological assessments. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) asked why the Department no longer allows psychological assessments to be

completed by other professionals such as BCBA under §5.05-4(B).

**Response**: The Department thanks the Commenter for this comment. This is not a change in regulation. The Department made no changes to the final rule as a result of these comments.

* + 1. ***Monitoring the Behavior Management Plan***

1. **Comment**: Commenters (10 & 11) expressed concern with the case manager's unrestricted access to the Person’s record granted under §5.05-5(G)(1). Commenter (11) understands and appreciates the intent behind making case managers responsible for monitoring behavior plans, confidentiality of records is an enumerated right of individuals receiving Developmental Services. Commenter (11) points out that in most cases, case managers will already have signed releases granting the Person’s consent to review their records. However, in the rare case where the individual does not consent to the release of these records, it would require Level 3-5 intervention to systematically violate their right to confidentiality. Commenter (10) believes the consent process provides as important check and balance for Persons. Commenter (11) recommends:

removing "and the Person's record" from proposed §5.05-5(G)(1).

**Response**: The Department thanks the Commenters for these comments. Without access to all relevant information the Case Manager would not be able to coordinate services and monitor implementation of the Plan for the individual under MaineCare programs. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (12) agrees with monitoring of plans but feels the proposed amount and times of review are confusing. Commenter (12) also wonders, if it is a plan across settings how it will be monitored across agencies by the “qualified professional”.

**Response**: The Department thanks the Commenter for this comment. Because Behavior Management Plans are intrusive to the Person the varying processes for reviews ensures a high level of oversight. When there are other agencies involved in carrying out a plan they must be involved in the planning and review process, including sharing information with the qualified professional. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) states that the Monitoring the Behavior Management Plan section also requires Case Managers “conduct an in-person review of the implementation of the plan at least quarterly. Commenter (19) asks if this is separate from the rest of the monitoring required under the regulation. Commenter (19) asks how the Department going to augment Case Manager’s training and supervision to insure they meet required professional competencies for this to conduct quarterly in-person review of the implementation plan.

**Response**: The Department thanks the Commenter for this comment. This level of review by the Case Manager may occur prior to or subsequent to the quarterly review of the Plan by the Planning Team. Case Managers are required to coordinate and monitor all services and supports. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) suggested that if these regulations supported enhancing the case manager training, role, and responsibilities, they would be in an excellent place to monitor what is going on relative to rights/practices, thereby eliminating the need for such dramatic oversight outlined in these 40 pages.

**Response**: The Department thanks the Commenter for this comment. Case Managers must be involved when Persons are experiencing Challenging Behaviors to ensure health and safety and compliance with regulatory requirements. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (14) asked whether agency representatives required to be present during monthly clinical reviews under §5:05-5 (B) can call in or provide progress via protected e-mail

**Response**: The Department thanks the Commenter for this comment. Alternatives to physical participation in the clinical reviews should be discussed within the Planning Team. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (19) states that§5.05-5, Monitoring the Behavior Management Plan, is confusing and not in line with MaineCare rule restricting the Behavioral Consultation hours for Psychologists and Licensed Professionals to 16 hours per year Commenter (19) states that under these regulations the qualified professional must review monthly, observes the person at least twice annually, an agency representative from each service sector must attend, and guardian and case manager should be invited to the monthly reviews. In addition the Planning Team must monitor the plan quarterly. So, the expectation is to do it monthly and quarterly. This is a lot and how do you balance this with the Maine Care rule restricting the Behavioral Consultation hours for Psychologists and Licensed Professionals to 16 hours per year---which includes creating the plan, doing home visits to observe, and meeting monthly and meeting quarterly.

**Response**: The Department thanks the Commenter for this comment. The Department believes that in addition to monthly monitoring there is still enough billable time available for the overseeing qualified professional to see the person at least twice per year. Unless the Planning Team requests, there is no requirement for the qualified professional to attend the quarterly meetings. Quarterly meetings can be used to ensure that all participants are working in a coordinated fashion, review clinical information and data, and discuss progress and strategies to reduce the need for a Behavior Management Plan**.** The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (14) stated that the requirement that agency representatives be present during

monthly clinical reviews under §5:05-5 (B) is likely to place a burden on community and work support entities.

**Response**: The Department thanks the Commenter for this comment. Best practice requires all parties that implement a Behavior Management Plan have the opportunity to provide input, discuss progress, and secure information from the qualified professionals. The Department made no changes to the final rule as a result of these comments

1. **Comment**: Commenter (20) states that there is nice clarity in §5.05-5(F) on "all modifications of the Behavior Management Plan which include a reduction of restrictive measures must be approved by the Planning Team prior to implementation,...and must be sent to the Review Team within 30 days."

**Response**: The Department thanks the Commenter for this comment. The Department made no changes to the final rule as a result of these comments.

**5.06 LEVELS OF INTERVENTION: POSITIVE SUPPORT AND BEHAVIOR MANAGEMENT PLANS (LEVELS 1-5)**

1. **Comment**: Commenters (8 & 20) ask for others to be specifically listed in the table in §5.06. Commenter (8) suggests that that the table in Section 5.06 be amended to include "Person, Guardian, and Correspondent or other” in all boxes labeled Required Approval. The Commenter suggested that this table which identifies Levels of Intervention would be more helpful if it included all required approvals as specified in proposed regulation §5.08. Commenter (20) stated that §5.06 "Required Approval" should include Guardian and not assume they were part of the Planning Team.

**Response**: The Department thanks the Commenters for these comments. The table in proposed regulation §5.06 specifies that the “Planning Team” approval is required for Levels 1-5. The definition of “Planning Team” in §5.02-32 includes the group of people required under 34-B M.R.S. §5470-B. This Maine law specifies that the planning process must “minimally include the person, the person's guardian, if any, the correspondent, if any, and the person's case manager” (See 34-B M.R.S. §5470 - B(2)(D)). The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (8, 11 & 13) question the use of examples on the right side of the grid. Commenter (13) asks what the intent is of the examples on the right column and whether they are the triggers which then require the Planning Team to convene and create a Functional Assessment and Positive Support Plan. Commenter (8) suggests that "Examples, Not Limited To" be removed from the grid in §5.06 to reduce the potential for confusion. Commenter (13) asks if the examples in the table aren’t comprehensive, how will service providers know all specific actions that fall within Levels 1-5. Commenter (11) has many concerns about the grid in §5.06 which describes and creates examples of Levels 1-5. Commenter (11) states that the grid unnecessarily restated what had already been stated in prior sections and which is again stated proposed §5.08. Commenter (11) feels, if anything, the grid only serves to provide conflicts and contradictions with the other sections. Commenter (11) is most concerned with Level 2 which the grid describes as both "Non-coercive intervention with voluntary participation by the Person" and "Some programs which restrict a Person's activities or Rights for safety reasons." Commenter (11) states that §5.05 explicitly states that all planned interventions which include restrictions of rights or the use of restraint are reviewed at Levels 3-5 as a Behavior Management Plan which is consistent with the current review of Severely Intrusive Plans. Commenter (11) feels it was unclear why the State chose to include multiple instances of rights violations within both its description and examples of Level 2 interventions. Commenter (11) recommends removing the grid entirely as it is simultaneously repetitive and inconsistent. If this is not possible Commenter (11) recommends removing the following rights violations from Level 2:

~~Some programs which restrict a Person’s activities or Rights for safety reasons. Preservation of personal property and safety measures involving incendiary material or sharps.”~~

~~In Home Stabilization for a maximum of one hour for safety and assessment.~~ Securing of incendiary material, clothes, shoes or sharps with documented safety issues or problematic misuse, to which the Person consents. ~~Restriction of food or liquid (with doctor’s health or safety recommendation~~.

**Response**: The Department thanks the Commenters for these comments. The Department believes that the examples in this grid are more useful than not. It is not possible to identify all interventions that exist now, nor is it possible to identify possible interventions that may be developed in the future. The Department expects Service Providers of services to Persons with intellectual disabilities or autism to be aware of the legal rights of the people they serve. Service Providers are encouraged to contact a Person’s Case Manager or the Department with any questions about a particular intervention. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (11) points out that the document describes instances in which a Planning Team is required to engage in a restraint and/ or an intervention which violates the individual’s rights. This is restated several times with slightly different ambiguous terminology each time, such as “danger", "harm” and "injury”. Commenter (11) recommends using the same consistent and clear terminology each time in order to reduce confusion and unnecessary restraints and rights violations. Commenter (11) recommends the following changes be made:

In §5.02-15 “Emergency: means a situation in which there is Imminent Risk of ~~harm or danger~~ physical injury to the Person or others. ~~Risk of criminal detention or arrest constitutes an Emergency~~.”

In §5.03-2 (A) “If the Planning Team determines that Positive Supports alone are insufficient to prevent ~~harm~~ Imminent Risk of physical injury to the Person or others, the Planning Team must develop a Behavior Management Plan or follow Emergency Intervention Procedures within this rule.”

