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SUMMARY:

These regulations are designed to implement Maine Law regarding the Rights of Children with Intellectual Disabilities or Autism Spectrum Disorder (Autism). These laws are primarily found in 34-B Maine Revised Statutes [henceforth M.R.S.] §§ 5601- 5610 (“Rights of Persons with Intellectual Disabilities or Autism”).

APPLICABILITY:

These regulations protect the Rights of any Child who resides or is found in Maine, as well as those Maine residents served by the Department outside of the state, who are Children, with Intellectual Disabilities or Autism Spectrum Disorder (Autism). These regulations apply to any Child with Intellectual Disabilities or Autism Spectrum Disorder (Autism) who receives services that are provided, licensed, or funded in whole or in part, directly or through a contractor, by the Department of Health and Human Services. Unless otherwise specified, these regulations apply in all circumstances where a Child with Intellectual Disabilities or Autism Spectrum Disorder who receives services is experiencing Challenging Behaviors. Where different standards of care or treatment apply, it is the intent of these rules that the more stringent standard be deemed applicable. If a Child is over 18 years of age services, the Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 Chapter 5) shall apply.

These regulations do not apply within schools, hospitals or correctional settings; nor do they apply to court-ordered restrictions, other than guardianship. These regulations generally do not apply to the use of Therapeutic Devices or Interventions implemented as part of occupational or physical therapy. They also generally do not apply to medical practice or the use of Psychiatric Medication for treatment of a diagnosed mental illness. However, when such devices or interventions are intended for Behavior Management they are subject to these regulations. It is the responsibility of the Child’s Planning Team to review and monitor these interventions.
I. STATEMENT OF PRINCIPLES AND INTENT

A. Principles

Provision of supports shall adhere to the principles of full inclusion, and services shall be delivered in a respectful, positive, healthy, and safe environment, while also taking into account each Child’s age and developmental ability. These services will also be provided with the goal of establishing positive social standing, building positive supports, increasing competencies and independence, learning life skills, and assisting the child to develop patterns and conditions of everyday life that are as close as possible to typically developing peers. Agencies providing support will be Trauma Informed and promote the Federal Substance Abuse and Mental Health Services Administration’s (SAMHSA) System of Care Principles of Family driven, 2) Youth guided, and 3) Culturally and Linguistically Competent care.

The Child’s Planning Team must create a Service/Treatment Plan that will assist the Child to develop skills and techniques that empower the Child to demonstrate positive, Prosocial Behavior. When a Behavior Plan is part of the Service/Treatment Plan, the child’s Planning Team must ensure and document in the Service/Treatment Plan consultation with licensed professionals to assess for the existence of conditions (physical and/or mental health) that may be contributing to Challenging Behaviors, including prescription and Psychiatric Medications. The child’s Planning Team will ensure that Service Providers work collaboratively when Behavior Plans are implemented across multiple environments. Each Service Provider is responsible for minimizing the negative impact of any restriction of Rights on other Children when a Behavior Plan is implemented that contains the use of restrictions of Rights and interventions that involve more than a minimal degree of risk.

Each child age 14 or over has the right to be fully and actively involved in the development or revision of his or her Behavior Plan. Involvement of Children who are younger shall be determined on a case by case basis, after assessment of the Child’s capacity to be involved. The exclusion of a youth age 14 or over requires the approval of the clinical director of the involved program or an independently licensed Clinician who have completed an assessment of the Child’s capacity to be involved. The Parent or Guardian shall be fully and actively involved in treatment or service planning to the maximum extent possible, given time and location constraints. Each Service Provider shall make good faith efforts, to involve Parents or Guardians and such efforts shall be documented.

B. Intent

The purpose of this rule is to ensure that services provided to Children with Intellectual Disabilities and Autism Spectrum Disorder, who are experiencing Challenging Behavior, are based upon positive support strategies, effective behavioral assessment, and least restrictive measures. Interventions are planned, consistent, and assure the Child’s individual Rights and well-being are recognized and protected during the course of treatment. It is the Department’s intent to ensure effective treatment is provided by trained and competent providers.

II. DEFINITIONS

Many of the terms or plans referenced in this regulation are technical in nature, such that the common understanding may not apply. 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.

Departmental rules may be viewed in their entirety at;  
http://www.maine.gov/sos/cec/rules/10/chaps10.htm#197

The Maine Revised Statutes (M.R.S.) may be viewed in its entirety at;  
http://www.mainelegislature.org/legis/statutes/

A. Advocate: means an employee of the Protection and Advocacy agency as designated pursuant to Title 5, section 19502 with whom the Department has contracted to provide the services described in 34-B M.R.S. 5005-A and 34-B M.R.S. 5605-B (3).

B. Autism Spectrum Disorder (Autism): means as defined by 34-B M.R.S. § 6002 “Definitions”.

C. Aversive: means an intervention or action intended to modify behavior that could cause harm or damage to a Child.

D. Behavior Management: means supports and strategies implemented to increase positive Prosocial Behaviors and prevent the occurrence of Challenging Behavior or to keep a Child or others safe by reducing the factors that lead to the Challenging Behavior or otherwise limiting a Child’s ability to engage in Challenging Behavior.

E. Behavior Plan: means a documented set of procedures that details the methods that will be used to prevent, mitigate, or respond to the Child’s Challenging Behaviors. The Behavior Plan includes all support strategies intended to reduce the likelihood of Challenging Behaviors. The plan is individualized, and must be written in language that is understandable to the people approving and implementing the plan and in alignment with SAMHSA’s System of Care principles.

F. Blocking: means a momentary deflection of a Child’s destructive or harmful movement, without holding, when that movement would otherwise be destructive or harmful. Blocking is not considered a Restraint. Blocking is considered protection.

G. Case Manager: means the individual assigned to coordinate and oversee the effectiveness of all providers, and who ensures the Child’s plan is implemented and addresses the assessed needs of the Child.

H. Challenging Behavior: means behavior that:

1. Presents an Imminent Risk to the health and safety of the Child or others;

2. Presents serious and Imminent Risk of damage to property of others;

3. Seriously interferes with a Child’s ability to have positive life experiences and maintain relationships, or independently perform age and developmentally appropriate activities of daily living, as determined by the Child’s Planning Team; or

4. Presents as persistent, chronic or repetitive behaviors(s) whose cumulative effects are deemed by a physician to pose a serious danger to the child’s health or well-being.
I. Chemical Restraint: means a medication is used to restrict the freedom of movement and/or to purposefully sedate a child.

J. Child(ren): means any person(s) who is under 18 years of age, with Intellectual Disabilities or Autism Spectrum Disorder (Autism).


L. Clinician – Doctoral Level: means a Clinician who has attained a Doctorate degree and has specific expertise in Children with Intellectual Disabilities and Autism Spectrum Disorder.

M. Coercion: means to persuade (an unwilling person) to do something by using force or threats.

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

O. Competing Response: means another behavior the Child may do in place of a repetitive behavior, often using the same muscle group.

