Eagle Lake Office
PO Box 310
Eagle Lake, ME 04739
Telephone (207) 444-5152
Fax (207) 444-6099

Caribou Office
PO Box 187
Caribou, ME 04736
Telephone (207) 492-1036
Fax (207) 492-1830

Testimony of Northern Maine General

LD 769 An Act Regarding Access to Behavioral Health Supports for Adults with Certain Disabilities. - **Ought Not to Pass**

To: Joint Standing Committee on Health and Human Services

March 18, 2025

Greetings Senator Ingwerson, Representative Meyer and esteemed members of the Health and Human Services Committee. Thank you for the opportunity to come before you to offer testimony on LD 769. *LD 769 An Act Regarding Access to Behavioral Health Supports for Adults with Certain Disabilities.*

My name is Michelle Raymond. I am the Chief Executive Officer for Northern Maine General (NMG), a not for profit social services organization that has been serving individuals throughout Aroostook County for over 117 years. Our mission is to provide individuals with the highest standards of care and help all of the people we serve enjoy life to their fullest potential. Our service area covers all of Aroostook County, but predominately the northern and central areas.

NMG has been known to support individuals with significant behavioral challenges over the years. NMG's policies include using the least intrusive method necessary to maintain a person's safety and we train our staff in the MANDT System. I have over 25 years' experience in implementing, developing, and/or training staff on the use of existing behavioral plans, that include physical interventions (i.e. blocking/restraints) to address challenging behaviors. To provide understanding, a challenging behavior is currently defined as: behavior that, "*Presents an Imminent Risk to the health and safety of the Person or the community*"; or "*Presents serious and Imminent Risk of damage to property of the community"*; or "*Seriously interferes with a Person's ability to have positive life experiences and maintain relationships*."

I have over ten years' experience as an instructor of the MANDT System, a Department approved training, that addresses healthy relationships and self-awareness as the first steps in the process of helping others co-manage their behavior and includes restraint as a last resort and only under the right circumstances. I have personally been restrained by other staff during training sessions many times over the years and can state that I do not enjoy being restrained or applying a restraint, but there are some circumstances and some needs that require that intervention to afford safety for all involved: the person, their peers/community, and staff. It is just as

important to a provider community that both the individual supported and their staff are safe and have the most useful and appropriate tools available.

I appreciate the opportunity given by the Department to participate in the stakeholder group they facilitated this past year to review and provide feedback on existing Chapter 5 rules. However, LD 769 came as a surprise to me and other stakeholders as we were not informed of what the final proposal would be, until this bill was drafted and submitted to Legislature. While I respect the Department's effort to respond to the many voices who have been negatively impacted by such interventions in their past, this Act doesn't take into consideration the needs and wants of those who have been positively impacted.

My 25 years' experience in supporting people with challenging behaviors has been that over time, the use of planned restraints can and are often reduced or even eliminated. However, there are others whose planning team continues to identify that the need remains, at least on occasion, for personal safety and to fully engage in their activities within their community. It's important to understand that current rule requires that before planned restraints can be implemented, that other less restrictive interventions must be first tried and fail to sufficiently address the challenging behavior. Sometimes these plans are a year in the making while attempting other interventions and documenting the response. For those individuals with a current planned restraint, there is no provision in the proposed Act that provides them with a practical alternative solution that meets their needs. While I agree that a planned restraint is intrusive and a least desirable option, in some cases there simply is no better alternative for the person and to terminate this support without an alternative, leaves individuals at risk for harm, loss of placement, loss of community, reduced participation in preferred activities, hospitalization, etc.

Concerns:

1. Removing planned restraint from rule as an option for those who currently **have <u>a need</u> (determined by their medical and clinical professionals, themselves and/or their guardian, and their planning team**), leaves people today and in the foreseeable future without a practical alternative. If a person needs 15-30 blocks a day to keep them from engaging in self injurious behaviors such as hitting their hand/fist against their eye repetitively during day, this rule would deny staff from accessing an individualized plan addressing the behavior in ways that least disrupt the person and make the intervention more therapeutic and less intrusive. Some people supported simply don't have the communication skills and revert to "old" learned behaviors during times of stress, frustration, discomfort, etc. This can be a process of elimination for some people and they need intervention until they and staff can better identify the trigger and meet the person's needs. In some cases, it is critical staff be trained on a person's triggers and signs of escalation and steps on when and how to intervene within a very short window of opportunity to be effective.
    - Example: a nonverbal person with IDD who has very limited communication skills reverts to old self harm behaviors when in pain or ill. It may take hours- days – weeks to find the "cause". During that time, the person planned restraints/blocking may be implemented as needed

while staff and team work diligently to find the cause. This person may only need this intervention 2-3 times a year but it could be as much as 30 times/day depending on their overall health and wellbeing.

2. The removal of this resource may unwittingly change how Providers consider referrals, leaving those with the most challenging behaviors without the supports of **qualified and experienced providers** likely resulting in more law enforcement responses and hospitalizations
3. There is no revision or definition of what "a planned restraint" is, so in current rule, this would also include "blocking" someone or releasing from a person's hold (hair pulling, grabbing extremities, clothing, etc. To remove a planned block from a person's support plan would only cause more escalation and/or injuries. What is the definition of a planned restraint as it relates to this bill? Currently providers understand this to be a restraint that is written into the plan, providing guided direction to staff to address the individual's specific medical/physical needs, history to include consideration of trauma, may include specific target behaviors that have been determined to be signals that safety is of imminent risk, etc.
4. Emergency restraints are those skills taught to a staff but not described in writing and without person-centered considerations. Staff are trained in skills that are general and combine principals of body mechanics and observation guidelines. The application is not specific to a person and may or may not work for that particular person in that particular situation. Some people have specific needs regarding restraints: they may have a medical consideration, a history of trauma, or a physical consideration that requires some strategizing and planning.
5. What is the difference or definitions of the positive behavioral support plans noted in subsection 13-A, A-C.?
6. I have concerns about the removal of the current oversight committee charged with approving and monitoring such plans. I believe this is a necessary added layer of oversight that supports a member and provides a level of experience and neutrality. I would welcome revision to the process to make it more efficient.
7. The removal of house rules was o discussed in the stakeholder group and denies housemates the ability to establish rules under which they can agree allows for a more harmonious environment among those residing in the home. This might include: which room(s) an overnight guest might stay when invited to stay over, it might include developing a quiet period, such as between 11pm and 7am where housemates identify a time span where each person moderates their noise level in the home to accommodate those who wish to sleep, it can include taking turns when deciding what to watch on the common television, etc.

I appreciate that there is an attempt to separate safety plans from behavioral support plans, reducing the need for cumbersome steps for approval.

I appreciate the idea that the Department would engage the services of a qualified psychologist to oversee the plans as currently Members have difficulty in finding a qualified professional to assist in plan development.

I am recommending that LD 769 Out Not to Pass and request the Department work more closely with experienced providers to review and develop a more practical change to the current rules that meets the needs of all Mainers.

Thank you for your time and consideration of my testimony. Please feel free to contact me with any questions you may have.

Respectfully,

Michelle Raymond, CEO
Michelle.raymond@nmgeneral.org
Town of Eagle Lake