In §5.05 -1 (A) “When a Person's Challenging Behavior presents ~~a threat of injury to self or others, threatens serious damage to the property of others, or threatens loss of placement,~~  an Imminent Risk of physical injury to the Person or others, the Planning Team must act to ensure the Person's safety.”

In §5.05-2(E) “Restriction of Rights or the use of Restraints may be used only to keep a Person or others safe from ~~harm~~ Imminent Risk of physical injury to the Person or others”

In §5.09-1 “Emergencies occur when a Person's Challenging Behavior presents an Imminent Risk ~~to the health and/or safety of~~ physical injury to the Person or others.”

In §5.09-1(A) “If necessary to protect the Person or others from Imminent Risk of physical injury to the Person or others, Restraint otherwise permitted in these regulations may be used on an Emergency basis.”

In §5.09-1(D) “Emergency intervention may include temporary removal of personal property ~~to protect the Person from Imminent Risk of injury~~ when there is an Imminent Risk of physical injury to the Person or others.”

**Response**: The Department thanks the Commenter for this comment. In response to this comment the Department had brought consistency to the sections listed in this comment.

***Level 2 Programs which are designed to modify or redirect a Person’s behavior***

1. **Comment**: Commenter (15) states that this new rule will require a seemingly endless round of assessments and reassessments, planning and monitoring, and re-planning, just to monitor if knives should be kept in a locked drawer when trained direct support professionals work side-by-side with the individuals every day and can easily assess the need for locked sharps.

**Response**: The Department thanks the Commenter for this comment. The Level system in these regulations pairs the degree of review, monitoring and documentation to the degree of restriction or intervention used and/or the seriousness of the Challenging Behavior. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (8) recommends that all In Home Stabilization Plans be classified and reviewed as Levels 3-5 without the option of a Level 2 intervention: In Home Stabilization restricts access to the community rather that modifying or redirecting a person's behavior.

**Response**: The Department thanks the Commenter for this comment. There are circumstances when a Person is so unsafe that the best option for the Person, and members of the community, is to have the Person stay with those who have the skill to assist the Person to have a positive experience when they move on with their day. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (10, 12 & 15) commented on how physical prompting/redirecting is regulated in the proposed rule. Commenter (10) stated that it’s experience is that using physical prompting and redirection is often a way to prevent more extreme out of control behavior and should be allowed under certain circumstance. Commenter (12) concludes that if a provider provides verbal redirection to remain on the sidewalk, a plan would have to be developed and a Functional Assessment with all those components developed. Commenter (12) views this result as missing the intent of the regulations, but rather just creating paperwork. Commenter (15) states that “verbal redirection and verbal prompting to redirect behavior” requires a Level 2 Plan. For example, when asking a person with autism to stay inside when they are heading outside where they may become lost or harmed by traffic.

**Response**: The Department thanks the Commenters for these comments. These commenters are correct that a Functional Assessment must be completed when a Challenging Behavior exists. The Department does not interpret these regulations as always leading to the result described by the commenters. The process in these regulations allows for thoughtful discussion regarding individual situations and appropriate interventions. This process is intended to increase the use of positive supports and decrease the use of more restrictive interventions The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (10) points out that is regulation language around controlling food being allowed in certain circumstance does not mention autism. The Commenter notes that certain Persons with autism, have extreme behavior around food and reasonable controls need to be allowed. The Commenter asks the Department to make sure allowances for controlling food includes persons with autism.

**Response**: The Department thanks the Commenter for this comment. Each situation will be reviewed on an individualized basis and the examples are not intended to be an exhaustive list. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (13) asked whether if the examples in the column on the right are a list of restrictions that must be included in a Plan, and those types of actions are commonly used by Service Providers for clients without behavioral challenges, by extension does that mean that when those “restrictions” are used with any client, they now require the Functional Assessment and Positive Support Plan whenever they are in use. Commenter (13) asks if this is so, how will the Department train and educate Service Providers to identify the new larger body of clients that will require these services

**Response**: The Department thanks the Commenter for this comment. It is the Planning Teams responsibility to identify the difference between addressing a Challenging Behavior and addressing actions or teaching skills that assist with day-to-day activities. The Department will develop and provide training to all interested Service Providers in a manner similar to trainings currently provided by the Department. The Department made no changes to the final rule as a result of these comments.

***Level 3 Programs which restrict a Person’s Rights as enumerated in 34-B M.R.S. §5605***

1. **Comment**: Commenters (11 & 23) ask for clarification on communication devices needed for expression. Commenter (23) suggests that the examples in §5.06 Level 3 clarify that restrictions on a Person's communication does not include the person's advocate, guardian, crisis team, or removal of communication devices needed for expression. Commenter (11) states that because “communication” is an undefined term, the "restriction of communication" within the Table in §5.06, Level 3 could be interpreted to allow the removal of communication devices or other means by which an individual uses to communicate. Commenter (11) states that because the example is so broad, it could be interpreted to include restriction of communication with family members which is later expressly prohibited. Commenter (23) would like the denial of basic needs to include access to communication devices.

**Response**: The Department thanks the Commenters for these comments. The Prohibited Practices section of these regulations specifically prohibits “denial of communication or visitation with family members or significant others for the purpose of behavior modification or behavior management.” To further clarify this matter the Department added language to the Level 3 grid in §5.03-2 to clarify that restriction of communication as a Level 3 intervention does not include restriction of communication to the person’s advocate, guardian, or crisis team. The Department added language to Level 3 grid in §5.03-2 to clarify that communication devices may be restricted if used for illegal activities. The Department added specific language to Level 4 in the grid in §5.03-2 to clarify that restrictions of communication devices used for expression or restraint that interfere with a person’s ability to communicate, such as by sign language or gestural communication, must be reviewed and approved as a Level 4 intervention

1. **Comment**: Commenter (13) asks, with respect to the “Advocates” that must be notified when the Planning Team is considering a Level 3 plan or above: how many Advocates are employed by the Protection and Advocacy Agency; how many in each county; and what is their role in developing and reviewing the Plans?

**Response**: The Department thanks the Commenter for this comment. Under §5.02-1, “Advocate” is defined as an employee of the Protection and Advocacy Agency. As such, the role of an advocate from the Protection and Advocacy Agency is the same as the role of the Advocate described in these regulations. There are Advocates available in each area of the State to assist individuals and their Planning Team to understand the Rights statute as it may pertain to the development of a Behavior Management Plan. The Department made no changes to the final rule as a result of these comments.

***Level 5 Programs considered only in exceptional and rare instances where no less restrictive measure can safely meet the need to keep a Person from danger to self or others***

1. **Comment:** Commenter (8, 11 & 23) commented on the use of floor restraints. Commenter (11) commends the Department for prohibiting the use of prone restraints. Commenter (11) remains concerned about the allowance of any floor restraints and specialized restraints which are not part of a service provider's nationally certified training. Commenter (11) is concerned because of the likelihood of asphyxiation with floor restraints. Commenter (11) states that many training programs, like Mandt, have already removed all floor restraint training from their program citing to the investigative report titled Deadly Restrain which accounted for approximately 150 deaths per year during floor restraints. Commenter (11) expressed concern because the members of the Review Team are not in a position to judge whether a restraint designed by a service provider is more dangerous to the Person than the Challenging Behavior. Commenter (11) states that as a society, we rely on nationally recognized physical intervention programs to do the necessary research and studies to determine the safety of a hands-on technique. Commenter (11) states that to allow service providers to amend those programs to include a new type of restraint invites risk of injury and liability. Commenter (11) recommends that the State prohibit any use of floor restraints which are not part of a current, nationally certified physical intervention program, Commenters (8 & 23) concur that both supine and prone floor restraints should be prohibited practices.

**Response**: The Department thanks the Commenters for these comments. Prone restraints are prohibited under §5.07 of the regulation. All supine restraints are subject to three levels of review (Review Team, Statewide Review Team and Commissioner approval). The use of restraints must be in accordance with DLRS approved programs or be approved as a Specialized Intervention. In response to this comment the Department amended these regulations.

1. **Comment**: Commenter (17) states that prone restraints are sometimes indicated for safety reasons. Commenter (17) notes that these regulations prohibits something that is used by a leading psychiatric hospital in Maine. Commenter (17) states that the key is training and that agencies training will result in the safe use of this safe technique.

**Response**: The Department thanks the Commenter for this comment. Prone restraints can be particularly dangerous to the health and safety of individuals and as such some restraint programs have eliminated the use within their programs. The Department made no changes to the final rule as a result of these comments.

1. **Comment**:Commenter (24) spoke about her son who requires prone restraints and is concerned that this is becoming a prohibited practice which only police and mental health hospitals will be able to use.

**Response**: The Department thanks the Commenter for this comment. The Department appreciates the concern of this parent for the health and safety of her son. Prone restraints can be particularly dangerous to the health and safety of individuals and as such some restraint programs have eliminated the use within their programs. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) asked is the approval required in §5.06 Level 5 is approval of the Review Team or the State Review Panel, as identified in proposed regulation §5.08.-1(C), or both.