P. Contingent: means reinforcement (or punishment) that is delivered only after the target behavior has occurred.

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

R. Differential Reinforcement (DR): means a procedure in which a specific desirable behavior is followed by Reinforcement while competing, undesirable behaviors are not. The expected result is an increase in the desirable behavior and extinction of the undesirable competing behaviors.

S. Electronic Device: means cell phone, device used for gaming, or other non-essential communication device. Excluded devices include any Electronic Device that serves as an augmentative communication device for that individual or durable medical equipment.

T. Emergency: means a situation in which there is Imminent Risk of harm or danger to the Child or others. Risk of criminal detention or arrest constitutes an Emergency.

U. Experimental Analysis: means an analysis involving the manipulation of consequences to determine behavior function.

V. Escort: means the temporary touching or holding of the hand, wrist, arm, shoulder, hip or back for the purpose of moving a Child voluntarily.

W. Functional Behavioral Assessment: means a formal evaluation conducted to identify setting events, antecedents, consequences, and motivating operations that influence the occurrence of Challenging Behavior.

X. Guardian: means Parent or person legally responsible for the Child.
Y. **Imminent Risk:** means reasonably certain to occur at any moment; such that a reasonable and prudent person would take steps instantly to protect the Child and others against the risk.

Z. **Intellectual Disability(ies):** is defined by “Definitions” [34-B M.R.S. § 5001(3)] as a condition of significantly subaverage intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period. For purposes of these rules, a child will be considered to have intellectual disability if the child meets the diagnostic criteria set forth in the most current version of the Diagnostic and Statistical Manual of the American Psychiatric Association.

AA. **Isolation:** means removing a Child from a stimulus by use of involuntary separation and restricted activity. Isolation may occur in an unlocked room where egress is not denied, with adequate supervision. It shall not mean confinement in a locked room.

BB. **Mechanical Restraint:** means an apparatus employed to restrain a Child, or the act of using an apparatus to address Challenging Behavior. A Mechanical Restraint is any item worn by or placed on the Child to limit behavior or movement and which cannot be removed by the Child. Mechanical Restraints include, but are not limited to, devices such as mittens, straps, arm splints, bed rails and helmets. They do not include positioning or adaptive devices when used prescriptively in accordance with 34-B M.R.S. § 5605 (“Rights and Basic Protections of a Person with Intellectual Disabilities or Autism”).

CC. **Noxious Stimuli:** means distasteful or unpleasant substance, procedure, action or condition and used only in cases of life threatening behavior or serious tissue damage.

DD. **Object of Repetitive Interest:** means an encompassing preoccupation with an object of interest that is abnormal in either intensity or focus.

EE. **Overcorrection:** means a response requiring a Child to clean or fix the environment more than necessary to restore it to its original state, and/or to practice repeatedly the correct way to do something as a consequence for having done something incorrectly.

FF. **Painful:** means that which causes strong emotional or physical discomfort to a Child.

GG. **Parent:** means a mother, father or legal Guardian of a Child.

HH. **Personal Property:** means privately owned items (such as clothing and jewelry) normally worn or carried on the Child and items of sentimental value. For the purpose of these regulations this does not include cell phones and electronic gaming devices. See Electronic Devices.

II. **Physical Prompt:** means a teaching technique that involves physical contact without coercion the Child and that seeks to enable the Child to learn or model the physical movement necessary for the development of the desired competency.

JJ. **Physician’s Evaluation:** means a review by a physician, physician assistant, or nurse practitioner to determine the safety of a proposed intervention.

KK. **Planning Team:** means the Parent/Guardian and the group of people, including the Service Provider, who are responsible for developing the Child’s Service/Treatment Plan, which may
include a Behavior Plan. Each Child age 14 or over has the right to be fully and actively involved in the development of the Behavior Plan.

LL. Prosocial Behavior means behavior that occurs when a Child demonstrates behavior accepted in society and acts in ways that benefits others.

MM. Protection and Advocacy agency (P&A): is the agency designated pursuant to Title 5, section 19502 with whom the Department has contracted with to provide the services described in 34-B M.R.S. 5005-A and 34-B M.R.S. 5605(B) (3).

NN. Psychiatric Medications: means drugs prescribed to stabilize or improve mood, mental status, or behavior. These medications are sometimes called “psychotropic” or “psychoactive” medications.

OO. Redirection: means the distraction or diversion of a Child’s attention away from a Challenging Behavior to a positive or neutral behavior; a suggestion, by word or gesture, that a Child try an alternate activity. Redirection does not include Coercion.

PP. Reinforcement / Reinforcer: means a response or event which increases the likelihood of the desirable behavior being repeated.

QQ. Response Cost: means the removal or withdrawal of some quantity of Reinforcers contingent on a response.

RR. Restraint: means a mechanism or action that limits or controls a person’s voluntary movement, deprives a person of the use of all or part of the person’s body or maintains a person in an area against the person’s will by another person’s presence or coercion. Restraint does not include:

1. Escort;
2. Physical prompt;
3. Physical contact when the purpose of the intervention is to comfort a Child and the Child voluntarily accepts the contact;
4. Blocking;
5. The use of seat belts, safety belts or similar passenger Restraint, when used as intended, during the transportation of a child in a motor vehicle;
6. The use of a medically prescribed harness, when used as intended; or
7. Therapeutic Devices and Safety Devices, to which the Child does not object and which are not intended as an intervention to a Challenging Behavior, are not considered Restraint under these regulations.

See also: Chemical Restraint and Mechanical Restraint.

SS. Review Team: a group, defined at 34-B M.R.S. § 5605(13) (B) (“Rights and Basic Protections of a Person with Intellectual Disabilities or Autism - Behavioral Support, Modification and Management”), that is responsible for reviewing and approving Behavior Management programs.
The group shall be composed of a representative from the advocacy agency designated pursuant to Title 5, section 19502, a team leader of the department's children's services division and the children's services medical director or the director's designee. The advocacy agency representative serves as a nonvoting member of the review team and shall be present to advocate on behalf of the person.

TT. Rights: means those Rights enumerated in 34-B M.R.S. § 5605 (“Rights and Basic Protections of a Person with Intellectual Disabilities or Autism”) and Rights of Recipients of Mental Health Services Who Are Children in Need of Treatment.

UU. Safety Device: means an implement, garment, gate, barrier, lock or locking apparatus, device, helmet, mask, glove, strap, belt, or protective glove, limited to the person in question whose effect is to reduce or inhibit the person’s movement in any way with the sole purpose of maintaining the safety of the person. Video monitoring and video alarms may also be considered Safety Devices when the child has a history of Challenging Behavior, and the video devices are used to monitor the Child in order to intervene when necessary to ensure safety. The Safety Device must be prescribed by a physician.

VV. Safety Procedures: means interventions in a Behavior Plan including the use of procedures that involve more than a minimal degree of risk, intrusion, restriction of movement, or possibility of physical harm or distress.

WW. Seclusion: means the solitary involuntary confinement of a Child for any period of time in a room or a specific area from which egress is denied by a locking mechanism, barrier or other imposed physical limitation.

XX. Service Provider: means an entity, organization, or individual, funded in whole or in part or licensed or certified by the Department, providing services to children with Intellectual Disabilities or Autism Spectrum Disorder (Autism). This includes employees of the State of Maine, and volunteers and students under the supervision and control of the Service Provider.

YY. Service/Treatment Plan: means a plan that identifies the needs of the child and describes services which will be provided to meet those needs. Behavior Plans may be a component of the Service/Treatment Plan. The Service/Treatment Plan is developed by the Planning Team.

ZZ. Systematic Desensitization: means a procedure to treat fear, phobia or avoidance. A hierarchy of fear or avoidance-producing stimuli is developed. Then, starting with the least avoidance-producing stimulus and working to the most avoidance-producing, the Child is exposed to stimuli on the hierarchy and is taught an alternative coping response (often relaxation response). Reinforcement is provided for success, and the Child moves on through the hierarchy as success is gained at lower levels.

AAA. Therapeutic Devices: means any device prescriptively designed by a qualified professional that has the effect of reducing or inhibiting a person’s movement in any way with the intent of providing medically necessary therapeutic benefit.

BBB. Timeout: means directing a child to a limited sensory situation or environment in the event of behavioral dysregulation. Timeout is used to immediately discontinue participation in the reinforcing activity when lesser restrictive interventions fail to correct inappropriate behavior. Timeout may be voluntary or involuntary.
1. Voluntary Timeout: means a break from an activity, or a quiet period initiated by the child to calm down. Voluntary Timeout may result from a non-Coercive choice or suggestion offered by staff.

2. Involuntary Timeout: means staff-directed removal from reinforcing stimuli. Removal from stimuli can take three forms: contingent observation, exclusion, or isolation. Contingent observation places a child away from an activity with the ability to continue to observe the activity and role-model positive behavior. Exclusion places a child away from an activity and prohibits observation of the activity. Isolation removes the child from the setting for a period of time before reintroducing the child to the reinforcing stimuli. Accepted practice for duration of Timeout is approximate age of child in minutes. Isolation must never become seclusion.

CCC. Token Economy: means a system in which tokens, which may later be exchanged for a desired item or activity, are used as Reinforcers.

DDD. Trauma Informed: means an approach to engaging people with trauma histories that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. Trauma-informed providers integrate trauma awareness and the following principles in all aspects of service delivery: safety, collaboration, choice, empowerment, and trustworthiness.

III. BEHAVIORAL PLANNING

When a Child is exhibiting Challenging Behavior, the Child’s Planning Team must design a Behavior Plan to help increase Pro-social Behavior and eliminate or reduce the frequency and severity of the Challenging Behavior. These Behavior Plan interventions must not be used for the convenience of others. The Child’s Planning Team must ensure that a Functional Behavioral Assessment is completed when required. Safety Procedures may also be a component of a Behavior Plan, and must be developed by or under the supervision of a qualified professional who must be a psychiatrist, a Clinician – Doctoral Level, or BCBA.

A. Behavior Plan

1. A Behavior Plan is a documented set of procedures that details the methods that will be used to prevent, mitigate, or respond to the Child’s Challenging Behaviors. The Behavior Plan includes all support strategies intended to reduce the likelihood of Challenging Behaviors. The plan is individualized, and must be written in language that is understandable to the people approving and implementing the plan and in alignment with SAMHSA’s System of Care principles. When a Child’s Challenging Behavior presents a threat of injury to self or others or threatens serious damage to the property of others, the Child’s Planning Team must act to ensure the Child’s safety and the safety of others. The Child’s Planning Team must continue to evaluate and implement the Behavior Plan while Emergency intervention is utilized or Safety Procedures are developed and implemented.

2. Behavior Plans include the following components:

   a. Rationale for the Behavior Plan, which includes occurrence, duration, intensity and/or severity of each Challenging Behavior;
b. Summary of any Functional Behavioral Assessment findings;

c. Relevant information from current evaluations, interviews, and any other information that provides justification for the Behavior Plan;

d. Target behaviors, precursor behaviors, and antecedent events are explicitly defined for the Challenging Behaviors addressed by the Behavior Plan – not all behaviors exhibited by the individual;

e. Preventative strategies including modifications to the environment and/or behavioral antecedents (visual and communication supports, modified schedules, switching out staff, etc.);

f. Teaching strategies that describe what skills will be taught and how;

g. Consequence strategies including positive Reinforcement systems and other responses to Challenging Behaviors;

h. Reactive Strategies that include explicit instructions (protocols) for responding to Challenging Behaviors and Precursor Behaviors, including Safety Procedures if applicable; and

i. Data Collection and Review system with attached data sheet and schedule of when and by whom data will be reviewed for the purpose of reducing reliance on restrictive procedures.

B. Functional Behavioral Assessment

1. A Functional Behavioral Assessment is a formal evaluation conducted to identify setting events, antecedents, consequences, and motivating operations that influence the occurrence of Challenging Behavior. It is required for Level 3 and 4 Behavior Plan development.

2. A Functional Behavioral Assessment must include information gathered by the following procedures:

   a. File review of current evaluations, reportable events, and data;

   b. Interviews with informants who can provide valid information regarding the current Challenging Behavior;

   c. Direct observation of the child at times when the Challenging Behaviors are likely and not likely to occur; and

   d. Any additional standardized social/behavioral measures the Child’s Planning Team will use to inform intervention planning.

3. A Functional Behavioral Assessment must include the following information regarding the Challenging Behavior:

   a. Definition;
b. Frequency and intensity;

c. History;

d. Factors that may contribute to its occurrence (e.g. illness, medication, environment);

e. Current management strategies, and their effectiveness; and

f. Other skills that may compete with the Challenging Behavior or promote a strengths-based approach to addressing it.

4. Either a descriptive or Experimental Analysis may be conducted. Experimental Analyses must be conducted in collaboration with a Board Certified Behavioral Analyst.

5. A report regarding the Functional Behavioral Assessment must be prepared and shall include the following sections:

a. Purpose of evaluation: A brief statement explaining the need for the Functional Behavioral Assessment. This may include information from archival records, interviews, data, etc.

b. Sources of information, including but not limited to:

1) Names of informants, and their relationship to the child;

2) Dates of interviews;

3) Names of rating scales used, if any;

4) Sources of any archival data that were analyzed;

5) Data collection methods;

6) Dates of direct observations; and

7) Any other sources of information that contribute to the Functional Behavioral Analysis.

c. Target Challenging Behavior definitions. Operational (explicit) definitions of Challenging Behaviors analyzed during the course of the Functional Behavioral Assessment.

d. Summary and analysis of gathered information, including:

1) Summary of relevant information from all data sources;

2) Explanation of why information was excluded from analysis (if applicable); and
3) Analysis of relevant information leading to the hypothesis about the function of the Challenging Behavior.

e. Hypothesis regarding Challenging Behavior function. Summary statement that includes setting events, antecedents, the target Challenging Behavior, and its probable function.

f. Recommendations that are linked to findings and address essential components of the Behavior Plan. This includes:

1) The rationale for the Behavior Plan;

2) Definitions of the target Challenging Behavior;

3) Preventative, teaching, consequence, and reactive strategies;

4) Data collection methods; and

5) Review schedule.