**Response**: The Department thanks the Commenter for this comment. The State Review Panel reviews but does not have the authority to approve or disapprove a Level 5 Behavior Management Plan. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) asked if the signatory required in §5.06 Level 5 is it the Commissioner or his/her designee as stated in proposed regulation §5.08-1(A)(3)

**Response**: The Department thanks the Commenter for this comment. The Commissioner or his/her Designee is responsible to sign Level 5 Behavior Management Plans. The Department has amended these two sections to clarify this.

* 1. **PROHIBITED PRACTICES**

1. **Comment**: Commenters (3, 18 & 19) commented on the prohibition of manipulation of personal property. Commenter (18) states that certain individuals currently receiving services have approved plans that allow temporary loss of access to personal property following the occurrence of Challenging Behavior. Commenter (18) states that implementation of these intervention was undertaken only after other less restrictive procedures had been attempted and failed and had proved to be the only alternatives to multiple crisis and police calls, multiple hospitalizations and staff injuries while attempting protective restraints in response to dangerous physical aggression. Commenter (18) states that temporary loss of access to personal property should be classified as Level 5 intervention. Commenter (19) asks if a person is unable to care for themselves because they are on the computer all night why is regularly limiting access to said personal property prohibited. Commenter (19) asked whether it is in the individual’s best interest to “prohibit” a limitation that could enhance their quality and participation in their life. Commenter (3) asked why a family could not set a limit on television use when an individual may otherwise be up all night so then unable to function the next day.

**Response**: The Department thanks the Commenters for these comments. The Department recognizes the need to balance a person’s health, safety and welfare with their rights to personal property. The Department believes these regulations strikes the appropriate balance. Restriction of personal property is allowed under these regulations address Imminent Risk of harm to self or others, or when the property itself is the cause of risk to health and safety. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (2 & 3) question the prohibition on the use of rewards as part of a Positive Behavior Plan.

**Response**: The Department thanks the Commenters for these comments. The use of rewards is prohibited when used in a punitive manner. Use of rewards as a positive support is allowed and considered best practice.

The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (18) states that §5.07 appears to prohibit simple restitution procedures common in everyday life. For example, if an individual routinely damages or destroys the property of others, the draft regulations appear to prohibit requiring the individual to reimburse others for losses. It would have a similar effect in cases of frequent theft when stolen items cannot be recovered. Such procedures are appropriate, “normal” and can be effective. Commenter (18) states that this procedure should be classified as Level 4 to ensure adequate oversight.

**Response**: The Department thanks the Commenter for this comment. The Department did not intend and does not interpret these regulations to prohibit restitution. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) asked for clarity on the applicability of §5.07, Prohibited Practices - Certain Mechanical Restraints, regarding H-harnesses used for support only.

**Response**: The Department thanks the Commenter for this comment. The Prohibited Practices specifies that the practices listed are “prohibited as elements of Behavior Management Plans or as Emergency Interventions” These practices are not prohibited under these regulations if used as a Safety or Therapeutic Intervention. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (2) questions the prohibition on the use of cameras as part of a Positive Behavior Plan

**Response**: The Department thanks the Commenter for this comment. These regulations does not specifically prohibit the use of cameras. Any use of cameras for behavior management or as a Safety Device would need to meet appropriate review and approval under these regulations. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (3, 12, 18 & 19) commented on the use of money and tokens. Commenter (3) asked whether the prohibition on withholding for behavior management, manipulation of personal property and use of token systems was “clinically informed”. Commenter (3) questioned whether it is better for individuals to spend all their money (or give it away) so their well-being is threatened since shelter and food are not able to be provided. Commenter (3) suggested that Token or point loss should not be classified as “withholding of funds” and should be allowed as part of approved plans because many individuals benefit from token or point systems, and procedures for token or point loss as a consequence for challenging behavior are a necessary element for the success of a number of these token/point systems. Commenter (3) suggested that such procedures should be classified as Level 4 procedures to ensure adequate oversight. Commenter (19) states the regulations say teams must “strive to avoid” token economies and if you have an “artificial reinforcer” you must have a written plan to move toward “natural reinforcer and personal control.” For some issues, intermittent reinforcers are going to be required for the duration of the symptoms so to have a regulation determine this limitation is far-reaching and is best done on an individual basis with qualified professionals.

**Response**: The Department thanks the Commenters for these comments. Person with intellectual disabilities or autism have a right to personal property specifically protected by Maine law. These regulations do not prohibit the use of the Person’s funds to meet his/her basic needs for food, shelter, clothing and medical care. These regulations does not prohibit the use of artificial reinforcers. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (12 & 19 ) asked if there is an exception for Representative Payees to the prohibition on withholding money for behavior management and “manipulation of personal property” unless with “imminent risk”. Commenter (12) asked about Person’s who are unable to appropriately manage their money and require assistance to monitor their spending in order to ensure their health and safety needs are met first Commenter (19) asks for language in this section adding an exception related to role of Representative Payee and their responsibilities regarding the prohibited practice of withholding money for behavior management, and “manipulation of personal property” unless with” imminent risk”. Commenter (19) asks if it should be okay to let a person become homeless because they spend their money on holiday crafts or not buy food. Commenter (19) asked how do you balance what is right for the individual relative to their personal property.

**Response**: The Department thanks the Commenters for these comments. These regulations does not conflict with the Representative Payees responsibilities, under the Social Security Act, to use the Person’s funds to meet his/her basic needs for food, shelter, clothing and medical care. These regulations applies to the remaining funds of the Person. The Social Security Act does not grant Representative Payees unlimited authority over the Person’s other personal property. With respect to the other personal property and remaining funds, manipulation for behavior management is prohibited. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (3, 12, 33, 34 & 37) question seclusion as a prohibited practice. Commenter (3) asks whether the prohibition on the use of seclusion was “clinically informed”. Commenter (3) asked about situations when seclusion is less upsetting and intrusive than a physical restraint; when the use of a hybrid holds which is less problematic for an individual than MANDT or a TCI hold. Commenter (3) asked what the Department plans to do to insure these decisions are made on an individual basis and if they are the least restrictive options. Commenter (12) thinks there should be some consideration of allowing Seclusion with constant visual monitoring (such as seclusion in a room with a staff member in the doorway). Commenter (12) states that due to the high number of trauma and sensory issues some individuals have, restraint is often contraindicated. This type of seclusion may in fact be less traumatic and harmful to the person than restraint. Commenter (34) states that a period of seclusion prior to any restraint has been proven to be the preferred treatment/ intervention for her adult child. Commenter (33) agreed with Commenter (34)’s statement. Commenter (33) states that people have died from restraints and restrains are more traumatic than seclusion or time-out.

**Response**: The Department thanks the Commenters for these comments. State law, 34-B M.R.S. §5605(13)(A-2)(1), specifically prohibits the use of seclusion as an element of a behavior modification or behavior management plan for persons with intellectual disabilities or autism. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (3) questioned why the Department would prohibit the use of hybrid holds when they are less problematic for an individual than MANDT or a TCI hold.

**Response**: The Department thanks the Commenter for this comment. The Department recognizes that a very small number of persons may need individualized physical management programs. The Department is exploring if such programs can be approved and how this process would occur as required under law and regulation. In Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (3) asked how the Department plans to insure these decisions are made on an individual basis and if they are the least restrictive options, the plan to make them available to the individual and family

**Response**: The Department thanks the Commenter for this comment. The individual and his/her family, if authorized by the individual are members of the Planning Team which reviews and approves Behavior Management Plans. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (21) finds the following statement under “Routine Use of Emergency Restraint” confusing: “When an IST is required regarding emergency intervention more than six times in any 365-day period and a justification to address the Challenging Behavior without a Behavior Management Plan has not been approved by the Review Team.” Commenter (21) asks what the alternative is to routine use of an Emergency Restraint when a Behavior Management Plan has not been approved, and a person presents with challenging behavior that necessitates the Emergency Restraint.

**Response**: The Department thanks the Commenter for this comment. The inclusion of “Routine use of Emergency Restraint” as a Prohibited Practice ensures that the Planning Team and Review Team are aware, and can appropriately respond when Challenging Behaviors are not being addressed with permissible interventions. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (9, 13 & 15) expressed concern with the prohibition of “Restraints that … put pressure on joints or chest”. Commenters expressed concern that this effectively disallows even the slightest physical re-direction. Commenter (9) requested additional parsing of these regulations, so that harm is, of course, prohibited while allowing for everyday minor, brief or sensory interventions. Commenter (15) stated its interpretation of this rule, based on guidance from our legal counsel, would prohibit a care giver from holding a client’s wrist if they were in danger of burning their hand on the stove or striking another client.

**Response**: The Department thanks the Commenters for these comments. In response to this comment the Department removed the language in Prohibited Practices, Certain Physical Restraints that prohibits putting pressure on joints or chest. The Department believes the actions this language was intended to prohibited is covered by other language in this rule

1. **Comment**: Commenter (12) states that the proposed regulations prohibit evidenced based behavioral health interventions (i.e. systematic desensitization or related interventions to address some behaviors – such as phobic responses to stimuli) that are effective, clinically sound approaches.

**Response**: The Department thanks the Commenter for this comment. The types of interventions mentioned by this Commenter can be a Level 2 Intervention if the Person voluntarily participates. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenters (13, 15, 17 & 28) expressed concern about the prohibition against putting a person off balance. Commenter (13) stated that putting the person off balance slightly is one of the principles of some behavioral intervention programs.  Commenter (13) asked for clarification. Commenter (13) specifically asked whether the regulation is prohibiting putting someone off balance so they fall verses putting a person off balance at all. Commenter (15) states that the prohibition of “A Restraint or physical intervention which puts the Person off balance” will result in prohibiting a standing, one arm MANDT system restraint used if a client tried to grab a child while in the community because the action may “put the person off balance”. Commenter (28) is concerned that non-violent physical crisis intervention is to put the person off balance. Commenter (17) states that the nature of restraints is that a person is in some way out of control, dangerous to themselves and/or others. Commenter (17) states that situations are fluid, mobile, and by definition, dangerous. Commenter (17) states that this is but one additional loophole to find fault with agencies who have bravely stepped forward to take troubled, mentally ill, “challenged” individuals. Commenter (17) states that a retrospective, Monday morning look back on incidents may find that consumers were off balance. Commenter (17) asked that the authors share their valuable insight as to how this can always be avoided. Commenter (17) states that Review Teams have staked out the territory of “Monday morning quarterbacking”, always, always, interrogating providers until the Review Teams satisfy themselves the provider’s staff was to blame. Commenter (15) states that some of the restrictions added to the list of Prohibited Practices are contrary to MANDT system restraints, a nationally accredited behavioral intervention program that is approved by Maine DHHS as an approved intervention system.

**Response**: The Department thanks the Commenters for these comments. This comment made the Department aware that it needs to be clear in these regulations that the use of a physical restraint techniques as part of an approved restraint program, such as CPI and MANDT, is allowed provided the program has been approved by the Department. In response to this comment and to provide the above-mentioned clarity, the Department amended the Prohibited Practices grid in §5.06.

1. **Comment:** Commenters (15, 24, 26, 29 & 30) spoke about interventions that are allowed under the current regulation that are prohibited under these regulations. Commenters (24 &26) spoke about the needs of their son who currently has a severely intrusive plan approved by the Commissioner. Commenter (24) is concerned that there is no exception for the use of a prohibited practice when there is no other alternative. Commenters (29 & 30) are concerned that practices which have been being used and allowing the person to make progress are becoming prohibitive. Commenter (15) states that the new prohibitions seriously threaten our ability to keep aggressive and sometimes violent individuals safe.

**Response**: The Department thanks the Commenters for these comments. The Department appreciates parents concern for the health, safety and welfare of their adult child. Without more specific information on the practice that is prohibited under these regulations, the Department is unable to provide a more detailed response. The Department made no changes to the final rule as a result of these comments.

**5.08 PROCEDURES FOR REVIEW AND APPROVAL OF POSTIVE SUPPORT PLANS AND BEHAVIOR MANAGEMENT PLANS**

***5.08-1 Review Levels and Review Teams***

1. **Comment**: Commenter (8) suggested that the Department consider including "Correspondent or other person chosen by the individual to support him or her in the process of developing Behavioral Support, Modification or Management plans " to §5.08-1(A)(1). Commenter (8) stated that amending the language would allow a Person, especially one without a guardian, specific access to the support of an informal advocate who has been vetted by the Department to support the individual in this and similar areas.

**Response**: The Department thanks the Commenter for this comment. State law, 34-B §5470-B, defines the Planning Team include “correspondent, if one exists”. It also allows the Person to include “people whom the person chooses to participate” Other sections of these regulations include the correspondent. In §5.05-1(B) the Correspondent must be interviewed whenever the Functional Assessment is updated. Under §5.05-1(C)(9) and §5.05-2(H) require the Behavior Management Plan to include training when the Correspondent supports the Person. In final regulation§5.07-2(C) a Level 5 Behavior Management Plan requires the Correspondent be consulted by the clinician conducting the second opinion. The Department made no changes to the final rule as a result of these comments.

***5.08-2 Review Procedures***

***B. Review Team Practices***

1. **Comment**: Commenters (8, 11, 14 & 20) comments on the discretion given the Review Team in proposed regulation §5.08-2(B)(3) to approve a Behavior Management Plan for up to one year. Commenter (8) asks whether this means that the Review Team will not meet quarterly to review severely intrusive plans or annually to review safety devices. Commenter (8) does not support this provision and urges the Department to require quarterly reviews Commenter (11) is unclear why the State has chosen to extend the minimal time for review of the most intrusive elements of behavior management four-fold. Commenter (11) is gravely concerned that increasing the minimum time for review will allow unnecessary and overly restrictive interventions to extend beyond the time needed. Commenter (11) strongly recommends keeping the current quarterly review and making the following changes §5.08-2(B)(3) to the proposed regulation:

“The voting members of the Review Team have the discretion to determine duration of Behavior Management Plan approval to a maximum of ~~one year~~ three months. If less than ~~one year~~ three months, the duration of plan approval must be indicated in writing.”

Commenter (20) adamantly opposes the change in proposed regulation §5.08-2(B)(3) that would allow a Behavior Management Plan to continue for one year without a Review Team meeting. Commenter (20) asks the Department to consider changing this to six months.

**Response**: The Department thanks the Commenters for these comments. As written, these regulations does not allow a Behavior Management Plan to be approved for more than one year. The Review Team retains the discretion to approve Behavior Management Plans for less than one year. In all cases, §5.05-5(D) requires the Planning Team, with input from the qualified professional responsible for the Behavior Management Plan, to review, monitor and document the effectiveness of the Behavior Management Plan at least quarterly. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (4) suggests that the higher the level of intervention (Levels 1-5) the higher the urgency of the need. Commenter (4) suggests that there be a time limit for each team and the Commissioner to complete their work if the person’s situation is the true primary interest. Commenter (4) notes that the request for further information by a review entity has extended the time to over a year before completion. Commenter (4) finds this frustrating and suggests that it may be dangerous for the Person and his/her support staff. Commenter (4) also suggests that an unintended consequence of a lengthy review is to reinforce the very behavior that was requested to be reduced.

**Response**: The Department thanks the Commenter for this comment. The Department agrees that timely review, response, approval or denial should occur in a timely manner. Because there are so many individualized circumstances that may lead to the need for more information it’s difficult to set a meaningful deadline. The Department intends Review Teams to continue following current practice for Levels 3 -5 of reviewing and issuing a decision at the Review Team meeting when all necessary and requested documents are available. For Level 5 Plans further review and approval is necessary. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (4) suggests that if a plan or part of a plan is not accepted at any level, a written report should be sent promptly to the Planning Team, the Person or Guardian and the Case Manager, explaining the shortcoming and even offering suggestions toward solution. Commenter (4) is concerned for the quality of life of the Person during the review period.

**Response**: The Department thanks the Commenter for this comment. The Review Team approval/denial form which will continue to be used, contains specific information. When a Plan is not approved this form contains relevant information on the reasons for the decision and notes on any follow up needed or recommended. This form is provided to the Review Team members present at the meeting. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (4) suggests that in the event a problem arises with a professional assessment the Review Team seek further information from the professional rather than hiring a professional full time to work as a liaison between the review committees and the professionals already involved. Either way, more clarity and expediency is desperately needed to avoid acceleration of the adverse behavior and possible loss of the professionals involved in the initial planning and care of the Person.

**Response**: The Department thanks the Commenter for this comment. The Department believes that Review Teams do seek further clarification from the professional who performed the assessment, when necessary. This may occur in a variety of ways; through the agency that hired the professional, through a Review Team member’s direct observation of the Person, or through direct consultation with the professional. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) asked if §5.08-2 (B)(6) language, "the Case Manager or case management supervisor must participate in the review process" means a plan cannot be approved if they do not attend the Review Team meeting. If so, Commenter (20) states that this will impede safety and the right to treatment.

**Response**: The Department thanks the Commenter for this comment. Participation of the Case Manager or case management supervisor is imperative to ensure continuity of care for the Person. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) states that §5.08-2 (B)(10) needs greater clarity. Commenter (20) asked for clarification on what distinguishes a new plan from an Emergency Plan and stated that this should not be left up to the Review Team as this would detract from establishing statewide consistency.

**Response**: The Department thanks the Commenter for this comment. An Emergency Plan is a provisional plan implemented to keep the Person safe while the Planning Team acquires all the required documentation to be approved as a new Behavior Management Plan. The Department made no changes to the final rule as a result of these comments

1. **Comment**: Commenter (13) asked if it is the case manager the person who will request plans from the

appropriate professionals, ensure the plan is followed, review plans as required, and coordinate the plans among separate service providers

**Response**: The Department thanks the Commenter for this comment. In response to this comment, and other similar comments about who is responsible for the work of the Planning Team, the Department has amended these regulations by adding new subsections B to §5.03-1 and §5.03-2

1. **Comment**: Commenter (17) commented that the ability of the Review Team to gather additional information prior to approval of any plan gives them “carte blanche” to be overzealous whose onerous misuse of authority has and will lead to endless pursuits of endless information.