6. The Functional Behavioral Assessment is updated when the team determines the Behavior Plan including either Level 3 or 4 Interventions, informed by the current Functional Behavioral Assessment, has been ineffective.

C. Safety Procedures

Safety Procedures include all planned interventions that involve more than a minimal degree of risk, intrusion, restriction of movement or significant physical distress, are designed to maintain the safety of the Child and those in his/her environment, and are Level 3 or Level 4 interventions in a Behavior Plan. Safety Procedures must be developed by or under the supervision of a qualified professional who must be a psychiatrist, Clinician – Doctoral Level, or BCBA. Trainees in any of these professional categories may not develop or supervise the development of Safety Procedures.

1. Behavior Plans that include Safety Procedures must be approved by the Child Planning Team and Clinician – Doctoral Level or BCBA, and either the Review Team and/or Commissioner, depending on the level of interventions included in the plan (Level 3 or Level 4 [see Section IV]). Any planned use of law enforcement in response to Challenging Behavior is considered a Safety Procedure and is subject to appropriate review.

2. When Safety Procedures are included in a Behavior Plan, the following are required:

a. A plan for documentation of staff training in the included Safety Procedures and supervision of implementation of Safety Procedures by the Clinician – Doctoral Level or BCBA who wrote or supervises the Behavior Plan;

b. Training must be offered to others who may be supporting the Child, including family members;

c. Indicators for when the identified Safety Procedures should be initiated and when they should cease and the Child can resume the regular schedule or a modified schedule;
d. Indicators for when the identified Safety Procedure is ineffective and/or potentially harmful to the degree that additional supports may be required for stabilization of the event;

e. Identification of a method for the quarterly evaluation and documentation of the effectiveness of the Safety Procedure included in the Behavior Plan, including input from direct care staff and others involved in implementing the Behavior Plan; and

f. Identification of the criteria for eliminating or revising the Safety Procedures. Safety Procedures may be eliminated, revised, or reduced because they have been successful, because continued implementation is unlikely to be successful, or because the Safety Procedures are causing the Child or those in his/her environment more harm than benefit.

3. Conditions for Use of Safety Procedures. Safety Procedures must be designed and approved as required by this regulation prior to implementation of any non-Emergency restriction of Rights as enumerated in 34-B M.R.S. § 5605.

a. Safety Procedures may be authorized only when there is documentation that:

1. less intrusive attempts to address the behavior have been tried and have not yet succeeded; and

2. the Challenging Behavior that the Safety Procedures are designed to address poses imminent risk of harm to the child or others in his/her community; or

   the Challenging Behavior presents as persistent, chronic or repetitive behavior whose cumulative effects are deemed by a physician to pose a serious danger to the child’s health or well-being.

b. Any proposed Safety Procedure must pose less risk of physical or emotional harm to the child than the Challenging Behavior which it is designed to address. Only the least restrictive procedures needed to protect the Child or others may be used.

4. Additional Requirements when using Restraints as a Safety Procedure. When a Behavior Plan with Level 3 or Level 4 Interventions is submitted to the Review Team, the Child’s Planning Team and Clinician must ensure staff implementing or supervising the implementation of Restraint shall have successfully completed an appropriate training program, approved by the Department, for the identification and de-escalation of potentially harmful behaviors and the safe use of proposed Restraint procedure. Proposed Restraint procedures shall specify strategies for continuous monitoring and assessment of the Child’s physical condition, breathing, circulation or pain and there shall be specific procedures for attempting release and re-initiation of the Restraint if necessary.

5. Any use of a prohibited intervention, or restriction of Rights in a manner inconsistent with this regulation must be reported as required by “Rights and Basic Protections of a person with an Intellectual Disability or Autism - 14-A, Restraints” (34-B M.R.S. §5605 14-A).

D. Safety Devices and Therapeutic Devices

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

Review of the use of a Safety Device pursuant to this rule does not require a finding of a Challenging Behavior.

Except as provided in Section III.D.3, a Safety Device may not have as its purpose, in whole or in part, the provision of Behavior Management.

1. Review Process
   a. Any use of a Safety Device must be pursuant to a written recommendation from a physician qualified to practice in the state of Maine.
   b. Any use of a Safety Device must be approved by the Child’s Planning Team, and that approval must be recorded in a document that is part of the Child’s planning record.
   c. When a Child has a Safety Device that may impact other Children residing in the home or participating in the program by restricting their Rights, accommodations must be identified and implemented to minimize the impact on the other Children. The Personal Plan of each Child affected by the use of the Safety Device must indicate how that Child will be supported to minimize the negative impact of any restriction.
   d. When a video monitoring device or video recording is used and it is highly predictable that another Person will trigger or appear on the monitoring or recording device, the consent of that Person must be obtained.

2. Therapeutic Devices
   a. Any therapeutic device may only be applied under the supervision of a medical doctor, occupational therapist, or physical therapist licensed to practice in the state of Maine. The professional may delegate responsibility for the day-to-day application of the use or application of the support to others, as long as any other persons applying the support have been trained in the proper use of the support and the professional retains professional responsibility for the application of the support.
   b. The use and design of any Therapeutic Device must be individualized to the specific need of the person who is using the support, so as to meet the need and maximize the comfort of the person.
   c. Any Therapeutic Device must make allowance for the person to change body position.
   d. The impact upon the person’s body alignment and blood circulation must be considered in the use of any Therapeutic Device.
3. A helmet whose primary purpose is to protect a Child from self-injurious behavior or to diminish the degree of injury of a Child engaged in self-injurious behavior, or whose purpose is to prevent a Child from biting others, is presumed to be part of a Level 3 Behavior Management Plan for the first year of its use. The use of the helmet during that year is subject to the requirements for review under Sections IV and VII. A Review Team may exercise its discretion to classify the use of a helmet for the purposes enumerated in this paragraph as a Safety Device if after the expiration of the first year of the device’s use it concludes that the primary purpose of the use of the helmet is as a Safety Device and that review of the use of the helmet as behavior intervention is no longer necessary.

IV. BEHAVIOR PLAN DEVELOPMENT, APPROVAL, SUPPORTING DOCUMENTATION, AND INTERVENTION LEVEL TABLE (1-4)

There are four different review tiers for Behavior Plans, based on the level of restriction proposed. The criteria for Behavior Plan development, review, and approval differ at each level. The Child’s Planning Team is responsible for obtaining and documenting approval prior to implementation of any Behavior Plan. All interventions must be consistent with the Rights of Recipients of Mental Health Services who are Children in Need of Treatment. The level of the proposed plan is determined by the most intrusive intervention that appears anywhere in the plan. Interventions proposed at each level must be the least restrictive, most effective for the child at that time, and must be consistent with the Intent of these regulations as specified in section I.B. Summary tables for Behavior Plans with Level 1, 2, 3, and 4 interventions are included at the end of this section.

A. Behavior Plan with Level 1 Interventions

Programs developed by the Child’s Planning Team that includes non-coercive, developmentally appropriate interventions with voluntary participation by the child, designed to support the Child’s meaningful participation in his/her community.

1. Behavior Plan Development

The Child’s Planning Team develops a Behavior Plan with this level of intervention.

2. Behavior Plan Approval

The Child’s Planning Team must approve a Behavior Plan with this level of intervention and must document this approval in writing.

3. Supporting Documentation

Documentation required prior to implementation of a Behavior Plan with this level of intervention:

Baseline data on Challenging Behaviors that the team is hoping to decrease and on positive behaviors the team is hoping to increase to replace those Challenging Behaviors (Competing Responses or appropriate alternative responses).

B. Behavior Plan with Level 2 Interventions
Programs developed by a Clinician and the Child’s Planning Team which are designed to modify or redirect a Child’s behavior, and support the Child’s meaningful participation in his/her community.

1. Behavior Plan Development, Monitoring, and Revision

A Clinician and Child’s Planning Team collaboratively develop a Behavior Plan with this level of intervention. The Child’s Planning Team must maintain this required documentation for all Behavior Plans with Level 2 interventions:

a. Any previously implemented Behavior Plan with Level 1 interventions;

b. Behavior Plan with Level 2 interventions;

c. Data collection that includes antecedents and consequences to Challenging Behavior; documentation of Behavior Plan implementation, evaluation and modification; and

d. A written plan for moving to less restrictive interventions.

2. Plan Approval

A Clinician and the Child’s Planning Team must approve a Behavior Plan with this level of intervention and must document this approval in writing.

3. Supporting Documentation

a. Data collection including antecedents and consequences to Challenging Behavior.

b. A Physician’s Evaluation when it is suspected that an underlying medical condition may be contributing to the occurrence of the Challenging Behavior.

c. A Behavior Plan with Level 1 interventions must be attempted prior to implementation of a Behavior Plan with Level 2 interventions unless:

1) The Challenging Behavior poses Imminent Risk of harm to the child or others in his/her community; or

2) The Challenging Behavior presents as persistent chronic or repetitive behavior whose cumulative effects are deemed by a physician to pose a serious danger to the child’s health or well-being.

C. Behavior Plan with Level 3 Interventions

Programs developed by a Clinician and the Child’s Planning team in consultation with a Clinician – Doctoral level or BCBA, which restrict the Child’s rights as enumerated in 34-B MRSA §5605. Level 3 programs require Review Team approval prior to implementation, and are designed to support the Child’s meaningful participation in his/her community.

1. Behavior Plan Development, Monitoring, and Revision
A Clinician and the Child’s Planning Team in consultation with a Clinician – Doctoral Level or BCBA, collaboratively develop a Behavior Plan with Level 3 Interventions for submission to the Review Team and are responsible for collecting and maintaining information required by the Review Team.

2. Plan Approval

A Clinician and the Child’s Planning Team in consultation with a Clinician – Doctoral Level or BCBA must approve a Behavior Plan with this level of intervention and must document this approval in writing prior to submission to the Review Team. Written approval by the Review Team is required prior to implementation of a Behavior Plan with this level of intervention. Review Team approval is in effect for a maximum of 90 days from the initial approval date.

Approval of Level 3 Plans requires, at minimum, the following:

a. Complete documentation, as specified in IV.C.3;

b. All interventions in the plan are at Level 3, or below;

c. The plan contains no Prohibited Practices;

d. The plan is consistent with the Intent of these regulations (as specified in I.B.)

e. The plan is consistent with other applicable regulations, contract provisions, and Department policies;

f. The plan includes provision for appropriate monitoring of implementation of any Behavior Management and/or Safety Procedures, and training and supervision of staff;


3. Supporting Documentation

a. Documentation submitted to the Review Team must include:

   1) A Functional Behavioral Assessment;

   2) A summary of reportable events for the past year;

   3) Behavior Plan with Level 3 Interventions;

   4) Plan for training those implementing the program;

   5) Plan for assessment of fidelity of program implementation;
6) Physician’s Evaluation conducted within 30 days of submission to specifically rule out the possibility that the Challenging Behavior is medically based and that the intervention would not be counter-therapeutic or harmful;

7) Documentation of any previously attempted Level 1 and Level 2 Interventions; and

8) Any other information requested by the Review Team.

b. Written approval by the Review Team is required to continue implementation of a Behavior Plan with this level of intervention beyond the initial 90-day approval and every 90 days of implementation thereafter.

Documentation submitted to the Review Team for each 90-day review must include:

1) Any updated assessments,

2) Behavior Plan with Level 3 interventions that has been reviewed and approved by a Clinician, the Child’s Planning Team, Clinician – Doctoral Level or BCBA, and Review Team;

3) A written consultation note from the Clinician who is overseeing the Plan that documents observation of Plan implementation twice in the first month and then monthly (subsequent months of implementation) basis that includes summarized data that indicates frequency, duration, and/or intensity of the Challenging Behavior and a summary of reportable events since the prior approval date.

4) At the fourth 90-day review or if a significant change in physical or medical condition has occurred, the Child’s Planning Team also must submit documentation that a Physician’s Evaluation was conducted within 30 days of resubmission to the Review Team to specifically rule out the possibility that the Challenging Behavior is medically based and that continuing the Plan would not be counter-therapeutic or harmful and documentation of medication administration for any prescribed medications.

D. Behavior Plan with Level 4 Interventions

Programs developed by a Clinician-Doctoral level or BCBA and the Child’s Planning Team which restrict the Child’s rights as enumerated in 34-B MRSA §5605. Level 4 programs are considered only in exceptional and rare instances where no less restrictive measure can safely meet the need to keep a Child from danger to self or others. Level 4 programs require Review Team approval and the Commissioner’s approval prior to implementation.


A Clinician – Doctoral Level or BCBA and the Child’s Planning Team collaboratively develop a Behavior Plan with Level 4 Interventions for submission to the Review Team. The submitted plan is either a Behavior Plan with Level 4 Interventions submitted for initial approval or a submitted Level 3 proposal with which one Review Team member did not agree.
2. Behavior Plan Approval.

A Clinician – Doctoral Level or BCBA and the Child’s Planning Team must approve a Behavior Plan with this level of intervention and must document his/her approval in writing prior to submission to the Review Team. The Review Team will review the Behavior Plan and submit an approved Plan to the Commissioner. Written approval by the Commissioner is required prior to implementation of a Behavior Plan with this level of intervention. This approval is in effect for the duration indicated by the Commissioner.