**Response**: The Department thanks the Commenter for this comment. The intent for any request for additional information is to ensure that all less restrictive methods have been attempted and failed. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) notes that the Review Team never has to justify its requests lacks and lack either responsibility or accountability which distinguishes their dilettante status from all of the service providers. Commenter (17) states that a simple statistic will reveal the depth of this problem. Commenter (17) asks how many actual appeals/grievances have been made since the DRC was injected in this process? This is information that should be made public.

**Response**: The Department thanks the Commenter for this comment. Further information on grievances and appeals may be obtained from the Protection and Advocacy Agency, Disability Rights Maine. The Department made no changes to the final rule as a result of these comments.

***C. Exceptions***

1. **Comment**: Commenter (4) asks whether the second opinion from a licensed psychologist or psychiatrist required for Level 5 plans may be either the psychologist or psychiatrist who has the Person on their caseload.

**Response**: The Department thanks the Commenter for this comment. The regulation does not specify who may or may not provide a second opinion. Discretion is left to the Person and their Planning Team who has the best knowledge of the Person and their needs. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (4) suggests that an optional form be developed that can be given to the professional providing the second opinion to help eliminate the need for additional requests as much as possible

**Response**: The Department thanks the Commenter for this comment. This is a practical suggestion that the Department will consider as it implements the changes from these regulations. The Department made no changes to the final rule as a result of these comments.

***5.08-4 Evidence and Documentation Required for Behavior Management Plans***

1. **Comment**: Commenter (20) asks for the meaning of Personal Plan in §5.08-4(A)(1). Commenter (20) states that the definition in §5.02-29 gives several options: Person Center Plan, service plan, Positive Support Plan (listed separately in §5.08-4(A)(3)) and Behavior Management Plan (listed separately in §5.08-4(A)(6), or other plans.

**Response**: The Department thanks the Commenter for this comment. The term “Personal Plan” and “Person Centered Plan” are often used interchangeably. The Department made no changes to the final rule as a result of these comments. The definition in the proposed regulations states that the “Personal Plan” may include a “Person Centered Plan”. The Department prefers “Personal Plan” as this term is used in Section 21 of the MaineCare Benefits Manual, Chapter II and in the sections of Title 34-B of Maine law that govern this regulation. A PCP is a type of Personal Plan for Case Management under Waiver programs. The Department made no changes to the final rule as a result of these comments

1. **Comment**: Commenter (23) suggests that the history of positive support interventions include the date and duration of each intervention, with an example of data from at least the last month the intervention was tried be required in §5.08-4(A)(3)

**Response**: The Department thanks the Commenter for this comment. The Department interprets the language of proposed regulation §5.08-4(A)(3) as requiring dates and duration of each intervention for a time frame appropriate to the Person and intervention. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (17) states that if the person with Challenging Behavior as a child still has the Challenging Behavior and is now an adult, and after all, has a secondary mental health diagnosis, there have been efforts at positive support plans in the past, and those have failed (or are in effect and need to continue). All dictates about documenting prior interventions have a nice ring but once again, constitute a blueprint for review boards to reject time-critical plans, and they have done so. Commenter (17) states that frequently as children age into the adult system, from somewhere else

(schools, out of state institutions) information about prior interventions cannot be obtained, so it is no use

hammering Maine agencies to get it.

**Response**: The Department thanks the Commenter for this comment. The Department made no changes to the final rule as a result of these comments.

**5.09 EMERGENCY INTERVENTIONS, INCLUDING RESTRAINT, REMOVAL OF PERSONAL PROPERTY AND SPECIAL ACCOMMODATIONS**

***5.09-2 Specialized Intervention***

1. **Comment**: Commenters (8, 11 & 23) commented on Specialized Interventions. Commenter (11) recommended that the State remove proposed §5.09-2 "Specialized Intervention" as it relates to physical restraints. Commenters (8 & 23) state that members of the Review Team do not have the training or expertise required to determine the risks associated with a specialized intervention.

**Response**: The Department thanks the Commenters for these comments. Specialized interventions are necessary to accommodate those unique situations that require an individualized, modified technique to be used on an emergency basis. In response to this and similar comments the Department amended these regulations by defining Specialized Interventions and categorizing them as a Level 4 intervention. As such, training of staff is required under these regulations.

***5.09-4 Recurring Patterns***

1. **Comment**: Commenter (4) asks whether the use of an Emergency Restraint will be allowed to be used and renewed while waiting for approvals from the Review Team or the Commissioner. Commenter (4) believes prior practice which required the resubmission of the Emergency Restraint forms and signatures during the review and approval process was burdensome on nongovernmental entities as well as stressful for the Person as they are in a short term situation, causing difficulty in providing stable additional supports or personnel that would be available in an approved plan. Commenter (4) stated that this highlights the need for review entities to be more prompt and to have the ability to discuss their issues with the planning directly with the professional involved if they do not accept the information provided by the psychiatrist and psychologist.

**Response**: The Department thanks the Commenter for this comment. The Department agrees that timely filing, review and approval of routine use of Emergency Interventions is beneficial to all involved. The Planning Team may request the presence of or input from a Review Team member prior to the submission of a Plan for approval if that presence or input is helpful to them. Given the serious nature of Emergency Interventions, the requirement to file a Reportable Event in every instance will continue until such use is approved. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (21) questions whether Emergency Restraints occurring 6 times in any 365 day period which are not related (e.g. 2 restraints in January because of behavior related to dental pain; 2 restraints in April because of a behavioral response to a loud new housemate; 1 restraint in November for behaviors of unknown reasons; and 1 restraint on December 24 due to behavior related to anxiety from the holidays) would fit within this section of the rule.

**Response**: The Department thanks the Commenter for this comment. Due to the serious nature of Emergency physical interventions oversight when a Person is restrained outside a Behavior Management Plan is necessary regardless of the reason for restraint. This promotes a more thoughtful discussion and plan to assist in diminishing the need for future physical management. The notification and oversight requirements in this section do not necessarily lead to the development of a Behavior Management Plan to manage these unrelated behaviors. The Department made no changes to the final rule as a result of these comments.

**5.10 TRANSITION OF EXISTING PLANS**

1. **Comment**: Commenter (23) supports the inclusion of the transition period in §5.10, but it is unclear about the meaning of the 90-day time frame. Commenter (23) asked whether it means that all plans must be in compliance with the regulations, once finalized, within 90 days or must they be in compliance by the date of the next review.

**Response**: The Department thanks the Commenter for this comment. For existing Plans the Planning Team can either: (1) develop a Behavior Management Plan that complies with the new regulations and submit and obtain approval within ninety (90) days of the regulations effective date; or (2) develop a Transition Plan and obtain Review Team approval within ninety (90) days provided a fully compliant Behavior Management Plan is developed and approved within 365 days of the regulations effective date. The Department made no changes to the final rule as a result of these comments.

1. **Comment:** Commenter (11) requests that plans with prohibited elements in them be stopped immediately as opposed to having some sort of transition period to continue doing something that would otherwise be held prohibitive.

**Response:** The Department thanks the Commenter for this comment. Continuation of Prohibited Practices after the effective date of these regulations will only be allowed when proposed by the Planning Team and approved by the Review Team. To require immediate cessation of an intervention that is not prohibited under the current regulations may be detrimental to the Person, his/her caregivers, family, and others. Time to develop and implement alternative interventions may be necessary in limited situations. The Department made no changes to the final rule as a result of these comments.

**5.11 THE USE AND REVIEW OF SAFETY DEVICES**

***5.11-2 Specific Examples of Devices Usually Considered to be Safety Devices***

1. **Comment**: Commenter (22) stated that while imperfect, the current Behavior Regulations provide a much clearer definition and examples of Safety Devices than the proposed regulations. Commenter (22) stated a concern that the proposed regulations include within the examples for Safety Device instances of intentional movement where the device appears to be used for behavior management. For example, in §5.11-2(C), “hand splints or gloves, for instance when used to prevent pica behavior; self-injury”. This appears to be in conflict with the statement in §5.11-1 that the device “may not have as its purpose, in whole or in part, the provision of behavior management”. This appears to be better defined as a mechanical restraint, which includes the use of “an apparatus to address Challenging Behavior...any item worn by or placed on the Person to limit behavior or movement and which cannot be removed by the Person” including “mittens, straps, arm splints…”

**Response**: The Department thanks the Commenter for this comment. The Department amended §5.11-2(C) of these regulations in response to this comment. The Department believes this amendment addresses Commenter’s other concerns.

1. **Comment**: Commenter (23) asks the Department to clarify the difference between the specific examples in §5.11-2(D) and (E).

**Response**: The Department thanks the Commenter for this comment. In subsection (D) the intention is to assist an individual with support of a seat belt who would otherwise fall out of a wheelchair. The intention in subsection (E) assumes a Person has the ability to maintain a sitting position in a wheel chair however if they were to attempt to stand without physical assistance they would fall. The Department made no changes to the final rule as a result of these comments.