Approval of Level 4 Plans requires, at minimum, the following:

a. Complete documentation, as specified in IV.D.3;

b. All interventions in the plan are at Level 4, or below;

c. The plan contains no Prohibited Practices;

d. The plan is consistent with the Intent of these regulations (as specified in I.B.)

e. The plan is consistent with other applicable regulations, contract provisions, and Department policies;

f. The plan includes provision for appropriate monitoring of implementation of any Behavior Management and/or Safety Procedures, and training and supervision of staff;

g. A clear step-by-step plan targeted to the elimination of the Challenging Behavior and the termination of the Level 4 procedures.


a. Documentation submitted for Commissioner review must include:

1) Any updated assessments;

2) A Functional Behavioral Assessment;

3) A summary of reportable events for the past year;

4) Behavior Plan with Level 4 Interventions;

5) Plan for training those implementing the program;

6) Plan for assessment of fidelity of program implementation;

7) Physician’s Evaluation conducted within 30 days of submission to specifically rule out the possibility that the Challenging Behavior is not medically based and that the intervention would not be counter-therapeutic or harmful;
8) Documentation from the physician that indicates the medical necessity of any Protective Devices;

9) Documentation of any previously attempted Level 1, Level 2, and or Level 3 Interventions;

10) Summary of any disagreements, Review Team recommendations, and any other information requested by the Commissioner. The Commissioner may choose to continue to review the Level 4 Behavior Plan at his/her discretion.

b. Written approval by the Review Team is required to continue implementation of a Behavior Plan with this level of intervention beyond the initial 90-day approval and every 90 days of implementation thereafter.

Documentation submitted to the Review Team for each 90-day review must include:

1) Behavior Plan with Level 4 interventions that has been reviewed and approved by a Clinician – Doctoral Level or BCBA, the Child’s Planning Team, and Review Team;

2) A written consultation note from the Clinician who is overseeing the Behavior Plan that documents observation of Behavior Plan implementation twice in the first month and then monthly (subsequent months of implementation) basis that includes summarized data that indicates frequency, duration, and/or intensity of the Challenging Behavior; and

3) At the fourth 90-day review or if a significant change in physical or medical condition has occurred, the Child’s Planning Team also must submit documentation that a Physician’s Evaluation was conducted within 30 days of resubmission to the Review Team to specifically rule out the possibility that the Challenging Behavior is medically based and that continuing the Behavior Plan would not be counter-therapeutic or harmful.

V. PROHIBITED PRACTICES

Prohibited Practices are those practices which will not be approved and must not be implemented at any level of intervention.

<table>
<thead>
<tr>
<th>PROHIBITED PRACTICES</th>
<th>Practices prohibited as elements of Behavior Plans or as Emergency Interventions. Descriptions include but are not limited to.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aversive stimuli</td>
<td>Interventions or actions intended to modify behavior that could cause harm or damage to a Child.</td>
</tr>
<tr>
<td>Corporal Punishment</td>
<td>The application of Painful stimuli to the body. Includes, but is not limited to, hitting, pinching, shocking, and shock devices.</td>
</tr>
<tr>
<td>Seclusion</td>
<td>The solitary involuntary confinement of a Child for any period of time in a room or a specific area from which egress is denied by a locking mechanism, barrier, or other imposed physical limitation.</td>
</tr>
<tr>
<td>Psychological/Verbal Abuse</td>
<td>The use of verbal or nonverbal expressions in any form which expose the Child to ridicule, scorn, intimidation, denigration, devaluation, or dehumanization. Includes humiliation or degrading treatment and threatening a Child with loss of his/her home.</td>
</tr>
<tr>
<td><strong>Restriction of Activities or Contact with Family or Significant Others</strong></td>
<td>Regularly scheduled social activities cannot be restricted as part of a Behavior Plan. This includes denial of regularly scheduled communication or visitation with family members or significant others for the purpose of Behavior Management.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>Denial of Basic Needs</strong></td>
<td>Denial of sleep, shelter, bedding, access to bathroom facilities, or withholding of food or drink not associated with prescribed medical treatment. Limiting medical or dental care. Taking away a communication system when it is the Child’s sole means of communication.</td>
</tr>
<tr>
<td><strong>Limiting a Child’s Mobility</strong></td>
<td>Removing or refusing, for the purpose of Behavior Management, items such as crutches, glasses, hearing aids, or a wheelchair to limit a Child's mobility.</td>
</tr>
<tr>
<td><strong>Manipulation of Personal Property</strong></td>
<td>Personal Property may not be manipulated for the purposes of behavior modification or behavior management, except to address imminent risk of harm to self or others, or when the object itself is the cause of risk to health and safety. Personal Effects do not include Electronic Devices.</td>
</tr>
</tbody>
</table>
| **Certain Restraints** | • Use of Restraint as punishment, for the convenience of staff or as a substitute for rehabilitative services.  
• Restraints involving excessive force, punching, hitting, head hold.  
• Prone Restraint, in which the Child is held face down.  
• Restraints that have the Child lying on the ground or in a bed with a worker on top of the Child, on the back or chest, or straddling or sitting on the torso.  
• Restraints that restrict breathing or inhibit the digestive system.  
• Restraints that hyper-extend a joint, or put pressure on joints or chest.  
• Restraints that rely on pain for control.  
• Restraints that rely on a takedown technique (in which the Child is not supported, allowing for free fall to the floor) or force the Child to his/her knees or hands and knees.  
• Restraint that involves physical contact covering the face.  
• Any Restraint face first against a wall, railing or post.  
• A Restraint or physical intervention which puts the Child off balance.  
• Restraints that do not conform to these regulations or Rights of Recipients of Mental Health Services Who Are Children In Need of Treatment. |
| **Certain Mechanical Restraints** | • Totally Enclosed Crib.  
• Binding of wrist to waist or wrist to bed.  
• Camisole or straightjacket.  
• Restraint Chairs.  
• Harnesses.  
• Bed netting.  
• Swaddling, from which the Child cannot remove him/herself. Swaddling from which the Child can remove him or herself but to which the Child or other member of the Planning Team communicates a specific objection.  
• Prone Mechanical Restraint in which the child is held face down. |
| **Emergency use of Chemical Restraint** | • Any Emergency Use of Chemical Restraint.  
• Use of medication as punishment, for the convenience of staff, as a substitute for a rehabilitation plan. |
| **Use of Emergency Restraint** | |
| in which there is no Imminent Risk |   |
## VI. INTERVENTION TABLE (Levels 1-4)

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Plan Development</th>
<th>Plan Approval</th>
<th>Supporting Documentation for Behavior Plan</th>
<th>Examples (<em>Include but are not limited to</em>)</th>
</tr>
</thead>
</table>
| 1     | Non-coercive, developmentally appropriate interventions. Voluntary. | Planning team | Planning team | Baseline data on challenging behaviors. | • Corrective feedback  
• Differential Reinforcement  
• Environmental modification  
• Physical Prompts for teaching or personal support without coercion  
• Positive Reinforcement  
• Scheduled access to toys or activities  
• Teaching skills (e.g. communication skills, relaxation, etc.)  
• Verbal Redirection or verbal prompting to redirect behavior  
• Voluntary Timeout |

| 2     | Interventions designed to modify or redirect a Child’s behavior, and support the Child’s meaningful participation in his/her community. | Planning team  
• Planning team  
• Clinician | Planning team  
• Clinician | Data collection  
• Physician’s evaluation  
• Behavior Plan from Level 1 | • Alarms/buzzers/sensors for safety on windows or unlocked doors  
• Removal of scheduled access to toys or Electronic Device for less than an hour other than for Imminent Risk  
• Response Cost procedures  
• Token Economy  
• Systematic Desensitization  
• Time out from Reinforcement less than or equal to the child’s age in minutes  
• Use of electronic self-monitoring devices (e.g. urine detectors, medical monitoring devices, MotivAider) |
<table>
<thead>
<tr>
<th>3</th>
<th>Restrict a Child’s Rights as enumerated in 34-B 5605</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planning team</td>
</tr>
<tr>
<td></td>
<td>Clinician</td>
</tr>
<tr>
<td></td>
<td>Consult w/Clinician—Doctoral, or BCBA</td>
</tr>
<tr>
<td></td>
<td>Submit to review team</td>
</tr>
<tr>
<td></td>
<td>Planning team</td>
</tr>
<tr>
<td></td>
<td>Clinician</td>
</tr>
<tr>
<td></td>
<td>Consult w/Clinician—Doctoral, or BCBA</td>
</tr>
<tr>
<td></td>
<td>Submit to Review Team</td>
</tr>
<tr>
<td></td>
<td>Functional Behavioral Assessment</td>
</tr>
<tr>
<td></td>
<td>Summary of reportable events for past year</td>
</tr>
<tr>
<td></td>
<td>Plan for training those implementing the program</td>
</tr>
<tr>
<td></td>
<td>Plan for assessment of fidelity of program implementation</td>
</tr>
<tr>
<td></td>
<td>Physician’s Evaluation conducted within 30 days of submission</td>
</tr>
<tr>
<td></td>
<td>Documentation from the physician that indicates the medical necessity of any Protective Devices</td>
</tr>
<tr>
<td></td>
<td>Documentation of any previously attempted Level 1 and Level 2 Interventions</td>
</tr>
<tr>
<td></td>
<td>Any other information requested by the Review Team</td>
</tr>
<tr>
<td></td>
<td>Indirect monitoring designed to track movement or activity (i.e. video monitoring)</td>
</tr>
<tr>
<td></td>
<td>Use of the following procedures as part of a Behavior Plan, or more than 3 times in a consecutive two-week period, or six times in 6 months, or in a recurring pattern intended to decrease the frequency, intensity, and/or duration of a behavior</td>
</tr>
<tr>
<td></td>
<td>Overcorrection</td>
</tr>
<tr>
<td></td>
<td>Removal of scheduled access to toys or Electronic Devices for longer than 1 hour</td>
</tr>
<tr>
<td></td>
<td>Restriction of access to an Object of Repetitive Interest that significantly interferes with daily functioning and/or ITP goals</td>
</tr>
<tr>
<td></td>
<td>Contingent changes in established routines to limit access to social opportunities</td>
</tr>
<tr>
<td></td>
<td>Time Out from reinforcement exceeding the child’s age in minutes</td>
</tr>
<tr>
<td></td>
<td>Vehicular Restraints more restrictive than typically used for that age and size</td>
</tr>
<tr>
<td></td>
<td>Use of Isolation and/or Emergency Physical Restraint</td>
</tr>
</tbody>
</table>
| 4 | **Restrict Child’s Rights as enumerated in 34-B 5605. Considered only in exceptional and rare instances.**  
- The level of risk or restriction must not outweigh the potential harm from the Challenging behavior being addressed.  
- Plans that pose a potential harm that the Review Team deems atypical may be required to meet Level 4 requirements.  
- Prohibited practices will not be considered for approval. |
|-----------------------------------------------|
| Planning team  
Clinician–Doctoral or BCBA  
Submit to review team |
| Planning team  
Clinician–Doctoral or BCBA  
Submit to Review Team  
Commissioner or designee |
| Updated assessments  
Functional Behavioral Assessment  
Summary of reportable events for past year  
Plan for training those implementing the program  
Plan for assessment of fidelity of program implementation  
Physician’s Evaluation conducted within 30 days of submission  
Documentation from the physician that indicates the medical necessity of any Protective Devices  
Documentation of any previously attempted Level 1, Level 2, and or Level 3 Interventions  
Summary of any disagreements, Review Team recommendations, and any other information requested by the Commissioner |
| Contingent presentation of noxious sensory or physical stimuli, intended to decrease the frequency, intensity, and/or duration of a behavior |
VII. REVIEW TEAM PROCEDURES

A. Review Team

A Review Team is responsible for review and disposition of all Behavior Plans at Level 3 or above. The Commissioner or Commissioner’s designee is responsible for review of all Behavior Plans at Level 4. Each proposed Behavior Plan must be reviewed at the appropriate level corresponding to the most intrusive intervention that is proposed in the Behavior Plan. The Review Team is responsible for determining whether the proposed Behavior Plan is at Level 3 or Level 4, based on its evaluation of the Safety Procedures outlined in the Plan.

Consistent with 34-B M.R.S. § 5605(13) (B), Review Teams shall be composed of:

1. Office of Child and Family Services Medical Director or designee;
2. Office of Child and Family Services Team Leader; and
3. Representative of the Protection and Advocacy Agency.

If any of the review timelines for initial or ongoing reviews cannot be met by the Review Team, current plans can remain in effect with written provisional approval until the Review Team convenes.

B. Initial Review Team Procedure (Level 3 Behavior Plans)

1. Each Service Provider will submit the proposed Behavior Plan with required supporting documentation requesting approval by the Review Team.

2. When all documentation has been received by the Review Team, a meeting will be scheduled with the Service Provider within 30 days of the request.

3. A representative of the Service Provider will be present for the Review Team meeting unless there are unusual circumstances which would prohibit in person participation (i.e. Service Provider out of state, weather, etc.). In that situation a Service Provider may participate by telephone or other means of long distance communication. The Parent/Guardian and Case Manager will be invited to attend, but may decline if they so choose.