1. **Comment**: Commenter (20) commented on the language in §5.11-2(N) which states “monitoring devices when used to monitor the movement of a person, but do not limit the person's movement”. Commenter (20) asked how this differs from devices that do not require Review Team approval under §5.11-4(D) such as “door chimes” or “chair/bed alarms”.

**Response**: The Department thanks the Commenter for this comment. The Department agrees these two sections create ambiguity. The Department has amended these regulations by removing §5.11-4(D) in its entirety, adding language to and reorganizing examples in §5.11-2(N).

1. **Comment**: Commenter (20) stated that the addition of a medical diagnosis in §5.11-2 might limit people who need the locked cupboards when reviewed by a physician to determine the behavior cannot be better treated medically.

**Response**: The Department thanks the Commenter for this comment. If an individual needs a locked cupboard due to a Challenging Behavior it is not considered a Safety Device and would be subject to the next level of review and approval. The Department made no changes to the final rule as a result of these comments.

***5.11-3 Review Process***

***A. Preliminary Requirements Prior to Review***

1. **Comment**: Commenter (20) commented on the requirement in §§5.11-3(A) & (C) that a physician monitor Safety Devices. Commenter (20) states that in some situations Safety Devices are better monitored by Occupational Therapists or Physical Therapists.

**Response**: The Department thanks the Commenter for this comment. The Department believes Safety Devices should be monitored by physicians. These regulations does not prohibit additional review by an Occupational Therapist or Physical Therapist. The Department made no changes to the final rule as a result of these comments.

***C. Standard Forms***

1. **Comment**: Commenter (21) asks whether the Department has developed the standard form for requests for permission to use a Safety Device.

**Response**: The Department thanks the Commenter for this comment. The Department plans to make a standard form available after the effective date of these regulations. The Department made no changes to the final rule as a result of these comments.

***D. Requests for Multiple Safety Devices for the same person***

1. **Comment**: Commenter (23) states that requiring separate requests for each safety device will result in a blizzard of unnecessary paperwork, both for the Person's Planning Team, and for the Review Teams. Commenter (23) believes this is inefficient and burdensome. Commenter (23) suggests continuing the current practice of listing all on the same document.

**Response**: The Department thanks the Commenter for this comment. The Department plans to continue the practice of allowing requests for multiple devices to be submitted at the same time and/or on the same application. Each separate device, with the exception of Safety Devices normally used in pairs, will require separate professional authorization. The Department made no changes to the final rule as a result of these comments.

***5.11-4 Use of Safety Related Devices or Practices that Do Not Need Approval of the Review Team***

1. **Comment**: Commenter (20) asked whether vehicles with doors that lock automatically falls would fall within §5.11-4(C) which states that when vehicle doors are locked pursuant to a written agency policy there is no need for Review Team approval of this Safety Device.

**Response**: The Department thanks the Commenter for this comment. The Department does not view automatic door locking mechanisms as within the definition of “Safety Device” found in §5.02-45. An automatic door locking mechanism is not “limited to the person in question” nor does this mechanism meet the requirement that the device have “the sole purpose of maintaining the safety of the person.” The Department made no changes to the final rule as a result of these comments.

***5.11-6 Distinctions Between Safety Devices, Devices that are Utilized for Behavioral Management, and Therapeutic Devices***

1. **Comment:** Commenter (22) is concerned that §5.11-6 creates an ambiguity about devices or apparatus that meet the definition as a therapeutic device, a behavioral management, and a safety device. Commenter (22) stated that the definition of “therapeutic devices or interventions” in the proposed regulations, includes “devices used for body positioning, alignment or safety”. The definition of Safety Device, which requires Review Team approval overlaps with this and leads to confusion.

**Response:** The Department thanks the Commenter for this comment. The Department acknowledges that some devices or apparatus meet multiple definitions. Under §5.11-6, the Department relies on the Person’s Planning Team to render an initial classification based on their knowledge of the Person. This initial classification will be examined by the Review Team during serving as a check and balance on these types of devices and apparatus. The Department made no changes to the final rule as a result of these comments.

***5.11-7 Helmets Used to Prevent or Diminish the Degree of Injury to a Person Engaging in Self***

***Injurious Behavior***

1. **Comment**: Commenter (21) was pleased that after one year the use of a helmet to diminish self-injury can be considered as a safety device and not be part of a Level 3 Behavior Management plan.

**Response**: The Department thanks the Commenter for this comment. The Department made no changes to the final rule as a result of these comments.

***5.11-8 Use of Monitoring Devices***

1. **Comment**: Commenters (8 & 20) asked the Department to address the use of Safety or Monitoring Devices for persons with dementia. Commenter (20) stated that the requirement, in §5.11-8, Use of Monitoring Devices, that motion detectors, sound monitoring, and video monitoring devices be supported by a history and a related medical diagnosis, such as Dementia will exclude people who do not have a medical diagnosis but who still need monitoring that allows people time without 1:1 staff. Commenter (8) suggested that the Department add language in §5-11 specifically addressing the use of Safety Devices in response to a medical diagnosis of dementia.

**Response**: The Department thanks the Commenters for these comments. The Department recognizes this section does not clearly reflect the intention. The Department has amended this section and added new §5.05-2(I) to provide clarity regarding monitoring devices. Monitoring devices may be used for safety purposes if supported by a history of a lack of environmental awareness and/or a related medical diagnosis. Monitoring devices may also be used as a Behavior Management. In all cases, every effort must be made to maintain privacy and confidentiality.

**Table of Commenters**

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REGULATIONS GOVERNING BEHAVIORAL SUPPORT, MODIFICATION AND MANAGEMENT FOR PEOPLE WITH INTELLECTUAL DISABILITIES OR AUTISM IN MAINE

1. Catherine Robertson, Independence Advocates of Maine
2. Cathy Dionne, Parent
3. Cathy Dionne, Autism Society of Maine
4. Darla Stimpson Chafin
5. David Winslow, Maine Hospital Association
6. Debbie Dionne
7. Diane Boas
8. Rachel Dyer, Maine Developmental Disabilities Council
9. Jennifer Putnam, The Progress Center
10. Kim Humphrey
11. Lydia Paquette, Disability Rights Maine
12. Karen MacDonald, Port Resources
13. Mary Lou Dyer, Maine Association for Community Service Providers
14. Mary Lee, OHI
15. Maureen Conley, Medical Care Development
16. Meg Dex, New Initiatives
17. Michael F. Smyth, Ph.D.
18. Paul Nau, Woodfords Family Services
19. Laurie Raymond, Parent
20. Rory Robb, Community Partners
21. Sue Murphy, Spurwink
22. Tiffany Haskell, Waban Projects
23. Valerie Smith, Maine Developmental Services Oversight & Advisory Board
24. Frank Capone
25. Carol Axtell
26. Karin Capone
27. John Carroll
28. Chris Defeo, BFLI
29. Cathy Curtis, BFLI
30. Alison Weaver, Coastal Opportunities
31. Jerry Silbert
32. Ray Breton
33. Cheryl Neiverth, Ed.M., LCSW
34. Lora Perry
35. Cullen Ryan, Chair Maine Coalition for Housing and Quality Services
36. Linda Fifield
37. Cheri Hurst, Independence Association

A summary of all changes to the final rule, including changes made in response to comments from the public and

advice from the Attorney General’s Office, is provided below:

1. In response to public comments the words “hospitals” were added to the 2nd paragraph of the Applicability section of these regulations. The amended sentence now reads

“These regulations do not apply within hospitals, schools or correctional settings …”

1. In response to public comments the Department deleted the work “Intervention” from the phrase “Therapeutic Devices or Interventions” throughout these regulations.
2. In response to public comments the Department added the phrase “under the supervision of a medical doctor” to the Applicability section of these regulations. The amended sentence reads:

“These regulations do not apply to: (1) the use of Therapeutic Devices implemented under the supervision of a medical doctor, or occupational or physical therapist….”

1. In response to public comments the Department reorganized these regulations as follows:
   * §5.08-3, Evidence and Documentation Required for Positive Support Plans was moved to §5.03-2
   * §5.08-4, Evidence and Documentation Required for Behavior Management Plans was moved to §5.03-4
   * §5.03-3, Emergency Intervention was deleted
   * §5.03-5, Safety Devices was deleted
   * §5.04-2, Requirements for the Functional Assessment, was moved to new Appendix One, Requirements for the Functional Assessment
   * §5.04-3, Requirements for the Positive Support Plan was moved to new Appendix Two, Requirement for the Positive Support Plan
   * §5.05-3(D)(2) – (6) was moved into new Appendix Three, In-Home Stabilization Requirements
   * Part 5.06, Levels of Intervention was moved in its entirety to new Appendix Four, Levels of Intervention. In addition Levels 1 -2 were copied into §5.03-2, Positive Support (Levels 1-2), and Levels 3-5 were copied into §5.03-4, Behavior Management (Levels 3-5)
   * §5.07, Prohibited Practices was copied into new Appendix Five
2. In response to public comments the Department added the following language to §5.01-2

“In defining Challenging Behavior in these regulations it is not the Department’s intent to expand the scope of this rule beyond what is now commonly understood in this field to be those types of behaviors which seriously interfere and impact a Person’s ability to have positive life experiences.”