4. At the conclusion of the Review Team meeting the following determinations may be made regarding the proposed Behavior Plan:

   a. Approval of Behavior Plan submitted to Review Team;

       Written documentation of the approval will be provided by the Review Team. This approval is in effect for a maximum of 90 days from the Review Team meeting date. The use of a Therapeutic Device or Safety Device may be approved for up to 365 days from the Review Team meeting date;

   b. Approval with modifications of the Behavior Plan submitted to the Review Team;
A Review Team may elect to approve part of the proposed Behavior Plan. In this case the Review Team is approving specific intervention(s) and not the entire Behavior Plan. This decision must be unanimous. Written documentation will be provided to the Service Provider regarding conditions of approval by the Review Team. This approval with modifications is in effect for a maximum of 90 days from the Review Team meeting date.

c. Behavior Plan submitted to Review Team Not Approved; and

Written documentation of the reason a plan is not approved will be provided to the Service Provider by the Review Team.

d. Behavior Plan submitted to Review Team not approved due to need for more information. The Review Team may require additional information to make a determination.

5. No Behavior Plan with Level 3 interventions shall be implemented without appropriate approval as provided by these regulations.

6. A Review Team member may grant written provisional approval of all or part of a Behavior Plan with Level 3 interventions requested for an Emergency. Provisional approval must not exceed thirty (30) days. After thirty (30) days the Child’s Planning Team must meet all regular requirements for the review and disposition of the Behavior Plan.

C. Initial Review Team Procedure – (Level 4 Behavior Plans)

1. Each Service Provider will submit the proposed Behavior Plan with required supporting documentation requesting approval by the Review Team.

2. When all documentation has been received by the Review Team a meeting will be scheduled with the Service Provider within 30 days of the request.

3. A representative of the Service Provider will be present for the Review Team meeting unless there are unusual circumstances which would prohibit in person participation (i.e. Service Provider out of state, weather, etc.). In that situation a Service Provider may participate by telephone or other means of long distance communication. The Parent/Guardian and Case Manager will be invited to attend, but may decline if they so choose. At the conclusion of this meeting the Review Team will make its recommendations.

4. The Review Team will forward the proposed Behavior Plan, supporting documentation and written recommendations from all the Review Team members to the Commissioner.

5. The Commissioner will approve or not approve the proposed Behavior Plan. The Commissioner may request additional information in order to make a determination.

6. If the Commissioner approves the proposed Behavior Plan, the Review Team will assume responsibility for monitoring the plan at the direction of the Commissioner.

D. Ongoing Review Team Procedure (Level 3 and Level 4 Behavior Plans)
1. Written approval by the Review Team is required to continue a Behavior Plan with Level 3 or Level 4 interventions beyond the maximum initial 90 day approval period, and every 90 days thereafter, or less as determined by the Review Team.

   Written approval by the Review Team is required to continue a Behavior Plan with Level 3 or Level 4 interventions beyond the maximum initial 365 day approval period for the use of a Therapeutic Device or Safety Device, and every 365 days thereafter, or less as determined by the Review Team.

2. Each Service Provider will submit the proposed Behavior Plan with required supporting documentation 10 business days prior to the scheduled meeting with the Review Team.

3. A representative of the Service Provider will be present for the Review Team meeting unless there are unusual circumstances which would prohibit in person participation (i.e. Service Provider out of state, weather, etc.). In that situation a Service Provider may participate by telephone or other means of long distance communication. The Parent/Guardian and Case Manager will be invited to attend, but may decline if they so choose.

4. At the conclusion of the Review Team meeting the following determinations may be made regarding the proposed Behavior Plan:

   a. Approval of Behavior Plan submitted to Review Team:

      Written documentation of the approval will be provided by the Review team. This approval is in effect for a maximum of 90 days from the Review Team meeting date. The approval for the use of a Therapeutic Device or Safety Device is in effect for a maximum of 365 days from the Review Team meeting date.

   b. Approval with modifications of the Behavior Plan submitted to the Review Team:

      A Review Team may elect to approve part of the proposed Behavior Plan. In this case the Review Team is approving specific intervention(s) and not the entire Behavior Plan. This decision must be unanimous. Written documentation will be provided to the Service Provider regarding conditions of approval by the Review Team. This approval with modifications is in effect for a maximum of 90 days from the Review Team meeting date.

   c. Behavior Plan submitted to Review Team Not Approved:

      Written documentation of the reason a plan is not approved will be provided to the Service Provider by the Review Team; and

   d. Behavior Plan submitted to Review Team not approved due to need for more information.

      The Review Team may require additional information to make a determination.

VIII. EMERGENCY INTERVENTIONS, INCLUDING RESTRAINT, REMOVAL OF PERSONAL PROPERTY AND SPECIAL ACCOMMODATION

A. Emergency Intervention
Emergencies occur when a Child’s Challenging Behavior presents an Imminent Risk to the health and/or safety of the Child or others.

1. If necessary to protect the Child or others from Imminent Risk, Restraint otherwise permitted in this regulation may be used on an Emergency basis.

2. When Emergency Restraint is utilized, the least restrictive technique necessary to make the situation safe must be used, and any specific procedures that take into account a particular medical condition, history of physical or sexual trauma, or other relevant factors regarding the Child must be followed.

3. Any Emergency intervention must be terminated as soon as the need for protection is over; no further restriction may be imposed.

4. Emergency intervention may include temporary removal of personal property to protect the Child from Imminent Risk of injury. The property must be returned as soon as it is safe to do so as required by “Rights and Basic Protections of a Person with Intellectual Disabilities or Autism - 6. Personal property” (34-B M.R.S. § 5605.6).

5. Whenever Emergency Restraint is used, it must be reported as required by “Rights and Basic Protections of a person with an Intellectual Disability or Autism - 14-A, Restraints” (34-B M.R.S. §5605 14-A).

6. Prohibited practices, as outlined in Section V of this regulation, must not be used on an Emergency basis.

B. Training in Emergency Interventions

Where there is any history of Challenging Behavior or cause to believe Challenging Behavior may occur, all direct care staff who support the Child must be trained, in accordance with these regulations, in appropriate use of behavior support strategies and Emergency Restraint. Training in Child-specific Emergency procedures (content, participation, proficiency, and ongoing review) also must be documented.

C. Recurring Emergency Restraint

The predictable and routine use of Emergency Restraint does not afford a Child the level of protection and oversight intended by these regulations.

If Emergency Restraint is used on a Child more than three (3) times in a two-week period, or six times in any six month period, or in a recurring pattern, the Child’s Planning Team must ensure a Functional Behavioral Assessment is conducted or updated and that the Behavior Plan is reviewed for effectiveness.

IX. TRANSITION OF EXISTING BEHAVIOR PLANS

A. Behavior Plans Already in Effect

For Behavior Plans approved and in effect prior to the effective date of this regulation, Planning Teams must within ninety (90) days:
1. Develop a Behavior Plan that meets all criteria, including required approvals, within this regulation regarding that Behavior Plan: or

2. Obtain Review Team approval for a transition Behavior Plan and within 6 months of the effective date of this regulation develop a Behavior Plan which meets all criteria, including required approvals, within this regulation.

B. New Behavior Plans

All Behavior Plans submitted on or after the effective date of this regulation must meet all criteria, at the time of submission.