1. In response to public comments the Department made the following change to the first paragraph of §5.02

~~Reference to definitions in this section or the descriptions of plans and assessments within the rule is necessary to ensure an understanding of intent. All terms, plans or assessments defined in this rule are capitalized throughout the text~~. Thus, capitalization of words or terms, such as “Emergency” or “Medical and Mental Health Assessment or Treatment” means that the word or term can be found either in the Definitions below or, if not found there, is defined elsewhere in these rules.

1. In response to public comments the Department added the sentence “This is a Prohibited Practice.” to the definitions of “Aversion” (§5.02-3), “Overcorrection” (§5.02- 25), and “Seclusion” (§5.02-47) and added the sentence “Some Restraints are Prohibited Practices” to “Restraint”, §5.02-43.

1. In response to public comments the Department amended the phrase “person and other” to “person and the community” throughout these regulations.
2. In response to public comments the Department amended the definition of “Functional Assessment” in §5.02-17 as follows:

“Functional Assessment: means a systematic analysis of factors, both internal and external to the Person, that what may be contributing to his/her Challenging Behavior.”

1. In response to public comments the Department changed “who’s” to “whose” in the definition of “In-Home Stabilization” in §5.02-20.
2. In response to public comments the Department amended the definition of “IST” in §5.02-22. The amended definition reads as follows:

“ IST: means an individual Support Team consisting of the Person, if they choose, members of the Person’s…”

1. In response to public comments the Department removed the phrase “bed rails” from the definition of “Mechanical Restraint” in §5.02-23.
2. In response to public comments the Department amended the definition of “Planning Team” in §5.02-31 as follows:

“Planning Team: means the ~~group of people~~ Person and others identified by the Person and/or his/her guardian who are responsible for developing Person’s Personal Plan as required by 34-B M.R.S. §5470-B (“Personal planning”). “

1. In response to public comments the Department added a definition for “Positive Behavior Modification Technique” in §5.02 as follows:

“Positive Behavior Modification Technique: means a method of changing behavior to increase opportunities for meaningful participation in community, making choices, and learning skill to engage in Prosocial Behavior.

1. In response to public comments the Department added a definition for “Specialized Restraint in §5.02, Definitions as follows:

“Specialized Restraint: is an individualized Restraint approved by the Department to meet a Person’s specific needs that cannot be met through a nationally recognized or certified behavior management. “

1. In response to public comments the Department amended the definition of “Therapeutic Devices” in §5.02, The amended definitions reads as follows:

“Therapeutic Devices: means devices used for body positioning or alignment under the supervision of a medical doctor, occupational therapist or physical therapist.”

1. In response to public comments that Department amended §5.03-1(A) and §5.03-3(A) as follows:

* §5.03-1(A)

“Positive Supports are the first approach that the Planning Team must implement to assist a Person experiencing Challenging Behaviors. The Planning Team must ~~conduct~~ ensure the development of a Functional Assessment and implement a Positive Support Plan. The goal of the Positive Support Plan must be to reduce Challenging Behavior and eliminate the need for more restrictive practices.”

* §5.03-3(A)

“If the Planning Team determines that Positive Supports alone are insufficient to prevent harm or danger to the Person or the community, the Planning Team must d~~evelop~~ ensure the development of a Behavior Management Plan …”

1. In response to comments the Department amended these regulations by adding the following language to §5.03-1(B) and §5.03-3(C) clarifying who is responsible for initiating the Planning Team processes respectively:

* §5.03-1(B)

“The entity or person who identifies the need to address a Challenging Behavior through a Positive Support Plan is responsible to initiate the Planning Team process. The Planning Team is responsible to ensure all documentation, assessments, plans and reviews are completed as required.”

* + §5.03-3(C)

“The entity or person who identifies the need to address a Challenging Behavior through a Behavior Management Plan is the member of the Planning Team responsible to initiate the Planning Team process. The Planning Team is responsible to ensure all documentation, assessment, plans and reviews are completed as required. “

1. In response to public comments the Department added new subsection §5.03-1(E)

“The Planning Team must develop an In-Home Stabilization Plan, as described in Appendix Three, whenever In-Home Stabilization will be used under one hour for safety and assessment.”

1. In response to public comments the Department amended language in these regulations as follows:
   * the Level 2 grid in §5.03-2 and in Appendix Four

“Securing of incendiary material, clothes, shoes or sharps with documented safety issues or problematic misuse, when the Person does not communicate an ~~specific~~ objection”

* + the Level 3 grid in §5.03-4 and in Appendix Four

“An intervention to which the Person or the Persons’ Guardian, as appropriate communications an objection~~s~~”

* + §5.05-3(F) is amended as follows:

“Therapeutic Devices or approved Safety Devices to which the Person does not communicate an object~~s~~ionand which are not intended as an intervention to a Challenging Behavior, are not considered Restraints under this regulation.”

* + Prohibited Practices in §5.08 and Appendix Five

“Swaddling from which the Person can remove him or herself but to which the Person or ~~other member of the Planning Team~~ the Person’s guardian communicates an object~~s~~ion.”

1. In response to public comments the Department deleted the phrase “response to Challenging Behavior” from:
   * Level 2 grid in §5.03-2 and Appendix Four

“Locks ~~in response to a Challenging Behavior~~ that the Persons is unable to unlock

* + Level 3 grid in §5.03-4 and Appendix Four

“Electronic monitoring Devices (video, ankle bracelet, etc.), when the Person or a member of the Personal Planning Team objects ~~or if a response to a Challenging Behavior~~.

1. In response to public comments the Department made an amendment in the Level 2 grid in §5.03-2 and Appendix Four as follows:

“Positive Behavior Modification Techniques ~~to teach Challenging Behavior~~

1. In response to public comments the Department amended §5.03-3(A) by repeating language from §5.05-1(C) as the last sentence to §5.03-3(A) and amending the first sentence. Together §5.03-3(A) is amended as follows:

“If the Planning Team determines that Positive Supports alone are insufficient to prevent harm or danger to the Person or the community, the Planning Team must ensure the development of a Behavior Management Plan or follow Emergency Intervention Procedures within this rule. Behavior Management Plans must be developed in consultation with a qualified professional who must be a psychiatrist, a licensed psychologist or psychological examiner, a Licensed Clinical Social Worker, Licensed Clinical Professional Counselor, or a Board Certified Behavior Analyst.

1. In response to public comments the Department added the word “Planned” as follows:
   * In Level 3 grid in §5.03-4 and Appendix Four

“Planned Restriction of Rights”

* In Level 4 in §5.03-4 and Appendix Four

“Planned Use of Restraint”

“Planned Removal of staff”

1. In response to public comments the Department made the following amendments in the
   * the Level 3 grid in §5.03-4 and in Appendix Four

“An intervention to which the Person or the Person’s Guardian, as appropriate, communications an objection”

* in §5.05-2(B)

“Whenever the Person or ~~a member of~~ the Person’s Guardian, as appropriate, ~~Personal Planning Team~~ communicates an objection to an …”

1. In response to public comments the Department added “Use of Coercion” in the Description part of the Level 3 grid in §5.03-4 and Appendix Four.
2. In response to public comments the Department amended these regulations by adding the following as examples of Level 3 restrictions in the Level 3 grid in §5.03-4 and Appendix Four:

* “Restriction of food or liquid”
* “Planned use of Law Enforcement”
* “Planned restriction of a communication device that prohibits the Person’s ability to communicate.”
* “Restriction of a communication device when the device is being used for an illegal activity”

1. In response to public comments the Department amended the examples in the Level 3 grid in §5.03-4 and Appendix Four as follows:

* “Restriction of communication (other than to a Guardian, Advocate or Crisis Team)”
* “Buzzers/alarms/sensors or locks that the Person is unable to disarm or unlockon doors/windows. ~~etc., if the Person or a member of the personal Planning Team communicates a specific objection~~”
* “Electronic monitoring Devices (video, ankle bracelet, etc.) ~~when the Person or a member of the Personal Planning Team communicates a specific objection~~.”

1. In response to public comments the Department amended the list of Required Documents in Level 3 in §5.03-4 and in Appendix Four by adding “Physician’s Evaluation, Psychiatric Medication Plan as indicated”.
2. In response to public comments the Department amended the examples in Level 4 grid in §5.03-4 and in Appendix Four by adding language as follows:

* “Restraint that prohibits the Person’s ability to communicate, such as a restraint that interferes with a person’s ability to use gestural communication or sign language”
* “Use of a Restraint without an attempt to release, longer than 15 minutes”
* “Use of a Specialized Intervention “

1. In response to public comments the Department amended the list of Required Documents in Level 4 in §5.03-4 and in Appendix Four by adding “Psychiatric Medication Plan as indicated”
2. In response to comments, the Department amended these regulations by adding “Noxious Intervention” into the examples in the Level 5 grid in §5.03-4 and in Appendix Four.
3. In response to public comments the Department amended the list of Required Documents in Level 5 in §5.03-4 and Appendix Four by adding “In-Home Stabilization Plan as indicated” and Psychiatric Medication Plan as indicated,” and amending “Physician’s ~~Assessment~~ Evaluation.”
4. In response to public comments the Department made the following amendments:

* Under Required Approval in the Level 5 grid, in both §5.03-4 and Appendix Four amend the phrase:

“Commissioner or designee’s Signature”

* In §5.07(1)(A)(3) amend the phrase:

“Commissioner~~’s~~ or ~~D~~designee”

1. In response to public comments the Department added new §5.04-2(D)

“The Planning Team must incorporate a Functional Assessment to develop an individualized Positive Support Plan. The Positive Support Plan and the Functional Assessment may be a combined document or separate documents.”

1. In response to public comments the Department added new §5.04-2(E)

“The Planning Team must develop a procedure for documentation and review of the use of all strategies. At a minimum this documentation must be reviewed and approved by the Planning Team annually.”

1. In response to public comments the Department amended §5.04-3 as follows:

“When Psychiatric Medications are prescribed, the Planning Team must adhere to special procedures to ensure monitoring of the effects of such medication on health and mental functioning. Psychiatric Medications used as a Chemical Restraint must also comply with sections of these regulations on Chemical Restraints.

1. ~~While most Psychiatric Medications are not considered Chemical Restraints, when Psychiatric Medication is used as a Chemical Restraint, it must be treated as such.~~ Planning Teams must monitor and document the use of Psychiatric Medications at least annually.”
2. In response to public comments the Department made the following amendments:

* §5.03-3(A) as follows:

“If the Planning Team determines that Positive Supports alone are insufficient to prevent harm or danger to the Person or the community ….”

* §5.05-1(A) as follows:

“When a Person’s Challenging Behavior presents a threat of Imminent Risk of harm or danger to the Person or the community, ~~injury to self or others, threatens serious damage to the property of others,~~ or threatens loss of placement …”

1. In response to public comments the Department amended §5.05-1(C) as follows:

“Behavior Management Plans must describe all planned interventions which include restrictions of Rights or the use of Restraint. Behavior Management Plans must be developed by or ~~under the supervision of~~ in consultation with a qualified professional who must be a psychiatrist …”

1. In response to public comments the Department amended §5.05(1)(C)(4)(C) as follows:

“a description of strategies, which will be conducted or overseen by the qualified professional who ~~wrote or supervises~~ provides consultation on the Behavior Management Plan, …”

1. In response to public comments the Department amended §5.05-2(H) by adding the following:

“Prior to any use of a physical restraint or Specialized Restraint being implemented, all staff must be trained in accordance with an physical restraint or Specialized Restraint program approved by the Department. “

1. In response to public comments the Department amended §5.05-3(E) by moving part of it into the subsequent subsection (F) as follows and amended other language as :

“E. ~~Therapeutic Devices or Interventions, or approved safety devices to which the Person does not object~~~~and which are not intended as an intervention to a Challenging Behavior, are not considered Restraint under these regulations.~~ Physical prompts, physical assistance and physical supports ~~used in this~~ context to intervene in a Challenging Behavior must be clearly described in the Personal Plan and comply with Section 5.10-6.

F.Therapeutic Devices, or approved Safety devices to which the Person does not communicate an objectand which are not intended as an intervention to a Challenging Behavior, are not considered Restraint under these regulations.”

1. In response to public comments the Department switched §5.03(G) and (H) and repeated the last paragraph of §5.10-8 as the last sentence of §5.03(H)

“When use of monitoring devices is approved by the Review Team every effort must be made to maintain privacy and confidentiality in the use of these devices. The Behavior Management Plan must include procedures used to maximize privacy and maintain confidentiality.”

1. In response to public comments the Department deleted §5.08-2, Specialized Intervention and added most of the language from that section as new §5.05-4(D) which reads as follows:

“When a Behavior Management Plan includes a Specialized Restraint, the Planning Team must take into account the particular medical condition of the Person, the Person’s history of physical or sexual trauma, or other relevant factors that necessitate the use of a Specialized Restraint. In addition to all other required elements the Behavior Management Plan must include: identification of the need; and a description of the Specialized Restraint”

1. In response to public comments the Department amended §5.05-5(D) as follows:

“The Planning Team, with ~~the input of~~ in consultation with the qualified professional ~~responsible for the Behavior Management Plan~~, must review, monitor and document the effectiveness of the Plan at least quarterly.”

1. In response to public comments the Department amended the list of Prohibited Practices in §5.06 and in Appendix Five as follows:

* “Restraints that hyper-extend a joint~~, or put pressure on joints or chest~~
* “Restraints that put pressure on the chest”
* “A Restraint or physical intervention which puts the Person off balance not part of a physical restraint program approved by the Department”
* Deleted “binding of wrist to waist or wrist to bed” in Certain Mechanical Restraints and added this to the Level 5 grid in §5.03-4 and Appendix Four

1. In response to public comments the Department amended the title of §5.08 to read as follows:

“Emergency Interventions, Including Restraint, Removal Of Personal Property and Specialized Restraint ~~Accomodations~~

1. In response to public comments, the Department amended all uses of the phrase “Emergency Restraint” in §5.08 to read “Emergency Intervention”. Emergency Intervention includes restraint. Use of the phrase Emergency Restraint in these regulations is intended to have a more limited meaning than Emergency Intervention.
2. In response to public comments the Department amended §5.08-1(A) as follows:

“If necessary to protect the Person or community from Imminent Risk, ~~Restraint~~, Emergency Interventions, including Specialized Restraints, otherwise permitted in this regulation may be used on an Emergency basis.”

1. In response to public comments the Department amended §5.08-2 as follows:

“Where there is any history of Challenging Behavior or cause to believe ChallengingBehavior may occur, all direct support professionals who support the Person must be trained, in accordance with these regulations, in Positive Supports and appropriate use of Behavior Managementstrategies, and Emergency or Specialized Restraint programs approved by the Department.”

1. In response to public comments the Department amends §5.08-4 as follows:

“If Emergency Restraint is used on a Person more than three (3) times in a two-week period, or six (6) times in any 365-day period, or in a recurring pattern, or other Emergency Intervention (Specialized Restraint or removal or personal property) is used more than three (3) times in a 365-day period, the Planning Team must ensure a Functional Assessment is developed or updated and the Positive Support Planreviewed for effectiveness. In addition:”

1. In response to public comments the Department deleted §5.08-4(E) which read:
2. In response to comments the Department amended §5.10-2(C) of these regulations as follows:

“Hand splints or gloves ~~for instance~~ when used to prevent pica behavior ~~self-injury~~ or as a medically necessary intervention.”

1. In response to comments on monitoring devices the Department amended these regulations by:

* Amending §5.10-2(N)

“Monitoring devices that do not limit the person’s movement when used to monitor the movement of a person due to lack of environmental awareness or history of unintentionally falling ~~but do not limit the person’s movement~~. Examples of these devices include a sound monitor that picks up sounds in the vicinity of the person and transmits those sounds to staff, a chair alarm, a bed alarm, an ankle bracelet, a door alarm or light (including infrared light) ~~that alert staff that the person is moving within or leaving a particular area, a sound monitor that picks up sounds in the vicinity of the person and transmits those sounds to staff~~ a chair alarm, a bed alarm, an ankle bracelet, a door alarm or light (including infrared light)”

* removing §5.10-4(D) in its entirety,

~~Door chimes on an entrance to the residence, 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.~~

* Amending §5.10-8

“~~Monitoring devices may be approved by the Review Team on an individual basis. These~~ Monitoring devices must only be considered after less intrusive techniques have been tried and failed. Motion detectors, sound monitoring, and video monitoring devices must be supported by a history of a lack of environmental awareness and/or a related medical diagnosis, such as Dementia”

1. In response to public comments the Department amended Appendix One §D(1) as follows:

“completed by or ~~under the supervision~~ in consultation with ~~of~~ a person who has been designated by the Planning Team and who has training and experience in behavior analysis and Positive Supports;

1. In response to public comments the Department added new §A(2) to Appendix Three,

“Criteria that will be used for assessment of discontinuing the In-Home Stabilization.”

1. In response to public comments the Department amended Appendix Three, §C

“The proposed use of In-Home Stabilization for a period greater than one hour, but not to exceed 24 hours, is a Level 3 intervention. The use of a Level 2 In-Home Stabilizations three (3) times or more during any two week period of time requires review and approval as a Level 3 Plan. …”

1. In response to public comments the Department has amended Appendix Three, §E(3) as follows:

“A plan for in-person safety assessment of the Person by the qualified professional overseeing the plan ~~or the therapist currently treating the Person~~.”

1. In response to public comments the Department amended these regulations by making numerous technical corrections in this rule, including changes in grammar, capitalization, punctuation, numbering and format, and to remove contradictory language.